Magellan Healthcare, Inc.*

Provider Handbook Supplement for Idaho Behavioral Health Plan

Revised Aug. 26, 2024

*Magellan Healthcare, Inc., its affiliates and subsidiaries, Is an affiliate of Magellan Health, Inc.

Magellan HEALTHCARE®

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SECTION 1: INTRODUCTION

Welcome

Welcome to the Idaho Behavioral Health Plan (IBHP) Provider Handbook Supplement, which addresses policies and procedures specific for the IBHP. This provider handbook supplement is to be used in conjunction with the Magellan National Provider Handbook (and Magellan organizational provider supplement, 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 IBHP supplement prevail.

Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our IBHP dedicated website at www.MagellanofIdaho.com. We have designed www.MagellanofIdaho.com for you to have quick and easy access to information and answers to questions you may have about working with Magellan.

- Through the Availity Essentials portal, accessed at www.Availity.com, you can look up authorizations and verify the status of a claim online, in addition to completing other key provider transactions.
- For authorizations, claims status inquiries and complaints and grievances, contact Magellan Healthcare of Idaho at 1-855-202-0983.
- For general inquiries, contact Magellan's national Provider Services Line at 1-800-788-4005.
- For Idaho network-specific inquiries, email us at IdahoProvider@MagellanHealth.com or call the provider line at 1-855-202-0983.

Idaho Behavioral Health Plan (IBHP) Introduction

The Idaho Department of Health and Welfare (IDHW) partnered with Magellan Healthcare to serve as the state-wide administrator for the new Idaho Behavioral Health Plan (IBHP) to administer and also transform the state's behavioral health system of care. The IBHP is the framework for how behavioral health and substance use disorders are administered in Idaho. Magellan manages behavioral health services for the Divisions of Behavioral Health and Medicaid. Magellan also manages the provider network for the Department of Juvenile Corrections. We oversee behavioral health services for Idahoans who don't have health insurance as well as those who have Medicaid or other types of insurance. IBHP serves approximately 425,000 children and adults with complex behavioral health needs.

Covered Services

Refer to Appendix C IBHP Program Services.

Eligibility Contact Information

Individuals who are not eligible for Medicaid, but who need services and may qualify for other state funding, may speak with a representative from Magellan who will help determine their eligibility for other state funding. You may refer a member to 1-855-202-0973 for assistance, or you may help them call Magellan. Magellan also has a referral form on www.MagellanofIdaho.com.

SECTION 2: MAGELLAN'S IBHP PROVIDER NETWORK

Network Provider Training

Overview

Magellan is committed to promoting quality behavioral healthcare services to members of the IBHP. In support of this commitment, providers must complete required trainings prior to caring for members. Magellan's comprehensive provider education and training strategy supports the provider learning journey through new provider orientation, ongoing education, and annual training. We utilize a blended approach of self-directed and leader-led trainings.

Provider Required Trainings

For required provider training, visit the Events & Training page of www.MagellanofIdaho.com. Magellan has developed online training courses approved by the state. Providers can access these training courses and submit an attestation form at the end of the training for proof of participation. Additionally, live, instructor-led training is also available to providers.

New Provider Orientation

Magellan has developed a comprehensive training to give Magellan network providers specific information on the delivery of behavioral healthcare services to members of the IBHP. The training is intended to complement this Idaho Provider Handbook Supplement and the Magellan National Provider Handbook. New provider orientation training provides information from Magellan in the following areas: network, contracting, authorization procedures, claims submission, quality and compliance, cultural competency, Magellan's systems, and provider data management. We designed it for providers who are new to Magellan, however, it also is a helpful overview for more tenured providers who want to refresh their knowledge of Magellan's policies and procedures. We share it with providers during the contracting process. It can also be obtained at any time by visiting the Events & Training page of the Magellan Healthcare of Idaho website or by contacting a member of our team. **We highly recommend that you complete the orientation training before providing services to IBHP members.**

Annual Training

Providers are responsible for completing required annual training to review updates to the Provider Handbook, the Center of Excellence, and other critical guidance and communications for providers. Annual training will be available online for all providers. The training seamlessly integrates with our Learning Management System, accessible through our website at www.MagellanofIdaho.com. This integration facilitates robust reporting functionalities essential for compliance purposes.

On Demand/Ad Hoc Training

Magellan offers ongoing provider training to support quality services for IBHP members. 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.

We look forward to working with you in the delivery of quality behavioral healthcare services to IBHP members. You can contact the Idaho Training Team at MagellanIdahoTraining@MagellanHealth.com with any questions.

Child and Adolescent Needs and Strengths (CANS) – Training and Online Certification*

The Transformational Collaborative Outcomes Management (TCOM) Center of Excellence (COE) and the Praed Foundation have partnered for CANS training and certification on the Collaborative Training website, TCOMtraining.com. This TCOM COE led training and certification is on the Idaho CANS 3.0 used in the Idaho system of care. Providers trained and certified in using the CANS assessment tool can access and use the Idaho CANS via the Magellan Healthcare of Idaho Payer Space in Availity Essentials.

Adult Needs and Strengths Assessment (ANSA) – Online Training and Certification*

The Praed Foundation and Magellan Healthcare of Idaho have partnered for ANSA training and certification on the Collaborative Training website, TCOMtraining.com. This online training and certification is on the ANSA 3.0 used in the Idaho Adult system. Providers trained and certified in using the ANSA tool can access and use the ANSA tool via the Magellan Healthcare of Idaho Payer Space in Availity Essentials. The ANSA is not a required tool in Idaho.

**The CANS and ANSA certifications are valid for one year, starting upon certification date, and must be renewed annually. Certified providers for CANS or ANSA should go to the Collaborative Training website TCOMtraining.com and recertify before current certification expires.*

What You Need to Do

Your responsibility is to:

- Review and become familiar with the required provider trainings by going to the Events & Training page of MagellanofIdaho.com.
- For providers of children and youth under age 18, attend the required provider CANS trainings with the TCOM COE. You can find information on training and certification at https://healthandwelfare.idaho.gov/providers/behavioral-health-providers/idaho-transformational-collaborative-outcomes-management-tcom.
- Find information on recertification at https://healthandwelfare.idaho.gov/providers/behavioral-health-providers/Idaho-transformational-collaborative-outcomes-management-tcom.
- For providers of members age 18 and older, review and certify on the ANSA by going to https://www.TCOMTraining.com and creating an individual account.
- Find How-To Guides on registering at https://praedfoundation.org/resources/tcom-training/.
- Complete the required training and attestation prior to service delivery and annually.

SECTION 2: MAGELLAN'S IBHP PROVIDER NETWORK

Updating Practice Information

Our Philosophy

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

Our Policy

Magellan's policy is to maintain accurate databases, updated in a timely manner with information received from our providers to facilitate efficient and effective provider selection, referral, and claims processing, and to provide accurate and timely information in provider-related publications, e.g., provider directories. The most efficient and effective way to communicate administrative information changes and to keep provider information up to date is through the Magellan Healthcare of Idaho Payer Space in Availity Essentials.

Providers must notify Magellan and/or confirm any changes in administrative practice information using the online application via the Magellan Healthcare of Idaho Payer Space in Availity Essentials. Providers who do not update their data when changes occur may be placed "on hold" for new referrals until review of data accuracy is completed.

Note: Some changes to provider information may result in the need for an amendment to your Magellan provider agreement, such as *facility or group name changes, changes of ownership, change of address, adding a new service location for a facility or a change to Taxpayer Identification Numbers; these still require notification to your assigned Network representative. The online application will direct you when these notifications need to occur. Providing or billing for services if there are changes to any provider information should* ***not*** *commence until you have notified Network staff and received confirmation that all required changes have been implemented, which could include the amending of existing agreements or the need for new agreements to be issued. Failure to provide notification can result in delay and/or denial of payment.*

What You Need to Do

Your responsibility is to:

- Update changes within 10 business days in your administrative practice information listed below using our online form by signing into Availity Essentials and accessing the Magellan Healthcare of Idaho Payer Space.
- Notify us within two business days if you are unable to accept new referrals along with the associated reason. Associated reasons include, but are not limited to:
    - Illness or parental leave
    - Practice full to new patients
    - Professional travel, sabbatical, vacation, leave of absence, etc.

- Notify us within 10 business days of any changes to information reviewed during the credentialing process, including, but not limited to:
    - Licensure or certification, including state licensing board actions on your license
    - Denial, loss of, or any negative change in accreditation status
    - Board certification(s)
    - Hospital privileges
    - Insurance coverage
    - New information regarding pending or settled malpractice actions.
- Respond to us within 10 business days regarding member or other inquiries about the accuracy of your practice information. Failure to respond to inquiries regarding the accuracy of your information may impact your network participation status.
- See the Magellan Organizational and Facility Provider Supplement to the Magellan National Provider Handbook for submitting changes in facility/organizational practices.
- Contact your assigned Network representative if directed by the online application – some changes may require a contract amendment before you can initiate or bill for services.
- Update and maintain your Provider Profile information, which members see, in online provider searches.
- Even if you have no changes, *Magellan requires that you review your practice information, including appointment availability, at least quarterly.* Failure to update administrative practice information may impact your network participation status.

What Magellan Will Do

Magellan's responsibility for provider data changes is to:

- Maintain an online form for providers to review/update practice information.
- Contact you for clarification, if needed.
- Notify you when Magellan members tell us that they believe your provider data is incorrect.
- Monitor and follow up on the completion of required quarterly provider data accuracy attestations.
- Notify you if your change in information impacts your referral and/or network participation status.
- Provide a hard copy provider directory for IBHP members at their request.

SECTION 2: MAGELLAN'S IBHP PROVIDER NETWORK

Contracting with Magellan

Our Philosophy

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

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

Our Policy

To be eligible for referrals and reimbursement for covered services rendered to IBHP members, each provider, whether an organization, individual practitioner, or group practice, must sign a Magellan Network Provider Agreement agreeing to comply with Magellan's policies, procedures, and guidelines.

Services must be provided directly by an independently licensed clinician for all members unless you have an executed Supervisory Protocol Addendum with Magellan. The Supervisory Protocol addresses the requirements that must be followed when non-credentialed practitioners employed by your practice provide services. Non-credentialed providers include providers who: 1) may be unlicensed, 2) are working toward independent licensure, or 3) are working toward an advanced healthcare degree.

