Magellan Healthcare, Inc.*

Provider Handbook Supplement for Idaho Behavioral Health Plan

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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. Additionally, Magellan requires all providers to adhere to the standards outlined in the Idaho Medicaid Provider Handbook.

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.

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) and the Praed Foundation have partnered for CANS training and certification on the Collaborative Training website, TCOMtraining.com. This TCOM 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. 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.

Staff Roster Maintenance

You must maintain an accurate roster of staff providing services to members. You can manage your roster electronically through the Magellan Healthcare Idaho Payer Space in the Availity Essentials portal. Note: Adding staff to the roster does not complete the credentialing process. Providers requiring credentialing must be fully credentialled to be considered active and eligible for reimbursement for services.

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 a provider who is an employee or contractor of a provider who provides covered services, but is not an independently licensed and credentialed provider. This individual may be a licensed clinician, an unlicensed provider with a graduate degree, or an unlicensed paraprofessional.

In order to complete credentialing, nurse practitioners who are not board certified in a psychiatric specialty and physician assistants who do not hold an added qualification (CAQ) in psychiatry must complete and return a form attesting to their experience and/or collaborative relationships.

Practitioners who do not meet Magellan's credentialing and participation requirements due to encumbered/restricted licensure, certification, or other credential encumbered/restricted licensure may not treat members and are not covered under the Supervisory Protocol.

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 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.

Please note that a person who has a background check waiver/variance is not eligible to provide family peer support or youth peer support services.

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.

Idaho Medicaid Provider Enrollment Requirements

Idaho Medicaid is implementing new provider enrollment requirements in compliance with federal law and the Social Security Act[1]. Under these requirements, all managed care providers must enroll with the State Medicaid Agency through the Medicaid Enterprise System (MES). This enrollment is necessary for providers to continue to render services to Medicaid members in contract with a Managed Care Organization (MCO), and Magellan is the MCO for the Idaho Behavioral Health Plan.

Providers must enroll to remain eligible for contracting, network participation, and reimbursement, as outlined in 42 CFR 438.602. This means that you/your practice/organization must enroll to remain in network and to be eligible for reimbursement by Magellan for the Idaho Behavioral Health Plan.

[1] (Section 1932(d) of the Act, 42 C.F.R. § 438.602 State responsibilities, 42 C.F.R. § 438.602(b) Screening and enrollment and revalidation of providers, Medicaid Provider Enrollment Compendium (MPEC) (March 22, 2021))

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 FQHCs 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 FQHCs 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 the 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 calendar days** of the date of service, providers must submit claims for Medicaid services.
- Within **60 calendar 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 calendar 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 in this provider handbook supplement.

Magellan's Responsibilities

Provide prior notice of changes to policies and procedures via MagellanofIdaho.com website, written communication or in accordance with law.

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

Federal Data Collection Requirements

Providers must ensure 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.

- Combined TEDS federal data collection is not required for Medicaid-funded members.
- Combined TEDS federal data collection is required for members of all ages receiving other state-funded services.
- Combined TEDS federal data collection is required for members of all ages receiving braided funding from both Medicaid and other state-funded services.

TEDS Data

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

Note: TEDS data is not required for braided funding, e.g. members with both Medicaid and other state funding.

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

SUPRT Data

Transition from GPRA to SUPRT

Effective Oct. 1, 2025, SAMHSA's Unified Performance Reporting Tool (SUPRT) replaced the former Government Performance and Results Act (GPRA) assessment tool for all State Opioid Response (SOR)–funded programs. SUPRT modernizes and streamlines data collection while maintaining compliance with federal reporting standards. Providers who previously completed GPRAs will now complete SUPRT assessments instead.

To maintain compliance with State Opioid Response (SOR) grant requirements, all members who are determined eligible for SOR-funded substance use disorder (SUD) services must participate in a series of federally required assessments. These assessments use the Substance Abuse and Mental Health Services Administration's (SAMHSA) Unified Performance Reporting Tool (SUPRT). The SUPRT assessments are designed to improve national reporting consistency, demonstrate program effectiveness, and strengthen accountability for SOR-funded services.

About SUPRT

SUPRT consists of two related components:

- **SUPRT-A (Administrative Tool):** Completed by the **treating provider** based on clinical and administrative records. This tool collects information on behavioral-health history, screenings, diagnoses, and the services provided through SOR funding.
- **SUPRT-C (Client/Caregiver Tool):** Completed by the **member, parent, caregiver, or proxy** and focuses on self-reported outcomes such as recovery progress, quality of life, and social supports.