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 submit the supervising provider's full name in Box 33 and NPI in boxes 33a and 24J.
    - Providers submit the supervised provider's full name in Box 19.

• Claims should be billed with modifier U1 or UD for appropriate paraprofessional pricing.
    - o U1: Prescribers under supervision
    - o UD: Master's-level provider operating under supervisory protocol

It is an IDHW requirement per IDAPA 16.05.06 to obtain a background check clearance or waiver. All providers **who are new to the IDHW program** (i.e., were not in the previous vendor's network or in the Medicaid fee-for-service system) must apply for a background check and get fingerprinted before Magellan can complete the credentialing and contracting process.

To initiate the background check process, go to the Idaho Background Check website at https://healthandwelfare.idaho.gov/bcu. Scroll down to Background Check System Training to find the information you need to complete this process. Once completed, you must send Magellan proof of clearance by either taking a screenshot of the clearance in the Background Check System (BCS) or by submitting a copy of your clearance letter from the BCS. Please send all evidence to IdahoProvider@MagellanHealth.com.

If you apply for network inclusion and are declined, Magellan will provide written notice of the reason for the decision.

Magellan does not employ or contract with providers excluded from participation in federal healthcare programs under either Section 1128 or Section 1128A of the Social Security Act.

What You Need to Do

Your responsibility is to:

- Submit evidence of your IDHW background check clearance or waiver letter (or official screenprint) to Magellan.
- Sign a Magellan Network Provider Agreement and applicable Addenda.
- Complete the Medicaid Disclosure Form via the Magellan Healthcare of Idaho Payer Space in Availity Essentials.
- Understand the obligations and comply with the terms of your Magellan Network Provider Agreement.
- Be familiar with and follow the policies and procedures contained within this handbook supplement and the Magellan National Provider Handbook.
- Complete required trainings (accessible at www.MagellanofIdaho.com) prior to service delivery.

What Magellan Will Do

Magellan's responsibility is to:

- Submit a Magellan Network Provider Agreement to providers identified for participation in the Magellan provider network.
- Indicate the plans/programs and services covered by the agreement based on the reimbursement schedule(s) provided.
- Execute the agreement after it has been returned and signed by the provider, and the provider has successfully completed the credentialing process. The effective date of the agreement is the date Magellan signs the agreement, unless otherwise noted.
- Magellan is committed to quickly processing credentialing for providers who submit a complete, accurate credentialing application.
- Through Dec. 31, 2024, Magellan will complete the credentialing process within 30 calendar days of receipt of a complete application.
- Magellan will notify providers of missing and required information within 30 calendar days of receipt of an incomplete application.
- Provide a copy of the executed agreement via an email notification.

SECTION 2: MAGELLAN'S IBHP PROVIDER NETWORK

Federally Qualified Health Centers (FQHCs)

Overview

Magellan believes that FQHCs, also known as community health centers, are a vital part of the Idaho provider delivery system and perform critical functions in their role as safety net providers in the Magellan network. FQHCs provide comprehensive affordable primary, behavioral health, and dental care in high need communities. FQHCs help increase access to crucial primary care by reducing barriers such as cost, lack of insurance, distance, and language for their patients. In doing so, they provide substantial benefits to the health care system.

Magellan must recognize FQHC's that provide behavioral health services as behavioral health providers and enroll them in the network. Magellan will interface with FQHC patient-centered processes to help ensure services are delivered in the most effective manner to the members.

Authorizations

All covered services that are reimbursed via an encounter rate and are provided to members by FQHCs do not require prior authorization. All services provided must be medically necessary and are subject to retrospective review by Magellan.

Payment to FQHCs

Magellan must ensure that reimbursement to FQHC's for behavioral health services done in the FQHC facility is made using Medicaid's reimbursement methodology, which is payment at an encounter rate, in an amount unique to each FQHC, as determined by the IDHW or its designee. Magellan will reimburse using a fee-for-service payment model for services identified by the IDHW that are deemed to be outside of the encounter rate.

Magellan must ensure that one behavioral health encounter rate must be paid for all covered behavioral health services provided on the same visit to an FQHC, unless otherwise agreed upon by the IDHW and Magellan. The IDHW may approve a service outside of the FQHC encounter rate on a case-by-case basis. Medicaid encounter rates for FQHC behavioral health providers are updated periodically and sent directly to Magellan. Payments to FQHC providers must be made in accordance with 42 CFR 405.2460-405.2472. Non-Medicaid services are not subject to the encounter-rate requirements.

Licensure and Accreditation

FQHCs are not required to maintain NCQA, Joint Commission, CARF, or other accreditation for delivery and payment of these services.

Cultural Competency

FQHCs shall assess the cultural and linguistic needs of the service area and deliver services that address these needs to the extent resources are available.

FQHCs shall abide by Magellan's Cultural Competency Plan as contained in Magellan Provider Handbook and in accordance with federal requirements for cultural competency under 42 USC Chapter 6A, subchapter II, Part D requirements and associated Health Resources and Services Administration (HRSA) requirements for grantees. Any conflict between Magellan Cultural Competency Plan requirements and the above federal requirements shall be resolved in consultation with FQHCs.

Claims Submission for FQHCs

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:
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.

Claims with *provider* billing errors are called "resubmissions." Resubmitted claims must be received by Magellan within **60 calendar days** of the date on Magellan's explanation of benefits (for all services).

FQHC Responsibilities

Follow the requirements of the Provider Handbook.

Magellan's Responsibilities

Provide prior notice of changes to Policies and Procedures via Magellan website, written communication or in accordance with Law.

Collaborate with you **60 days** prior to changes that may affect your procedures, including any changes that may cause administrative burden or cause additional costs for you.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Federal Data Collection Requirements

Providers must assure that the appropriate assessment is conducted for all members who receive federal funds (Medicaid or other state funding) for their mental health or SUD treatment. Magellan has created a state-approved comprehensive assessment within the Magellan Healthcare of Idaho Payer Space in Availity Essentials, which includes all required data sets that must be collected and reported to Magellan at the beginning and end of treatment, as well as at intervals throughout treatment.

TEDS Data
Magellan of Idaho will collect Combined Mental Health and SUD Treatment Episode Data Set (TEDS) data to complete federal reporting as required by SAMHSA and by CMS in states that have expanded Medicaid. TEDS data includes a member-level compilation of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly funded substance use and/or mental health services. To collect TEDS data, Magellan SUD providers use the outcomes and assessment system available within the Magellan Healthcare of Idaho Payer Space in Availity Essentials. Complete the required data fields in the Comprehensive Assessment at admission, upon change in level of care and at discharge.

To ensure compliance with federal requirements, providers must complete assessments at the following intervals throughout treatment:

- At admission to services (mental health and SUD)
- At any change in level of care
    - For SUD services, levels of care include:
        - 24 hour hospital detox
        - 24 hour free standing residential detox
        - Rehabilitation/Residential Hospital
        - Rehabilitation/Residential Short Term (30 days or fewer)
        - Rehabilitation/Residential Long Term (more than 30 days)
        - Ambulatory Intensive Outpatient
        - Ambulatory Non-Intensive Outpatient
        - Ambulatory – Detox
    - For mental health services, levels of care include:
        - State psychiatric hospital
        - State Mental Health Authority funded/operated community-based program
        - Residential Treatment Center
        - Other psychiatric inpatient
        - Institutions under the justice system

- For mental health members who do not experience a level of care change, an annual update is required.
- For both mental health and SUD members, a discharge from services requires data collection as well.

Providers are responsible for collecting data at appropriate times and for notifying Magellan when a member leaves care.

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 benefits are funded through the Idaho Department of Health and Welfare. Funding is limited and may only be used until funding has run out.

Once an individual is determined to be eligible for services:

- Magellan will refer members to a contracted network provider of the member's choosing to complete the standardized assessment to determine clinical eligibility for services.
- Providers are required to complete assessments within five business days of the referral.
- Providers must ensure members receive recovery support interim services when necessary until standardized assessment is completed and ongoing services have started.

Eligibility Requirements

- Must be a resident of Idaho and plan to reside in Idaho after treatment is completed.
- Must be legally residing in the U.S.
- Must not have other insurance, including Medicaid; or if possessing other insurance, must have a hardship that prevents coverage of needed services by that insurance. Individuals believed to have a hardship should contact Magellan to go through the screening process.
- Must have applied for and been denied Medicaid with a permissible denial code within 30 days of other state funding eligibility.
- For individuals who are seeking SUD services: Must fall at or below 200% of the current year's federal poverty guidelines.
- For individuals who are seeking mental health services: Must fall at or below 300% of the current year's federal poverty guidelines or be willing to self-pay for services.

Treatment Services Priority Populations

The federal requirements that govern other state funding specify certain priority populations that must receive additional support in obtaining services.

Priority populations for treatment services:

- Pregnant Women or Women with Dependent Children (PWWC) providers must ensure that each pregnant woman be given preference in admission to treatment facilities.

When the facility has insufficient capacity, or if no such facility has the capacity to admit the woman, providers must make available interim services within 48 hours. These services must also include education on alcohol and drug use (needle use as indicated) on the fetus and a referral for prenatal care.

- Persons Who Inject Drugs (PWID)
    - Providers must ensure individuals are admitted into treatment within 14 calendar days.
    - If a provider is unable to admit within 14 calendar days, the provider should notify Magellan. Magellan will assist with finding another provider or add the member to a wait list.
        - In the interim, the provider must provide services for those who cannot access treatment within that timeline.
        - At a minimum, interim services must include education on effects of intravenous drug use, Human Immunodeficiency Virus (HIV) and tuberculosis (TB) and risk of needle sharing. Interim services must also include regular contact with the individual while waiting for access to care.
    - All eligible members must be admitted to treatment within 120 calendar days.
    - Providers must conduct outreach activities to encourage PWID to seek treatment.
- PWWC and PWID individuals are also to be given priority on waitlists for services.
- Individuals with tuberculosis
    - The provider directly or through arrangements with other public or nonprofit private entities, is required to make available the following TB services to each individual receiving treatment for substance use:
        - Counseling the individual with respect to tuberculosis;
        - Testing to determine whether the individual has contracted such disease and testing to determine the form of treatment for the disease that is appropriate for the individual; and
        - Providing such treatment to the individual.

Specialized data collection for members who are funded under the State Opioid Response Grant
Members receiving services under the State Opioid Response Grant (SOR) funding must participate in three questionnaires during treatment.