Together, SUPRT-A and SUPRT-C provide SAMHSA with a comprehensive view of client outcomes and program performance.

Assessment timeline

SUPRT assessments must be completed at the following key intervals:

1. **Baseline SUPRT assessment**
    - Conducted within 30 days of the member's first SOR-funded service.
    - Establishes the member's initial behavioral-health profile, service needs, and baseline data for future comparison.
    - Includes both SUPRT-A (completed by the provider) and SUPRT-C (completed by the member, parent, caregiver, or proxy, when consent is provided).
2. **6-month reassessment SUPRT**
    - Conducted approximately six months (180 days) after the baseline assessment date.
    - Evaluates member progress, treatment outcomes, and continued service needs.
    - Providers complete SUPRT-A based on updated clinical and service data; members, parents, caregivers, or proxy complete SUPRT-C when applicable.
3. Providers must complete the 6-month SUPRT-A Reassessment for clients who remain in services. Records must be submitted within the SUPRT assessment window (+/- 30 days of reassessment date).**Annual SUPRT assessment (both A & C)**
    - Conducted 12 months after the baseline and each year thereafter if the member continues in services.
    - Focuses on long-term treatment progress, recovery stability, and service utilization.
4. **Closeout SUPRT assessment (SUPRT A)**
    - Completed within 30 days of the member's discharge from SOR-funded services or after 12 months without contact or service.
    - Captures final data on treatment completion, discharge reason, and services provided.

Important notes

- SUPRT assessments are required for all adults and adolescents who receive SOR-funded services.
- Even if a member or caregiver declines to complete the SUPRT-C, the provider must still complete the SUPRT-A.
- Completion of all SUPRT assessments ensures compliance with federal and state reporting requirements.
- Data from SUPRT assessments are submitted through SAMHSA for national performance monitoring and program improvement.

Assessment	Completion Window	Example Date	Example Assessment Completion Window[2]	
			Start	End
SUPRT-A Baseline	Within 30 days of intake	3/3/2025		
6-month reassessment	Due 180 days from baseline assessment Completed +/-30 days from due date	8/30/2025	7/31/2025	9/29/2025
SUPRT-A/C[3] Annual	Due every 12-month anniversary of the baseline assessment Completed +/-30 days from due date	3/3/2026	2/1/2026	4/2/2026
Close Out	Due w/in 30 days of end of episode of care	5/1/2026	5/1/2026	5/31/2026

Failure to complete required SUPRT assessments may affect the provider's compliance with SOR grant reporting requirements and hinder the State's ability to evaluate program performance and maintain federal compliance. Magellan will work with providers who are found to be out of compliance with SOR grant reporting.

Viewing a member's funding source in Availity

What providers should know

Providers can view a member's funding source and program alignment in Availity Essentials by completing an Eligibility and Benefits Inquiry. Funding information may identify the member's program, including:

- State Opioid Response (SOR)
- Substance Use Prevention, Treatment and Recovery (SUPTR)
- Adult Mental Health (AMH)
- Children's Mental Health (CMH)
- Youth Empowerment Services (YES)

Funding visibility is available for both Medicaid and non-Medicaid members and supports accurate billing and alignment with program requirements.

Examples of funding visibility in Availity

When completing an Eligibility and Benefits Inquiry in Availity Essentials, funding and program information may display under the Member ID in the Plan Name and Plan Number fields.

Examples include:

- **Plan Name:** Non Medicaid Exception Enrollment – Adult MH Adult Mental Health

[2] Excludes programs designated by CSAT as homeless programs, which have different completion ranges
[3] Note that only adults are required to complete a SUPRT-C annual assessment

    - **Plan Code:** IDD01 01
- **Plan Name:** Medicaid Children (Age 0–17) YES Program
    - **Plan Code:** IDB01 01
- **Plan Name:** Non Medicaid SUD-PWID SOR-PWID
    - **Plan Code:** IDA05 01
- **Plan Name:** Non Medicaid SUD-ESSH SUPTRS-ESSH
    - **Plan Code:** IDA09 02

These fields indicate whether services are funded through Medicaid or other state funding and identify the applicable program (e.g., SOR, SUPTR, AMH, CMH, YES).

How to view member plan and funding information in Availity
To view funding and plan information for a member:

- Navigate to **Patient Registration**.
- Select **Eligibility and Benefit Inquiry** from the dropdown menu.
- Enter required member information and select **Submit**.
- Review the eligibility results.
    - The **Plan Name** displays to the left of the Magellan Healthcare logo.

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 (TTY 711). 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.

This is a prior authorization. Screening must be completed prior to admission or enrollment.

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.

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.
- To support timely access to care, individuals may receive up to 30 days of Other State Funding (OSF) services even if they have not yet applied for Medicaid. During this period, providers must ensure the individual completes a Medicaid application. If Medicaid is subsequently denied with a permissible denial reason, OSF eligibility can be maintained beyond the initial 30 days.
- The individual must have a clinical need for services.
- Youth who are seeking CMH services must meet the eligibility requirements outlined in Idaho Code 16-2406A.
- Individuals who are seeking SUD services must meet the eligibility requirements outlined in Idaho Code 39-306.
- Individuals who are seeking mental health services must meet the eligibility requirements outlined in Idaho Code 39-3131A.
- Individuals receiving SOR funding must have a primary diagnosis of an opioid use or stimulant use disorder. Providers must verify the type of Other State Funding for which the member has been approved and ensure the member's diagnosis aligns with the diagnoses allowable for billing under that funding source. If they do not align, we support the member to access the proper funding for their treatment needs.
- Individuals receiving SUPTRS funding must have a primary diagnosis of a substance use

disorder, with the exception of opioids or stimulants. Any claims submitted for SUPTRS-funded members, regardless of date-of-service, will be denied if they do not include a primary diagnosis of a substance use disorder, with the exception of opioids or stimulants.

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
    - Providers must ask each SUPTRS funded client if they are in need of TB services.
    - 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 TB;
        - 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 the SAMHSA Unified Performance Reporting Tool. .

SUPRT-A (Administrative Form)

- **Baseline:**
  Providers must complete the SUPRT-A Baseline assessment for all clients receiving SOR-funded services. Baseline data must be submitted to Magellan within the required **30-day completion window** (30 days before or after the first date of services).
- **Reassessment (6-Month):**
  Providers must complete the 6-month SUPRT-A Reassessment for clients who remain in services. Records must be submitted within the SUPRT assessment window (+/- 30 days of reassessment date).
- **Annual Assessment:**
  Providers must complete the required Annual SUPRT-A for adult clients each 12-month anniversary of the baseline date. This must be submitted within the required SUPRT assessment window (+/- 30 days).
- **Closeout:**
  Providers must complete the SUPRT-A Closeout assessment within **30 days of the client's end of services** and submit it to Magellan for SPARS entry.

SUPRT-C (Client/Caregiver/Proxy Form)

- **Client Participation:**
  Providers must administer the SUPRT-C (Client or Caregiver version, depending on age) at the Baseline and required Reassessment/Annual time points. SUPRT-C must be offered to every client, and refusal must be documented. If the client/caregiver declines SUPRT-C at baseline, providers must still complete the demographics section of SUPRT-A.
- **Submission Requirements:**
  SUPRT-C forms must be completed by the client/caregiver and submitted to Magellan within the appropriate SUPRT time frame so Magellan can enter the data into SPARS within **30 days of completion**.

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 SUPRT assessment collection as needed by Magellan to complete federal reporting requirements .
- 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 either affiliated with federally certified methadone clinics or meet specific qualifications for prescribing buprenorphine/naltrexone. Following the elimination of the federal waiver requirement (X-waiver)

under Section 1262 of the Consolidated Appropriations Act, 2023, any practitioner with a valid DEA registration that includes Schedule III authority may prescribe buprenorphine for the treatment of opioid use disorder (OUD), in accordance with applicable state law.

Magellan providers must:

- Utilize an evidence-based practice identified for the treatment of 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 MAT 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) to 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 residential treatment facility (e.g. PRTF or RTC) 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 support member choice and 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 other state funding if the client is eligible for this funding and the funding is 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).
- Most current assessment

The combined clinical assessment for a prior authorization (PA), available via the Magellan Healthcare 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 apply to 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. Please use the applicable authorization request form (either inpatient or outpatient) based on the service being requested, when submitting a paper NOA. These forms can be found on MagellanofIdaho.com, on the Provider Forms page.