- Intake Assessment: Will be conducted by Magellan staff during screening for funding eligibility
- Discharge: Magellan will outreach to the provider to obtain service level information and will complete the questionnaire on behalf of the provider.
- Follow up: Magellan will complete the follow-up questionnaire by talking with both the member and the provider.

Provider Responsibilities for SOR funding

- Providers must collect TEDS data as noted above on these members.
- Providers accepting members with SOR funding must inform Magellan the day the member begins services.
- Providers must keep Magellan informed of any changes in the member's address, contact information, or collateral contact information during treatment.
- Providers must participate in the questionnaire as needed by Magellan to complete required service detail information.
- Providers must notify Magellan upon discharge of a member.

Provider qualifications for SOR members

Magellan contracts with providers for medication-assisted treatment (MAT) who are with either federally approved methadone clinics or are prescribers who have obtained the Data 2000 Waiver to prescribe buprenorphine. Magellan providers must:

- Utilize an evidence-based practice identified for the treatment of opioid use disorders (OUDs);
- Allow members to access MAT;
- Not require members to taper off or stop the use of MAT at any time when it is inconsistent with the prescriber's recommendation or valid prescription to remain in the program;
- Encourage members to receive naloxone training and kits; and
- Collect all required outcome data.

To be eligible to be a part of the specialty network, a provider must:

- Meet all of the requirements to provide services paid for through SOR funds (above);
- Develop a partnership with a MAT prescriber to facilitate the member accessing MAT;
- Coordinate treatment and MAT services in close partnership with the member and the MAT prescriber;
- Facilitate payment to the MAT prescriber and payment for the medications within the approved limits;
- Link members with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)/infectious disease treatment providers; and
- Work with pregnant women who identify as having an OUD to access appropriate care for themselves and their pregnancy.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Care Management Overview

Magellan values individuals and families as partners in treatment and believes that:

- All individuals and families have strengths.
- Hope is encouraged when someone really listens.
- Empowering is better than controlling.

Magellan is committed to the principles of recovery and resiliency for all members and believes that participation within the community is possible for all individuals with access to appropriate services and supports. Magellan is committed to working together with members, families, providers, IDHW, and other community partners to achieve this reality. Magellan's philosophy of care also recognizes that full participation of the member and/or family members in the treatment process maximizes the likelihood of a successful clinical intervention. Magellan care managers and recovery and family support navigators work together with providers and members, to address treatment, supports, and environmental factors impacting recovery and resiliency.

Magellan supports providers in ensuring that treatment for all individuals is recovery and resiliency oriented, stage-of-change specific, strengths-based, and member/family-centered. For children, treatment will be family-focused – refer to Appendix A for information about Idaho's YES system of care. For adults, treatment will involve natural supports to the extent desired by the member. Community-based treatment, using natural supports and extensive community supports, will be standard. Additionally, treatment will be multi-systemic in nature; culturally competent; flexible and accountable; coordinated; provided in the most appropriate, least-restrictive, and least-intrusive setting; and evidence-based and reflective of best practices. Magellan supports providers' efforts to foster resilience through the promotion of protective factors and reduction of risk factors.

Intensive Care Coordination (ICC)

Magellan's Intensive Care Coordination program consists of intensive care management for:

- Adults with serious and persistent mental illness (SPMI) or serious mental illness (SMI); and
- Youth with serious emotional disturbance (SED) and need a higher level of care, or who are transitioning from an out-of-home placement such as therapeutic foster care, an acute psychiatric hospital, or a psychiatric residential treatment facility (PRTF) and when intervention is needed to keep a child from being moved to an out-of-home placement or involved in multiple child-serving systems related to their mental health needs. SED is defined as a youth having a diagnosis from the most recent version of the DSM and a functional impairment as identified by the CANS.

ICC includes a single, consistent Magellan intensive care coordinator who empowers the member and the member's family to identify their care preferences and supports the member to receive services to meet their changing needs and strengths. ICC includes the development of a coordinated care plan

through facilitation of team meetings (including Child and Family Teams for youth) that include the intensive care coordinator, the member, their family, services providers, and supports identified by the member to ensure collaborative communication and decision-making across the system of care. Magellan's intensive care coordinators are knowledgeable about how multiple systems work together and work collaboratively with members and their supports using person-centered, strengths-based care planning and motivational interviewing to identify, secure agreement and coordinate treatment and other supports so members have continuity of care and progress toward the goals they identify.

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.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Before Services Begin

Our Philosophy

When members contact Magellan for a referral, our philosophy is to direct them to practitioners who best fit their needs and preferences, including provider location, service hours, specialties, spoken language(s), gender, and cultural aspects. Magellan has written preauthorization criteria and concurrent review and retrospective review guidelines for utilization reviews that are based on sound medical evidence and are consistently applied, reviewed, and updated. You can find information about these criteria on www.MagellanofIdaho.com.

Our Policy

Our policy is to make available for selection and/or refer members to providers who best fit their needs and preferences. We also confirm member eligibility for Medicaid or other state funding and manage access to behavioral health benefits.

What You Need to Do

Your responsibility is to:

- For individuals who are uninsured, or for individuals with insurance that does not cover the services being requested, you should refer individuals or families to Magellan at 1-855-202-0973 to complete a brief screen for eligibility for services. Magellan will use approved other state funding if available to cover the services. This funding is limited each year and is reserved for those with an exhibited need for services.
- Obtain an authorization for services when required by signing in to Availity Essentials, submitting a request via fax, or by calling Magellan to determine member eligibility and to obtain authorization for requested services before rendering care to a referred member.
- View your authorizations (synonymous with certifications) on Availity Essentials.
- Contact Magellan as soon as possible following the delivery of emergency services to certify admission to inpatient care or to initiate ambulatory services.
- When additional time may be needed for members in an inpatient setting or in an intermediate ambulatory service (e.g., partial hospitalization, intensive outpatient), contact Magellan at least one day before the end of the period of time covered by the current authorization to ensure medically necessary services are not interrupted.
- Contact Magellan if, during the course of treatment, you determine that services other than those authorized are required, or if you believe the member to be at risk for admission to a higher level of care and want to refer the member for care management services.
- For members presenting for services requiring prior authorization, be prepared to provide Magellan with a thorough assessment of the member, including, but not limited to, the following:
    - Symptoms,
    - Precipitating event(s),

- Potential for risk, such as harm to self or others,
- Level of functioning and degree of impairment (as applicable),
- Clinical history, including medical, mental and substance use conditions or treatments,
- Current medications,
- Plan of care, and
- Anticipated discharge and discharge plan (if appropriate).

The combined clinical assessment for a prior authorization (PA), available via the Magellan Healthcare of Idaho Payer Space in www.Availity.com, contains all the required elements for review and will be automatically shared with Magellan's review team once you complete it.

What Magellan Will Do

Magellan's responsibility is to:

- Actively assist with securing appointments for members needing emergent or urgent care. Note: those needing emergent care are referred to network facility providers as appropriate.
- Outreach to members for care management referrals within five business days and coordinate with referring provider on status of referral.
- Notify and coordinate with treating providers for all members enrolled in care management.
- Identify appropriate referrals based on information submitted by our providers through the credentialing process.
- Make benefit certification determinations based upon the information provided by the member and/or the provider during the benefit certification process.
- Include the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the benefit certification determination information.
- Communicate the benefit certification determination (when necessary) by telephone, online and/or in writing to you and the member, required by regulation and/or contract.
- Note: while most certification/authorization approval notices will only be communicated online, denial notices and other legally mandated correspondence is sent to you and the member via U.S. Mail and/or fax.
- Offer you and the member the opportunity and contact information to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested level of care based on clinical criteria.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a Magellan healthcare professional who has appropriate clinical expertise in treating the member's medical, behavioral health, or long-term services and supports needs.

Authorization Processes

Magellan believes that the member should be in the most supportive, least restrictive level of care necessary to have the best opportunity to improve their health. Magellan's processes include members

who are enrolled in and receiving services through Medicaid, and members who receive IBHP services through other state funding.

Magellan identifies certain procedures and services as requiring prior authorization. Prior authorization includes:

- Preservice authorization review to determine medical necessity prior to provision of the service or procedure; or
- The notification of an admission (NOA) to the service. With the NOA process, Magellan applies the same pre-screening process to determine the scope of benefits covered and the member's eligibility status. Magellan requires NOA when an IBHP member has been admitted into a hospital, subacute facility, psychiatric residential treatment facility (PRTF), or residential treatment facility (including institutions for mental disease [IMDs]), with a review of facility information to justify a continued stay.

Services Requiring Prior Authorization

The following services require prior authorization (PA) or notification of admission (NOA):

Service Name	Medicaid Covered Service	Service Paid Through Other Funding**	Medical Necessity Criteria	Prior Authorization or Notification of Admission
Inpatient (acute, subacute facilities and IMDs)	YES	YES	MCG	NOA
Residential Treatment – PRTFs, RTCs, IMDs	YES	YES	MCG	Prior Authorization
ASAM 4.0	YES	NO	ASAM	NOA
ASAM 3.7	YES	YES	ASAM	NOA
ASAM 3.5	YES	YES	ASAM	Prior Authorization
Partial Hospitalization	YES	YES	MCG	Prior Authorization
Partial Hospitalization SUD ASAM 2.5	YES	YES	ASAM	Prior Authorization
IOP – Intensive Outpatient Program/ASAM 2.1	YES	YES	ASAM	No authorization requirement
IOP – Intensive Outpatient Program/Mental Health	YES	YES	N/A	No authorization requirement
Electroconvulsive Therapy (ECT)	YES	YES	MCG	Prior Authorization

Service Name	Medicaid Covered Service	Service Paid Through Other Funding**	Medical Necessity Criteria	Prior Authorization or Notification of Admission
Transcranial Magnetic Stimulation (TMS)	Yes	Yes	IBHP Supplemental MNC	Prior Authorization
Child Day Treatment	YES	YES	MCG	Prior Authorization
Psychological / Neuropsychological Testing	YES	YES	IBHP Supplemental MNC	Prior Authorization after threshold of 14 units per member per calendar year
Respite	YES	NO	N/A	Hard cap threshold of 300 hours per calendar year
Health & Behavior Assessment and Intervention (HBAI)	YES	YES	HBAI Billing and Coding Guide	Prior Authorization after threshold of 60 units per member per calendar year
Homes with Adult Residential Treatment (HART)	YES	YES	IBHP Supplemental MNC	Prior Authorization
HART 1:1 Supervision	NO*	YES	IBHP Supplemental MNC	Prior Authorization
Assertive Community Treatment (ACT)	YES	YES	MCG	Prior Authorization
Parenting with Love and Limits (PLL)	YES	YES	IBHP Supplemental MNC	Prior Authorization after threshold of 12 weeks per calendar year
Wraparound	YES	YES	IBHP Supplemental MNC	NOA

Service Name	Medicaid Covered Service	Service Paid Through Other Funding**	Medical Necessity Criteria	Prior Authorization or Notification of Admission
CBRS (Skill Building/Community Based Rehab services)	YES	YES	IBHP Supplemental MNC	Prior Authorization after threshold of 308 units.
Case Management for Behavioral Health	YES	YES	MCG	Prior Authorization after threshold of 240 units per member per calendar year
Case Management for SUD - Basic and Intensive	NO*	YES	N/A	No authorization requirement
Adult Peer Support	YES	YES	IBHP Supplemental MNC	Prior Authorization after threshold of 416 units per member per calendar year
Youth Peer Support	YES	YES	IBHP Supplemental MNC	Prior Authorization after threshold of 416 units per member per calendar year
Family Support	YES	YES	IBHP Supplemental MNC	Prior Authorization after threshold of 416 units per member per calendar year
Recovery Coaching	YES	YES	IBHP Supplemental MNC	Prior Authorization after threshold of 416 units per member per calendar year
Behavioral Health Modification and Consultation	YES	YES	IBHP Supplemental MNC	Prior Authorization

Service Name	Medicaid Covered Service	Service Paid Through Other Funding**	Medical Necessity Criteria	Prior Authorization or Notification of Admission
Alcohol and Drug Testing	YES	YES	N/A	Prior Authorization after threshold of 24 units/tests per member per calendar year
Intensive Home and Community Based Services - Multisystemic Therapy (MST) Multidimensional Family Therapy (MDFT) Functional Family Therapy (FFT) Family Program (FP)	YES	YES	IBHP Supplemental MNC	Prior Authorization
Early and Serious Mental Illness (ESMI)	YES	YES	IBHP Supplemental MNC	NOA
Basic Housing Essentials	NO*	YES	IBHP Supplemental MNC	Prior Authorization
Adult Safe and Sober Housing	NO*	YES	IBHP Supplemental MNC	Prior Authorization
Enhanced Adult Safe and Sober Housing	NO*	YES	IBHP Supplemental MNC	Prior Authorization
Child Care for SUD	NO*	YES	IBHP Supplemental MNC	Prior Authorization

*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.
**Other funding excludes 638 funding.

EPSDT (Early Periodic Screening, Diagnosis and Treatment- Medicaid only)

In accordance with federal Medicaid law and IDAPA 16.03.09.880, Magellan covers inpatient and outpatient behavioral health services that fall under EPSDT that are outside of the Idaho Medicaid State Plan, when considering the duration of treatment or coverage limitations and determined to meet medical necessity to "correct or ameliorate a defect, physical or mental illness, or a condition

identified by the screening" for a member under age 21. If a member needs a medically necessary service that is not available within Magellan of Idaho's network, we will arrange for the service to be provided outside the network by a qualified provider.

Prior authorizations for EPSDT services may be requested by the child's behavioral health or primary care provider. You can find authorization forms on www.MagellanofIdaho.com. Medical necessity decisions related to service requests that fall under EPSDT will be reviewed on a case-by-case basis, considering the individual needs of the member and services available or lacking within the region of the member's primary residence. Refer to 42 CFR Part 441 Subpart B -- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21.

Requesting a Prior Authorization

Magellan offers multiple methods to submit authorization requests.

Electronic Submission

Electronic submission is available through the secure website application within Availity Essentials with access 24/7. You simply submit your information and member information, providing clinical rationale for the member meeting MCG care guidelines, and then the initial authorization request will be reviewed. This type of authorization is a notification of admission (NOA). In some instances, the NOA may result in an immediate authorization. NOA is required for certain levels of care such as: Inpatient Mental Health hospital or Institution for Mental Diseases (IMD), American Society of Addition Medicine (ASAM) 4.0 Medically Managed Intensive Inpatient Service, and 3.7 Medically Monitored High Intensity Inpatient Services.

Telephonic Review

Telephonic review is completed on a live phone call with a Magellan care manager to review the member's clinical treatment needs and medical necessity. If approved, an authorization is verbally provided during the call.

Please have the following ready to be discussed for the member's care:

- Diagnosis with ICD-10 codes
- Medication update
- Changes in psychosocial status including updates on living arrangements, cultural issues, legal/court related concerns, school status if applicable
- Physical health concerns
- Substance use concerns – including use pattern
- System involvement – legal, child services, other
- Behavioral concerns/referral behaviors leading to this episode of care
- Treatment plan with interventions to target referral behaviors
- Crisis plan/relapse prevention plan
- Summary of progress related to referral behaviors (i.e., what is working)
- Barriers to recovery (i.e., what is not working)

- Coordination of care with other programs and referrals made (i.e., agency name(s), contact person(s), and phone contact information)
- Discharge/aftercare plan with related appointments confirmed (i.e., date/time/contact person for this appointment to be provided)
- Any other areas that have not been covered.

Paper Submission

As a last option, a paper submission is a treatment request that is faxed to Magellan for clinical review of treatment needs and medical necessity. Using the fax form available on www.MagellanofIdaho.com is recommended. Fax paper requests to 1-888-656-2586.

When submitting a paper request, please remember to:

- Include all pertinent clinical information. You may know the member better than us, so when in doubt, include it.
- It is best practice to print or type the information. It must be legible for review.
- Be aware of your computer or fax machine's quality of transmission. Again, the information must be legible.
- All forms will be available on www.MagellanofIdaho.com.

Authorization Determination Timelines

Magellan adheres to the Program Standards and Requirements timeframes for authorization of care turnaround times as outlined below.

Timeframes for Idaho Medicaid and IBHP services paid through other state funding:

Service Authorization Decision Timeframes	Authorization Turnaround Times
Behavioral Health: Preservice Authorization Review	
Preservice: Inpatient (acute, subacute facilities and IMDs)	Notification of admission (NOA) is required to be submitted within 72 hours of admit. Magellan will provide a decision notice within 1 business day of receipt of a 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.
Preservice: ASAM levels of care 4.0, 3.7	Notification of admission (NOA) is required to be submitted within 24 hours of admit. Magellan will provide a decision notice within 1 business day of receipt of a completed request.
Preservice: Standard	For standard authorization decisions, Magellan will provide the decision notice as expeditiously as the member's health condition requires, not to 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.
Preservice: ASAM 3.5 and PRTF or Residential Treatment Centers (RTC)	For ASAM 3.5 and PRTF, Magellan will provide the decision in 5 business days upon receipt of completed request.
Behavioral Health: Concurrent Review	
Concurrent: Inpatient (acute, subacute facilities, IMDs)	Magellan will provide the decision notice within 1 business day upon the receipt of the completed request.
Concurrent: Outpatient (PHP, IOP)	Magellan will provide the decision notice within 1 business day upon the receipt of the completed request.

Behavioral Health: Concurrent 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, 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.
Post Service (Retrospective) Review	Magellan will provide the decision notice within 30 calendar days upon receipt of the completed request.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Concurrent Review

The continued need for a level of care is based on medical necessity and is reviewed on a regular basis. You may submit requests for a concurrent review using any of the methods below.

Electronic Submission

You can request concurrent reviews through the secure website application within the Magellan Healthcare of Idaho Payer Space in Availity Essentials. You simply submit your information and member information, providing clinical rationale for the member meeting MCG care guideline and the concurrent request will be reviewed. You can use electronic submission for any level of care or service.

Telephonic Submission

Telephonic review is completed on a live phone call with a Magellan care manager to review the member's clinical treatment needs and medical necessity. If approved, an authorization is verbally provided during the call.

Have the following ready to be discussed for the member's care:

- Diagnosis with ICD-10 codes
- Medication update
- Changes in psychosocial status including updates on living arrangements, cultural issues, legal/court related concerns, school status if applicable
- Physical health concerns
- Substance use concerns – including use pattern
- System involvement – legal, child services, other
- Behavioral concerns/referral behaviors leading to this episode of care
- Treatment plan with interventions to target referral behaviors
- Crisis plan/relapse prevention plan
- Summary of progress related to referral behaviors (i.e., what is working)
- Barriers to recovery (i.e., what is not working)
- Coordination of care with other programs and referrals made (i.e., agency name(s), contact person(s), and phone contact information)
- Discharge/aftercare plan with related appointments confirmed (i.e., date/time/contact person for this appointment to be provided)
- Any other areas that have not been covered.

Paper Submission

As a last option, a paper submission is a treatment request that is faxed to Magellan for clinical review of treatment needs and medical necessity. Using the fax form available on www.MagellanofIdaho.com is recommended. Fax paper requests to 1-888-656-2586.

When submitting a paper request, please remember:

- To include all pertinent clinical information. You may know the member better than us, so when in doubt, include it.
- It is best practice to print or type the information. It must be legible for review.
- Be aware of your computer or fax machine's quality of transmission. Again, the information must be legible.
- All forms will be available on www.MagellanofIdaho.com.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Medical Necessity Criteria

Our Philosophy

Magellan is committed to promoting treatment at the most appropriate, least intensive level of care necessary to provide safe and effective treatment to meet the individual member's biopsychosocial needs. Magellan's care guidelines are applied based on the member's individual needs.

Our Policy

Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. Magellan Care Guidelines include the 26th edition MCG Guidelines® for behavioral health services. Magellan Care Guidelines also include proprietary clinical criteria that Magellan has developed and maintains for specialty behavioral outpatient services. Magellan also uses American Society of Addiction Medicine (ASAM) criteria for management of substance use services or Idaho's state specific guidelines to ensure that the member is placed in the most appropriate, least restrictive level of care necessary to meet their needs. Find information about these criteria at www.MagellanofIdaho.com.

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.

What You Need to Do

Your responsibility is to:

- Review and be familiar with care guidelines used by Magellan. You can find information about these criteria at www.MagellanofIdaho.com.
- Keep apprised of Magellan's care guideline implementation dates and care guideline changes via communications posted on www.MagellanofIdaho.com.
- Submit suggestions for revisions to the Magellan Care Guidelines by submitting your feedback in writing to the Magellan Healthcare of Idaho medical director via fax at 1-888-656-2586.