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 Authorizations, Threshold Authorizations, or Notification of Admission (NOA)
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	17 and under: No authorization requirement 18+: Prior authorization after threshold of 50 units

Service Name	Medicaid Covered Service	Service Paid Through Other Funding**	Medical Necessity Criteria	Prior Authorizations, Threshold Authorizations, or Notification of Admission (NOA)
IOP – Intensive Outpatient Program/Mental Health	YES	YES	MCG	17 and under: No authorization requirement 18+: Prior authorization after threshold of 50 units
Transcranial Magnetic Stimulation (TMS)	Yes	Yes	MCG	Prior Authorization
Child Day Treatment	YES	YES	MCG	Prior Authorization
Psychological / Neuropsychological Testing	YES	YES	Magellan Care Guidelines for IBHP	Prior Authorization after threshold of 14 hours 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
Parenting with Love and Limits (PLL)	YES	YES	Magellan Care Guidelines for IBHP	Prior Authorization after threshold of 12 weeks per calendar year
Wraparound	YES	YES	Magellan Care Guidelines for IBHP	NOA

Service Name	Medicaid Covered Service	Service Paid Through Other Funding**	Medical Necessity Criteria	Prior Authorizations, Threshold Authorizations, or Notification of Admission (NOA)
CBRS (Skill-Building/Community-Based Rehab services)	YES	YES	Magellan Care Guidelines for IBHP	Prior Authorization after threshold of 308 units for ages 17 and under. Prior Authorization for 18+
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	Magellan Care Guidelines for IBHP	Prior Authorization after threshold of 416 units per member per calendar year
Youth Peer Support	YES	YES	Magellan Care Guidelines for IBHP	Prior Authorization after threshold of 416 units per member per calendar year
Family Support	YES	YES	Magellan Care Guidelines for IBHP	Prior Authorization after threshold of 416 units per member per calendar year

Service Name	Medicaid Covered Service	Service Paid Through Other Funding**	Medical Necessity Criteria	Prior Authorizations, Threshold Authorizations, or Notification of Admission (NOA)
Recovery Coaching	YES	YES	Magellan Care Guidelines for IBHP	Prior Authorization after threshold of 416 units per member per calendar year
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	Magellan Care Guidelines for IBHP	Prior Authorization
Basic Housing Essentials	NO*	YES	Magellan Care Guidelines for IBHP	Prior Authorization
Adult Safe and Sober Housing	NO*	YES	Magellan Care Guidelines for IBHP	Prior Authorization
Enhanced Adult Safe and Sober Housing	NO*	YES	Magellan Care Guidelines for IBHP	Prior Authorization
Child Care for SUD	NO*	YES	Magellan Care Guidelines for IBHP	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 16.03.26, 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's network, we will arrange for the service to be provided outside the network by a qualified provider. A youth does not need to already be enrolled in or receiving the service they're requesting before their 18th birthday in order to request EPSDT services..

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). NOA is required for certain levels of care such as: Inpatient Mental Health hospital or Institution for Mental Diseases (IMD), American Society of Addiction 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 are available on www.MagellanofIdaho.com.
- Use the Outpatient Care Authorization Request Form when faxing NOAs.

Requesting a Retrospective Review

A retrospective review is an evaluation of the medical necessity of treatment services after the treatment has been rendered without preauthorization. Retrospective reviews may be requested under the following circumstances:

Emergency Services

Magellan performs retrospective reviews of emergency services performed without preauthorization. The review considers services performed from the time of the emergency until the member is in a safe setting. For services provided in an emergency situation, Magellan must receive a request for retrospective review within 180 days of the service date. Magellan may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition.

Member's medical condition precludes provider's ability to identify member's eligibility

Magellan will perform a retrospective review when a service is provided, and the member's medical condition precludes the provider from identifying the member's eligibility with Magellan. The review will consider services performed through the date that eligibility was reasonably discovered. Magellan must receive the retrospective review request within 180 days after the service was performed. Magellan will conduct the review using Magellan Care Guidelines for the Idaho Behavioral Health Plan.

IBHP eligibility is retroactively initiated

Magellan will perform a retrospective review when services are provided to a member whose eligibility is retroactively initiated by IBHP based on information in either Partner Data Access Portal (PDAP), Magellan's provider portal, or other system verification. Magellan will review services from the date of eligibility through the date that eligibility was initiated or reinstated. For retrospective review requests

due to a member's retroactive enrollment in IBHP, Magellan must receive the retrospective review request within 180 days after the service was performed. Magellan will conduct the review using Magellan's Care Guidelines for the Idaho Behavioral Health Plan.

Service was not covered by the member's primary insurer
Magellan will consider the services provided for any dates of service for which the member's primary insurer was believed responsible for coverage. For requests for retrospective review based on the service not being covered by the member's primary insurer, Magellan must receive the retrospective review request within 180 days after the service was performed, or within 180 days of the primary insurer's final decision notice. Magellan will conduct the review using Magellan's Care Guidelines for the Idaho Behavioral Health Plan, as appropriate.