What Magellan Will Do

Magellan's responsibility is to:

- Make Magellan Care Guidelines available to you free of charge.
- Invite and consider your comments and suggestions for revisions to the Magellan Care Guidelines.
- Conduct a comprehensive annual review of the Magellan Care Guidelines using scientific literature, expert advice from regional Provider Advisory Boards, other committees, and suggestions from the provider and consumer community.

- Implement updated Magellan Care Guidelines annually.
- Monitor use of the Magellan Care Guidelines to make sure they are applied consistently.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Member Access to Care

Hours of Operation

Network providers must offer hours of operation to IBHP members that are no less than the hours of operation they offer to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.

Access Standards

Magellan monitors members' ability to access care through the IBHP, based on an individual evaluation of the level of urgency at the time of request. Network providers should offer flexibility of appointment times to members whenever possible, establishing and monitoring the following thresholds for appointment times:

- An initial mental health (MH)/substance use disorder (SUD) appointment must be offered and, if accepted by the member, provided within 10 business days of the request.
- For non-life-threatening emergencies, services must be offered and, if accepted by the member, provided within six hours. A non-life-threatening emergency is a condition that requires immediate intervention to stabilize the condition. There is no imminent risk of harm or death.
- For life-threatening emergencies, immediate services must be offered by the provider or appropriate referral to 911 or 988. Refer to the Crisis System of Care section in Appendix C.
- For an acute inpatient discharge, a MH/SUD outpatient appointment with a prescriber must be offered and, if accepted by the member, provided within seven business days.
- Appointments must be confirmed with the member by network providers within 72 hours prior to the appointment.
- If a member with complex needs unexpectedly misses appointments or discontinues treatment, promptly outreach to members to determine if there is a problem that can be resolved and to promote continuation of services. If a member abruptly discontinues treatment, please contact Magellan's Provider Line if you are unable to reach them after three attempts.
- When a member discharges or transfers to another level of care, notify Magellan. Notification of discharge will be provided via Availity Essentials, fax or telephonic reviews.
- 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 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.

- Screen members for co-morbid physical health conditions, developmental disability/intellectual disability, SUD, and suicidal ideation;
- In discharge planning, include collaboration with community-based providers or care managers to promote continuity of care and ensure appropriate services and supports are identified as early as possible and accessed appropriately after discharge. You should contact members and community-based providers through the most effective means (email, text, or phone call) within 72 hours after discharge.

Providers should refer members to available providers within their geographic area. Contact Magellan for help finding a provider and/or assisting with telehealth when available. Providers are prohibited from placing members on a waiting list for service requests. Find the federal guidelines related to waiting lists at
42 C.F.R. § 447.204 Medicaid provider participation and public process to inform access to care.

Websites

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

Our Policy
Magellan's website at **www.MagellanofIdaho.com** is dedicated to IBHP information. We continually update the website with the latest information to assist you in treating IBHP members.

You will find a wealth of information in the *For Providers* area of www.MagellanofIdaho.com, including access to forms, upcoming events, web-based trainings, newsletters, handbooks, and other helpful material to assist you with navigating your way around Magellan.

In addition, Magellan IBHP providers sign in to the **Availity Essentials** provider portal to perform a variety of secure transactions, such as checking member eligibility, requesting authorization, submitting claims and more.

What You Need to Do
Your responsibility is to visit the websites regularly to ensure you have the most recent information.

What Magellan Will Do
Magellan's responsibility is to provide pertinent and up-to-date information on its websites.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Advance Directives

Our Philosophy
Magellan believes in a member's right to self-determination in making healthcare decisions.

Our Policy
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.
- Maintain a copy of the advance directive in the member's file, if applicable.
- Understand and follow a member's declaration of preferences or instructions regarding medical and/or mental health treatment.
- Use professional judgment to provide care believed to be in the best interest of the member.

What Magellan Will Do
Magellan's responsibility to you is to:

- Meet state, tribal, and federal advance directive laws.
- Document the execution of a member's medical and/or mental health advance directive.
- Not discriminate against a member based on whether the member has executed an advance directive.
- Provide information to the member's family or surrogate if the member is incapacitated and unable to articulate whether an advance directive has been executed.

Medical Advance Directive

Advance directives are legal documents that provide instructions for healthcare and only go into effect if someone cannot communicate their wishes. The two most common advance directives for healthcare are the living will and the durable power of attorney for healthcare.

Living will: This is a written legal document that outlines an individual's preferences for medical care if they are unable to make decisions for themself.

Durable power of attorney for healthcare: This is a legal document that names the individual's healthcare proxy who is empowered to make healthcare decisions for them if they cannot communicate their decisions about treatment.

The Idaho Department of Health and Welfare established the Idaho Healthcare Directive Registry, a safe way for Idahoans to create, share, and store their advance directive. https://healthandwelfare.idaho.gov/services-programs/birth-marriage-death-records/start-your-advance-directive

Mental Health Advance Declaration

Mental Health Advance Declarations allow members to plan for their future mental healthcare in the event they can no longer make mental healthcare decisions on their own as a result of illness. This can be accomplished by creating a Mental Health Declaration or by appointing a Mental Health Power of Attorney, or both.

A Mental Health Declaration is a set of written instructions informing a provider of the member's:

- Type of treatment preference
- Treatment location preference
- Specific treatment instructions

A Mental Health Power of Attorney is a document that allows a member to name a person, in writing, to make mental healthcare decisions for the member, if the member is unable to make those decisions individually. The Mental Health Power of Attorney will make decisions about the member's mental healthcare, based on the member's written instructions.

If a member would like to have a Mental Health Declaration or a Mental Health Power of Attorney, or both, they can connect to the National Resource Center on Psychiatric Advance Directives https://nrc-pad.org/states/idaho/. You should encourage members to share their written Mental Health Advance Directives with the you so that the Declaration can be followed. If a member does not have a Mental Health Declaration drafted, you should ask if they want assistance developing one.

SECTION 4: THE QUALITY PARTNERSHIP

A Commitment to Quality

Our Philosophy

Magellan is committed to continuous quality improvement and outcomes management through its Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and service.

Our Policy

Magellan maintains an internal Quality Assurance Process Improvement (QAPI) program that complies with state and federal standards specified in 42 CFR §438.200, the Idaho Medicaid State Plan, and any other requirements as issued by IDHW. In support of our Idaho Quality Improvement Program, our providers are required to be familiar with Medicaid and Magellan guidelines and standards and apply them in their work with members.

What You Need to Do

Your responsibility is to:

- Understand federal, tribal, and Idaho state standards applicable to providers.
- Comply with federal, tribal, and Idaho state laws, the provider agreement, and all other quality management requirements.
- Adhere to clinical practice guidelines, as appropriate.
- Provide feedback and recommendations to improve Magellan's performance.
- Support members and their families/caregivers to submit complaints, appeals, feedback, and recommendations to improve Magellan's performance.
- Participate and cooperate fully in any monitoring and site reviews conducted by Magellan.
- Participate in quality reviews and/or quality improvement activities as requested by Magellan and IDHW.

What Magellan Will Do

Magellan's responsibility to you is to:

- Operate a toll-free telephone line to respond to provider questions, comments, complaints, and inquiries. The provider line number is 1-855-202-0983 and is available 8 a.m. to 6 p.m. Mountain time. Magellan will respond to voice messages left by providers on this line within two business days.
- Establish an Idaho Quality Improvement Program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria.
- Form an Idaho Quality Improvement Committee (QIC) that meets the following requirements:
    - Be co-chaired by Magellan Healthcare of Idaho's medical director.
    - Include the appropriate Magellan staff representing the various departments of Magellan, IDHW staff, and IDHW-identified external stakeholders.

- Implement an annual written Quality Improvement Program description and work plan, which includes complaints, grievances and critical incidents, and complies with IDHW requirements as specified in our contract and reviewed and approved by IDHW.
- Submit an annual Quality Improvement Program evaluation to IDHW that includes, but is not limited to, results of quality activities and findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of care.
- Ensure that quality improvement processes are data-driven, including the continual measurement of clinical and non-clinical processes. These are driven by the measurement and the re-measurement of effectiveness and continuous development and implementation of improvements as appropriate.
- Take appropriate action to address service delivery, provider, or other quality issues as they are identified.
- Have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, youth and their families/caregivers, and providers, and use the feedback and recommendations to improve performance.
- Participate in the review of quality findings and act as directed by IDHW.
- 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.
- Monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.
- Survey members on an annual basis to assess member satisfaction with quality, availability, and accessibility of care and experience with their providers and Magellan. The Quality team will share results with Magellan's Provider Advisory Councils and in existing network communications.
- Cooperate fully in quality reviews conducted by IDHW and ensure full cooperation of our network providers.
- Use quality review findings to enhance the Quality Improvement Program and take action to address identified issues in a timely manner, as directed by IDHW.

SECTION 4: THE QUALITY PARTNERSHIP

Youth Empowerment Services (YES) System of Care

Our Philosophy

Magellan believes system of care principles are vital to the well-being of youth and their families seeking behavioral healthcare. The Youth Empowerment Services (YES) system of care helps children and youth in Idaho under age 18 who are identified as having serious emotional disturbance (SED) gain access to the mental health services they need. YES uses a youth and family-centered, team-based, and strengths-focused approach for early identification, treatment planning, and implementation of behavioral healthcare. *See Appendix A – YES System of Care.*

Our Policy

Magellan upholds the YES Principles of Care and Practice Model through our policies and practices defined through the YES Authoritative Documents, which include the Services and Supports Crosswalk, Access Pathways Map, YES Practice Manual, Due Process Protocol, and Quality Management, Improvement, and Accountability (QMIA) Plan; established and maintained pursuant to the Jeff D. settlement agreement and the Implementation Assurance Plan. Find information on YES history through project updates to present at https://yes.idaho.gov/youth-empowerment-services/about-yes/yes-history/. Find the Principles of Care Practice Model at https://yes.idaho.gov/wp-content/uploads/2021/04/PrinciplesofCare_PracticeModel_inPractice.pdf.

What You Need to Do

Your responsibility is to:

- Understand and apply YES philosophy and practices through provider training and the yes.idaho.gov website.
- Review the Transformational Collaborative Outcomes Management (TCOM) COE training and material found at https://healthandwelfare.idaho.gov/providers/behavioral-health-providers/idaho-transformational-collaborative-outcomes-management-tcom.
- Be familiar with and, if your role requires, maintain Child and Adolescent Needs and Strengths (CANS) active certification annually to participate in YES service provision.
- To the extent your role requires, utilize the Magellan Healthcare of Idaho Payer Space in Availity Essentials to access and submit CANS, Comprehensive Diagnostic Assessments (CDA), and Wraparound Plans of Care for youth.
- Participate and support person-centered plan development, review, and revision through the Child and Family Teaming (CFT) process.
- Respond to and participate in IDHW YES quality review requests and activities.

What Magellan Will Do

Magellan's responsibility is to:

- Provide tools and technical assistance to improve YES programs and practices.
- Develop and maintain public and secure provider websites which support “One-Kid-One-CANS” and person-centered care practices by the provider network.
- Coordinate ongoing with the TCOM COE for training and education to assist providers in delivering YES services that maximize youth and family voice, choice, and strengths.
- Monitor CANS active certification annually by all staff participating in YES service provision.
- Model PCSP and CFT best practices through intensive care coordination and support of the provider.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Input

Our Philosophy

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

Our Policy

Magellan obtains provider input through provider participation in various workgroups and committees of the care management center. We actively incorporate provider feedback received through sources such as emails, surveys, websites and quality programs.

What You Need to Do

To comply with this policy your responsibility is to:

- Provide input and feedback to Magellan to help improve the quality of care provided to members.
- Participate in quality improvement and utilization oversight activities if requested by Magellan.

What Magellan Will Do

Magellan's responsibility to you is to:

- Actively request input and feedback regarding member care.
- Operate a toll-free telephone line to respond to provider questions, comments, and inquiries.
- The provider line number is 1-855-202-0983 and is available 8 a.m. to 6 p.m. Mountain time. Magellan will respond to voice messages left by providers on this line within two business days.
- Establish a multi-disciplinary Idaho Quality Oversight Committee to oversee all quality functions and activities.
- Maintain a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data.
- Provide designated staff with expertise in quality assessment, utilization management and continuous quality improvement.
- Develop and evaluate reports, indicate recommendations to be implemented, and facilitate feedback to providers and members.
- Conduct Idaho provider satisfaction surveys annually.
    - Magellan sends provider satisfaction surveys to providers via email and uses results to develop quality improvement projects. Magellan also will send results to IDHW annually and to providers upon request.

Complaint and Grievance Process

Our Philosophy

To achieve a high level of member satisfaction and care, Magellan believes in providing a mechanism for providers and external agencies to express complaints related to care, service, confidentiality, policy, procedure, payment, or any other communication or action by Magellan. External agencies and/or providers can also file grievances about a network provider.

Our Policy

Magellan maintains a provider complaint system for providers to dispute Magellan's policies, procedures, or any aspect of Magellan's administrative functions. Magellan defines a provider complaint as any verbal or written expression originating from a provider and delivered to any employee of Magellan that voices dissatisfaction with a policy, procedure, payment, or any other communication or action by Magellan. Please note that we process member grievances and appeals filed by providers on behalf of a member using our *member* grievance and appeals policies (in the member handbook, accessed at www.MagellanofIdaho.com).

What You Need to Do

To submit a complaint, call 1-855-202-0983 (TTY/TDD: 711) 8 a.m. to 6 p.m. Mountain time, fax us at 1-888-656-9795, or email us at IDAC@MagellanHealth.com. You also may submit complaints in writing to: Magellan Healthcare, Inc., Attn: Idaho Quality Department, P.O. Box 2188, Maryland Heights, MO 63043.

If the complaint is about the Youth Empowerment Services (YES) system of care and you wish to file anonymously, you may file a complaint with the Idaho Department of Health and Welfare (IDHW) via the contact information posted at https://yes.idaho.gov/youth-empowerment-services/about-yes/contact-us/?target=4. Complaints about YES that do not need to be made anonymously can be filed with Magellan.

What Magellan Will Do

Magellan's responsibility to you is to:

- Operate a toll-free telephone line to respond to provider questions, comments, and inquiries. That number is 1-855-202-0983 and is available 8 a.m. to 6 p.m. Mountain time. Magellan will respond to voice messages left by providers on this line within two business days.
- Have a designated Magellan staff person administer and oversee the provider complaint system.
- Allow providers to file a written complaint and provide a description of how providers can file complaints with Magellan and the resolution timeframe.

- Thoroughly investigate each complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying Magellan's written policies and procedures.
- Resolve and provide written notification of complaint resolution within 30 business days of receipt.
- Ensure a Magellan executive with the authority to require corrective action is involved in the provider complaint escalation process, as necessary.
- Operate a system to capture, track, and report the status and resolution of all provider complaints, which includes all associated documentation, whether the complaint is received by telephone, in person, or in writing.
- Submit a monthly report of all complaints to IDHW including the nature of the complaint, resolutions, and timeframes.
- Address any irregular trends, identified either internally or by IDHW, which require corrective action by Magellan.

Options After Adverse Benefit Determination (ABD) - Appeal

Our Philosophy

Magellan supports the right of members, their providers, or authorized representatives acting on the member's behalf, to appeal adverse benefit determinations.

Our Policy

Magellan maintains an appeal process and access to the State Fair Hearing system once Magellan's appeal process has been exhausted, in accordance to/with all applicable federal, tribal, and state laws and regulations and contract requirements. An appeal is defined as a review by Magellan of an adverse benefit determination. Magellan defines an adverse benefit determination as a change, limit, or denial in amount, duration, or scope of service.

What You Need to Do

To comply with this process your responsibility is to:

- Have knowledge of the following steps for filing an appeal.
- Obtain and submit the member's written consent when filing an appeal on behalf of the member. Magellan will only process an appeal filed by a provider on behalf of the member if they have obtained and submitted the member's written consent with the appeal request. The Authorization to Release Protected Health Information form is sent in the mail with Adverse Benefit Determinations or can be requested by contacting Magellan.
- You can give Magellan information to support your appeal over the phone or in writing.
    - Phone: Call Magellan Provider Services at 1-855-202-0983 Monday through Friday, 8 a.m. to 6 p.m. Mountain time
    - Email: IDAC@MagellanHealth.com
    - Mail: Magellan Healthcare, Inc. Attn: Idaho Quality Department, P.O. Box 2188, Maryland Heights, MO 63043
    - Fax: 1-888-656-9795.
- To process an appeal:
    - The appeal must be requested within 60 calendar days from the date on the Magellan Notice of Action letter.

What Magellan Will Do

Magellan's responsibility to you is to:

- Ensure Magellan's staff are educated concerning the importance of the appeal procedures, the rights of the member, and how to instruct a member, member's authorized representative, or provider to file an appeal.
- Facilitate timely due process, which can include but is not limited to:

    - Allowing the member, a representative acting on the member's behalf, or network provider, with the member's written consent, to request an appeal either orally or in writing.
    - Maintaining a website (Magellan Healthcare of Idaho's Payer Space in Availity Essentials) through which an appeal can be initiated via an electronic appeal form.
    - Assisting members in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
    - Sending a written acknowledgement of the appeal request within five business days of receipt.
    - Providing the member an opportunity to examine their case file, including treatment records, other documents and records considered during the appeals process, and any new or additional evidence considered, relied upon, or generated by Magellan in connection with the appeal. This information must be provided free of charge and well in advance of the date by which Magellan must resolve the appeal.
- Ensure that Magellan staff who are involved in the appeal decisions:
    - Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
    - Have the appropriate clinical expertise in treating the member's condition or disease.
    - Consider all comments, documents, records, and other information submitted by the member or member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Not take any punitive action against any member, member's authorized representative, or provider who requests or supports an appeal.
- Resolve an appeal and provide written notice, as expeditiously as the member's health condition requires, but no later than the timeframes established below:
    - For standard resolution of an appeal and notice to the member or member's authorized representative, the timeframe is 30 calendar days from the day the appeal is received.
    - For expedited resolution of an appeal and notice to affected parties, the timeframe is 72 hours after receipt of the appeal.
- At the request of the member, or if Magellan believes that there is need for additional information and the delay is in the member's interest, Magellan will extend the timeframe for completing appeals by up to 14 additional calendar days.
- 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.

SECTION 4: THE QUALITY PARTNERSHIP

Member Rights and Responsibilities

Our Philosophy

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

Our Policy

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

What You Need to Do

Your responsibility is to:

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

What Magellan Will Do

Magellan's responsibility is to:

- Make the Magellan Healthcare of Idaho Members' Rights and Responsibilities Statement available for distribution (see Appendix B).
- Provide instructions on how and when to share the statement with members (see "What You Need to Do" above).
- Make the Members' Rights and Responsibilities Statement available in languages and formats that members can understand.

SECTION 4: THE QUALITY PARTNERSHIP

Site Visits

Our Philosophy

Site reviews are a joint responsibility of Magellan Network Management and Magellan Quality Improvement staff, depending on the purpose of the site visit. Administrative reviews may be conducted by non-clinicians, while treatment record reviews evaluating the clinical care and services provided are performed by licensed clinicians. Magellan's approach is to collaboratively partner with a provider on any Quality treatment record review, as this has the benefit of improving network performance and service delivery. We provide results of a Quality treatment record review conducted on site or electronically to the provider in a timely manner.

Our Policy

Site visits may be conducted at minimum:

- During initial credentialing for participation in the network.
- On other occasions when Magellan determines it is necessary, including, but not limited to, for quality reasons.

Magellan evaluates site visit findings and sends a written report to the provider within 30 calendar days. The report includes the following information:

- The findings from the site visit.
- Recommendations for improvement, if needed.
- A request for a corrective action plan to improve care or services, if indicated.

What You Need to Do

To comply with this policy your responsibility is to:

- Comply with requests for site visits within five business days.
- Provide information in a timely manner, including files as requested by the site visit reviewer. This is also within five business days.
- Be available to answer questions from the reviewer at the time of review or follow up.
- Participate in developing and implementing a corrective action plan if required.

What Magellan Will Do

Magellan's responsibility to you is to:

- Notify you in writing if a site visit is required. Magellan Quality will provide two weeks' advance notice for any routine visit.
- Advise you of what you need to do to prepare for the site visit.
- Notify you of the results of the site visit in a timely manner. This is within 30 calendar days.
- Work with you to develop a corrective action plan, if required.

SECTION 4: THE QUALITY PARTNERSHIP

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 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.

Our Policy

Magellan conducts routine treatment record reviews to monitor the behavioral health record documentation of providers against Magellan/IDHW standards and to measure network provider performance against important clinical process elements of Magellan approved clinical practice guidelines. Magellan may also conduct treatment record reviews under special circumstances to investigate or follow up on quality-of-care concerns, adverse incidents, or complaints/grievances about the clinical or administrative practices of a provider. We provide feedback in a consultative manner, to help the provider understand strengths and areas for improvement.

What You Need to Do

To comply with this standard your responsibility is to:

- Ensure that record-keeping practices are fully compliant with all requirements outlined by IDHW and Magellan (see Treatment Record Review Tool).
- Ensure all records, including administrative and member records, are the property of the provider and secured against loss, tampering, destruction, or unauthorized use.
- Safeguard the confidentiality of member records.
- Make all administrative, personnel, and member records available to IDHW, Magellan or appropriate state and federal personnel upon request.
- Have a separate written record for each member served by the provider.
- Have adequate documentation of services offered and provided to, or on behalf of, members served for the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received. This documentation should be an ongoing chronology of activities and services provided to or on behalf of the member(s).
- Ensure the organization of individual member records and the location of documents within the record is consistent among all records.
- 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 electronic signatures 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 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

Magellan's responsibility to you is to:

- Conduct reviews of member medical and treatment records by a licensed mental health professional.
- Communicate with providers at the time of request that treatment records are to be made available for review within five business days.
- Use the Treatment Record Review Tool.
- 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.
- Monitor and evaluate corrective actions taken to ensure that appropriate changes are made in a timely manner. Magellan defines timely as within five business days for provider response to a specific action plan question and spanning 90 days for routine action plan monitoring and collaborative dialogue.
- Submit quarterly reports to the IDHW that summarize results of treatment record reviews and corrective actions taken for specialized behavioral health services.

SECTION 4: THE QUALITY PARTNERSHIP

Critical Incident Reporting

Our Philosophy

In our quest for our members to receive quality behavioral healthcare services, we review all critical incidents to affirm member safety and identify opportunities for improvement. Magellan is committed to accomplishing early identification of potential or existing risk to eliminate or mitigate risks to members and Magellan.

Our Policy

Magellan requires providers to provide written notification within 24 hours of becoming aware of the occurrence of a reportable critical incident. If the critical incident occurs on a weekend or holiday, the Critical Incident Report (CIR) submission is due on the next business day. There is no statute of limitations for critical incident reporting.

Critical incidents are defined as any event involving member(s), provider(s), or contractor staff that causes, or is alleged to cause, an actual risk of physical or mental harm, to themselves or others. This can include incidents that significantly hinder access to medical care on the part of the provider or agency providing services or have detrimental effects on the member, including death or serious injury, that occurs during, or subsequent to, a member receiving behavioral health treatment.

The definitions alphabetically are:

1. **Abandonment** including any incident where a member who requires an attendant, other supervision, or has special healthcare needs is left alone for any period during service delivery.
2. **Abduction** of a member that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
3. **Abuse**
    a. **Physical abuse** including any incident of physical violence or unwelcome physical contact on or by a member, regardless of who perpetrated the physical violence or contact at any level of care.
    b. **Verbal abuse** including any abusive or hurtful language, including threats of violence and any comments deemed to be offensive regarding a person's race, sex, sexual orientation, gender identity, color, national origin, religion, age, appearance, or mental or physical disability when a Member is present at any level of care.
    c. **Abuse, neglect, exploitation** of a member that occurred on an agency's premises, by agency staff, or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
4. **Assault** - Serious physical assault of a member that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care,

including home-based services.

5. **Arrest of a member** while under the care of a treatment program or staff.
6. **Breach of confidentiality**/misuse of member information.
7. **Critical Delay** - Failure to inform the parent or guardian of a member requiring an attendant or other supervision of the delay, location, and updated estimated time of arrival of a Member when arrival at appointment or drop off is delayed by more than 15 minutes.
8. **Death**
    a. **Unexpected death** of a member that occurred while the member was engaged in treatment services at any level of care or within 60 calendar days of a member having received treatment services.
    b. **Completed suicide** by a member who was engaged in treatment services at any level of care at the time of the death or within the previous 60 calendar days.
    c. **Homicide** that is attributed to a member who was engaged in treatment services at any level of care at the time of the homicide or within the previous 60 calendar days.
    d. **Serious suicide attempt** by a member who was engaged in treatment services at any level of care that required an overnight admission to a hospital medical unit.
9. **Elopement** - Any instance of elopement that occurred on an agency's premises at the time the member was receiving treatment services at any level of care.
10. **Impersonation -** Care ordered or provided for a member by someone impersonating a physician, nurse, or other healthcare professional.
11. **Injury**
    a. **Member injury** including any physical injury sustained by a member while using Medicaid services, whether accidental or intentional, up to and including death.
    b. **Serious injury** of a member that required an overnight admission to a hospital medical unit that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
12. **Naloxone** used to treat an overdose.

What You Need to Do

To comply with this policy your responsibility is to:

- Review critical incident training material found on www.MagellanofIdaho.com.
- Know the definitions of reportable incidents. Definitions and instructions on how to file critical incidents are accessible on www.MagellanofIdaho.com.
- Ensure all provider staff comply with state, tribal, and/or federal regulations for mandated reporting of child or adult abuse, neglect, exploitation, and extortion.
- Notify Magellan within 24 hours of the discovery of a reportable incident involving an IBHP member, whether it occurs at the provider's location or at another location.
- Participate in Magellan's investigation of any critical incident and complete corrective action as needed.

Providers can use the Magellan Critical Incident Reporting Form located on the Magellan Healthcare of Idaho Payer Space in Availity Essentials.

Idaho providers should include all the following information when notifying Magellan of a critical incident:

- Member's name, address, and Medicaid number (if Medicaid member)
- Member diagnosis – where applicable behavioral health diagnosis and physical health diagnosis
- Reporting facility/provider name, address, and level of care setting
- Type of incident
- Name(s) of staff involved (if applicable)
- Detailed description of the incident, including the date and location of the incident
- Outcome, including the person(s) notified
- Current location and status of the member
- Steps taken to ensure continued member safety.

What Magellan Will Do

Magellan's responsibility to you is to:

- Review critical incidents to ensure immediate member safety issues are resolved.
- Initiate investigations and require corrective action as needed.
- Investigate all critical incidents in a timely manner, collect information and take appropriate action, which may include notification of appropriate parties and/or a review of facility/practice safety procedures. Magellan's Quality staff will first and foremost confirm the incident is reported within 24 hours, and will complete review and response no later than 30 business days.
- Track and trend incidents to identify and address systematic member safety issues.
- Report individual-level remediation actions taken for critical incidents involving alleged abuse, neglect, exploitation, and death to IDHW.

SECTION 4: THE QUALITY PARTNERSHIP

Inquiry and Review Process

Our Philosophy

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

Our Policy

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

What You Need to Do

Your responsibility is to:

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

What Magellan Will Do

Magellan's responsibility to providers is to:

- Contact you by phone or in writing to inquire about the nature of the concern and request additional information if a concern regarding quality of care or service is raised.
- Advise you if any type of review is required.
- Review all inquiries for adequate resolution of any performance concerns.
- Advise you when a corrective action plan and follow-up are required.
- Advise you of a change in the conditions of your network participation, if required.
- Advise you, in writing, if any action is taken because of the inquiry and review process.

SECTION 4: 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, 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.

The foundation of this program is our Special Investigations Unit (SIU). The SIU employs controls to detect FWA, including technology to identify aberrant billing patterns, claims edits, pre- and post-processing review of claims, and records reviews. The components of the program are documented in our FWA compliance plan.

The components of the plan include:

- Policies and procedures on handling FWA including responding to IDHW requests for records and documentation of any sort, such as provider agreements and all written and telephonic communications with a provider per the terms of the contract.
- Procedures for reporting of possible instances of FWA within contractual timeframes.
- A method to verify whether services reimbursed were furnished to eligible members as billed by providers.
- Providing the IDHW with a quarterly update of surveillance activity, including corrective actions taken.
- A mandatory compliance plan that is designed to guard against FWA.

Magellan's SIU will proactively review claims and other data to identify unusual activity, potentially indicating FWA. SIU may review and audit medical or other administrative records, possibly onsite at a provider's location, to validate claims for services were rendered in compliance with applicable requirements and regulations. Providers and their staff are required to comply with all requests timely.

The result of the SIU review may include:

- Further audit to include onsite inspection of a provider's location
- Education or corrective action
- Recovery of unsupported or overpaid claims
- Implementation of pre-payment review of claims
- Reporting of suspected FWA, as required by contract.

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.

Provider Exclusions and Outstanding Debts

Magellan is required to terminate a provider from the IBHP network within 30 calendar days upon notification by the IDHW of a provider termination. Magellan checks the federal and state exclusion lists, including the Social Security Administration's Death Master File, monthly, and of behavioral health providers currently excluded by the state and the federal government per the provisions of 42 CFR § 455.436. On a monthly basis, Magellan also checks the Idaho Medicaid Provider Outstanding Debt/Termination List located on the MPIUs SharePoint site or provided by the IDHW staff. Magellan is not permitted to enter into agreements with providers who have been excluded, terminated, or have outstanding debts.

Magellan must notify the IDHW in writing within one business day when any provider is identified on any of these exclusion, debt, or termination lists. If Magellan finds a provider on an exclusion list or on the bad debt list, Magellan is required to recover from the provider all payments made for services provided by the excluded individual or entity during the exclusion period and must terminate the provider from participation within 10 calendar days, if the entity was excluded, or the individual is the owner or managing employee. If providers are found listed on the outstanding debt/termination list, Magellan must terminate the provider from participation within 30 calendar days.

Payment Suspension

Magellan must suspend all payments to a provider at the direction of MPIU in certain circumstances, after MPIU determines there is a credible allegation of fraud, for which an investigation is pending under the IBHP and a determination to suspend payment has been made.

How to Report Suspected Cases of Fraud, Waste and Abuse

Submit reports to Magellan via one of the following methods:

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

If you believe you have identified fraud, waste, or abuse, please contact:

Medicaid Program Integrity Unit
PO Box 83720
Boise, Idaho 83720-0036
prvfraud@dhw.idaho.gov
Fax: 1-208-334-2026

Provider Exclusion from Federally or State-Funded Programs

Our Philosophy

Magellan is committed to screening all network providers against federal and state-specific exclusion lists to ensure that excluded providers do not participate in federally funded healthcare programs. This commitment includes screening not only against the federal exclusion lists as referenced in Magellan's National Provider Handbook, but also Idaho-specific exclusion lists.

Our Policy

Consistent with federal and state requirements, Magellan is contractually bound with the Idaho Department of Health and Welfare (IDHW) to exclude Idaho providers from participating in the Idaho Medicaid program if a provider is listed on a federal exclusion list or either of the Idaho exclusion lists.

What You Need to Do

In addition to the responsibilities listed in the Magellan Healthcare National Provider Handbook, you are also responsible to:

- Screen all employees, agents, and contractors immediately upon hire or contracting, and then monthly on an ongoing basis, against the publicly available Idaho Medicaid Provider Exclusion List located near the bottom of the page through this link: https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers.

What Magellan Will Do

In addition to the responsibilities listed in the Magellan Healthcare National Provider Handbook, Magellan will do the following:

- Check the Idaho Medicaid Provider Exclusion List and Idaho Medicaid Provider Outstanding Debt/Termination List, as received from the IDHW, prior to the employment of any prospective Magellan employee and prior to contracting with any vendor/subcontractor, and monthly thereafter.
- Notify the IDHW in writing, within one business day, when any Idaho provider is identified on any of these exclusion, debt, or termination lists. A provider identified on a federal exclusion list or on the bad debt list will be terminated from network participation within 10 calendar days. A provider identified on the Idaho outstanding debt/termination list will be terminated from network participation within 30 calendar days.

SECTION 5: 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 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*).

If filing on paper, send claims to:

Magellan Healthcare, Inc.
P.O. Box 1029
Maryland Heights, MO 63043

Third-Party Liability

Medicaid is always the payer of last resort; therefore, providers must exhaust all other insurance benefits prior to pursuing payment through Magellan Healthcare, Inc.

Claims for services provided to IBHP members who have another primary insurance carrier must be submitted to the primary insurer first in order to obtain an explanation of benefits (EOB). Magellan will not make payments if the full obligations of the primary insurer are not met. If an individual has a primary health insurance other than Medicare and that service is covered by the other insurance, members must seek the service from a provider that is in both the network of the other insurance and Magellan's IBHP network.

As a Magellan provider, you are required to hold IBHP members harmless and cannot bill them for the difference between your contracted rate with Magellan and your standard rate. This practice is called balance billing and is not permitted.

Resubmitting Claims

Claims with *provider* billing errors are called “resubmissions.” Resubmitted claims must be received by Magellan within 60 calendar days of the date on Magellan’s explanation of benefits (for all services).

Resubmitted claims can be sent electronically, via an 837 file. When submitting electronically, in Loop 2300 the claim frequency type code in (CLM-03) should be sent as a 7 for Replacement of Prior Claim or an 8 for Void/Cancel of Prior Claim, and the original Magellan claim number must be sent in the REF*F8 segment. For additional questions please contact Magellan’s EDI support team at EDIsupport@MagellanHealth.com.

When resubmitting on paper, the claim must be stamped “resubmission” (or otherwise noted on box 22 of Form CMS-1500) and include:

- The date of the original submission
- The original claim number, if applicable
- Box 22, resubmission code, of CMS-1500 form
    - 7, Replacement of Prior Claim
    - 8, Void/Cancel of Prior Claim
- Box 4, Type of Bill, UB-04 Claim Form
    - 3 digit.

7	**Replacement of Prior Claim (See adjustment third digit)** - Use to correct a previously submitted bill. Provider applies this code to corrected or "new" bill
8	**Void/Cancel of Prior Claim (See adjustment third digit)** - Use to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information

You may be able to correct/edit claims submitted on Availity Essentials on the same day; however, for claims corrections on a different day than submitted, you may only be able to amend certain fields. You may be required to submit on a hard copy corrected claim, via postal mail as noted above.

Claims Billing and Other Reminders

Proper Claims Forms and Codes
For the proper procedure code and/or modifier(s) to use for claims, consult your Magellan agreement and reimbursement schedules. Form CMS-1500 or UB-04 (formerly UB-92) should be used, if submitting claims on paper. Please see Elements of a Clean Claim, which is available within the appendix of Magellan's national provider handbook.

Claims Review
Upon receipt of a claim, Magellan reviews the documentation and makes a payment determination. As a result of this determination, a remittance advice known as an explanation of payment (EOP) is sent to you. The EOP includes details of payment or the denial. It is important that you review all EOPs promptly. If you have questions about EOPs, contact Magellan Healthcare of Idaho at 1-855-202-0983.

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 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.

Claims Submission – Helpful Tips
The following suggestions will help expedite the processing of your claims:

- Use the appropriate billing revenue codes, procedure codes, and modifiers. This also applies to third-party liability (TPL) claims submitted to Magellan.
- Submit claims in a timely manner (see "Timely Claims Submission").
- If submitting on paper, use the appropriate claim form (UB-04 [formerly UB-92] or CMS-1500).
- Complete all required data on the form, including the Tax ID/SSN and NPI.

The following are common claims errors that may result in a denial. Check all claims prior to submission to avoid delays due to these errors:

- Authorized units do not match billed units.
- More than one month of service is billed on one claim form.
- The recipient's Medical Assistance ID number is incorrect or not utilized.
- The recipient's date of birth is missing.
- Itemized charges are not provided when a date span is used for billing.
- An EOB is not attached to a third-party claim form.
- Revenue code, procedure code and/or modifier(s) are incorrect.
- Duplicate claim submissions are not identified as "duplicate."
- The diagnosis code is not an accepted code.
- Service and/or diagnosis billed is not permitted under the provider's license.

Interim Outpatient Billing

- Providers who submit Bill Type 133 should provide the date when the member was first seen in the *admit date* field on the UB Claim form. When the admit date is left blank, and there is no history, Magellan's system defaults to the service date.
- Use Bill Type 133 to bill interim outpatient claims.
- Submit Bill Type 132 first, then Bill Type 133, and then Bill Type 134. A claim will deny if Interim bill (Type 133) is submitted as the first claim on file in the member history.

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:

Modifier	License Level
AF	Physician
HP	Medical Psychologist
AH	Psychologist
AJ	Master's Level
TD	Advanced Practice Registered Nurse/Physician's Assistant

Electronic Funds Transfer (EFT)

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

Visit the Getting Paid section in the *For Providers* area of www.MagellanofIdaho.com for information on how to register for EFT and access EOP and EOB information.

Providers who do not enroll in EFT may be defaulted to the Virtual Credit Card method of payment.

- It is important to note that there is a fee associated with the card, however once the provider enrolls in EFT there are no longer fees.

National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a 10-digit identifier that has been required on all HIPAA standard electronic transactions since May 23, 2008. NPIs replaced all separately issued identifiers on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI was put in place, so that each provider has one unique, government-issued identifier to be used in transactions with all health plans with which the provider conducts business. An NPI does not replace a provider's Taxpayer Identification Number (TIN). TINs continue to be required on all claims – paper and electronic. The NPI is for identification purposes, while the TIN is for tax purposes.

Important: Claims that do not include a TIN will be rejected.

All healthcare providers, including paraprofessionals who are HIPAA-covered entities, must obtain an NPI. Atypical providers who do not meet the HIPAA definition of a healthcare provider will not have an NPI.

There are two different types of NPIs: Type 1 is for healthcare providers who are individuals, including physicians, psychiatrists, and all sole proprietors. An individual is eligible for only one NPI. Type 2 NPIs are for healthcare providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates themself.

Organizations can choose to enumerate subparts by taxonomy/specialty, TIN, or site address; however, if you are an organization with a single-site address and multiple TINs, we prefer that you enumerate subparts at the TIN level. If you are an organization with multiple site addresses, we prefer that you enumerate subparts at the site address level. In other words, organizations should have one unique NPI for each rendering service location for billing purposes. An individual practitioner is assigned only one NPI (Type 1) regardless of the number of places where they may practice.

To apply for an NPI, there are two options:

- For the most efficient application processing and the fastest receipt of an NPI, use the web-based NPI application process. Log on to the National Plan and Provider Enumeration System (NPPES) and apply online at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Or, obtain the paper NPI Application/Update Form (CMS-10114) by contacting the Enumerator by phone at 1-800-465-3203 (TTY 1-800-692-2326); email customerservice@npienumerator.com; or, mail at NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

Providers should submit any changes to their NPI to Magellan via the Magellan Healthcare of Idaho Payer Space in Availity Essentials, and entering it into the practice data form. Providers can also submit these changes to their NPI by mail or fax, by sending us a copy of their NPI notification letter or email from NPPES: Magellan Healthcare, Attn: Data Management, 14100 Magellan Plaza, Maryland Heights, MO 63043; fax number: 1-314-387-5584.

Claims submission procedures specific to the NPI:

- For claims submitted via the ASC X12N 837 professional healthcare claim transaction, place the Type 2 NPI in the provider billing segment, loop 2010AA; and the Type 1 NPI in loop 2310B.
- On the CMS-1500 paper form (version 08/05), insert the main or billing Type 2 NPI number in Box 33a. Insert the service facility Type 2 NPI (if different from main or billing NPI) in Box 32a. Group providers only must also insert Type 1 NPIs for rendering providers in Box 24J.
- On the UB-04 form, insert the main Type 2 NPI number in Box 56.
- For claims entered/submitted via Availity Essentials:
    - *Organizations/facilities* should complete the "Billing/Pay-To Provider Information" section, using the NPI associated with the rendering service location.
    - *Individual providers* should complete the "Billing/Pay-To Provider Information" section with their own Type 1 NPI. The individual's NPI should be entered in that section only.
    - *Group providers* should complete the "Billing/Pay-To Provider Information" section with the Group's Type 2 NPI. The "Rendering Provider Information" section should be completed using the rendering provider's Type 1 NPI.

National Correct Coding Initiative Edits

The CMS developed the National Correct Coding Initiative (NCCI), to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include PTP code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. The purpose of the NCCI Medically Unlikely Edits (MUE) program is to prevent improper payments when services are reported with incorrect units of service.

For more information visit NCCI.CMS.