To request a retrospective review, submit the following to Magellan:

- A complete Magellan Retrospective Review Request Form (available at MagellanofIdaho.com > For Providers > Provider Forms).
- Sufficient clinical information to establish medical necessity for the services provided. This may include information from the medical record or ASAM summary evaluations.
- A copy of the Explanation of Benefit (EOB) form or final decision letter that demonstrates that the treatment rendered was not covered by the primary insurer.

Submit your request for retrospective review by fax to 1-888-656-2586. **Attention: Retrospective Review.**

Requests that do not include an electronically completed Magellan Retrospective Review Request Form or are missing required documentation cannot be processed.

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 3 calendar days of receipt of a completed request.
Preservice: ASAM levels of care 4.0, 3.7, & 3.5	Notification of admission (NOA) is required to be submitted within 72 hours of admit. Magellan will provide a decision notice within 3 calendar days of receipt of a completed request.
Preservice: PRTF or Residential Treatment Centers (RTC) & Partial Hospitalization Programs (PHP)	Magellan will provide the decision in 5 business days upon receipt of 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 7 calendar days following receipt of the request for service.
Preservice: EPSDT requests	Magellan will review and render a decision on requests for services that fall under EPSDT for medical necessity within 7 calendar days of receipt of a completed request and medical history information.

Behavioral Health: Concurrent Review	
Concurrent: Inpatient (acute, subacute facilities, IMDs)	Magellan will provide the decision notice within 3 calendar days upon the receipt of the completed request.
Concurrent: ASAM levels of care 4.0, 3.7 & 3.5	Magellan will provide the decision notice within 3 calendar days upon the receipt of the completed request
Concurrent: PRTF or Residential Treatment Centers (RTC) & Partial Hospitalization Programs (PHP)	Magellan will provide the decision notice within 5 business days upon the receipt of the completed request.
Concurrent: Standard	Magellan will provide the decision notice within 7 calendar days upon the receipt of the completed request.

Behavioral Health: Retrospective Review	
Post Service (Retrospective) Review	Magellan will provide the decision notice within 30 calendar days upon receipt of the completed request.
Behavioral Health: Expedited Review	
Expedited/Urgent 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.
Behavioral Health: Timeframe Extensions	
Request for Extension	For any authorization request, a possible extension of up to 14 additional calendar days may be initiated if (1.) the member or the provider requests extension or (2.) Magellan justifies to the Idaho Department of Health and Welfare (IDHW) upon request that the need for additional information per 42 CFR §438.210(d)(1)(ii) is in the member's interest.

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 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.
- Most current assessment

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.

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 6 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 7 business days.
- Network providers must have a process to confirm appointments within 72 hours.
- If a member with complex needs unexpectedly misses an appointment or discontinues treatment, the provider will promptly outreach to the 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, 7 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 if unable to set an appointment within appropriate access to care timeframes. 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.

Access to care standards and definitions:

- **Non-life-threatening emergencies/Critical Behavioral Health Need**: For situations such as suicidal ideation requiring stabilization but without imminent danger, appointments ***should be offered within 6 hours from the time of the request.***

  Urgent behavioral health appointments: For conditions that are serious but not immediately life-threatening, appointments ***should be offered within 48 hours of the request.*** Examples may include severe distress, increased risk of deterioration, or other acute symptoms requiring prompt assessment or treatment.

- **Non-urgent/Routine appointments:** These should be offered ***within 10 business days*** from the date of the request. Examples include initial intake assessments and ongoing outpatient therapy for stable conditions.

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.

For Medicaid Provider Enrollment, visit:
Website: Idaho Medicaid Health PAS OnLine
Email: idproviderenrollment@gainwelltechnologies.com
Phone: 1-866-686-4272

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.

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 (TTY 711) 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.

Quality of Care

A key function of the quality department is investigating Quality of Care Concerns (QoCC's). The quality team utilizes IDHW-approved policies and procedures to guide these investigations.

QoCC's are received through:

- Complaint processes
- Critical incident reporting
- Medical director treatment record reviews
- Care coordination
- Utilization management
- Fraud, waste, abuse investigations
- Provider or member concern escalation

QoCC's are conducted by licensed professionals with medical director oversight.

Professionals review documentation and medications records, claims, and policies and procedures. In some cases, an onsite review may occur.

QoCC's help Magellan to identify areas of improvement that we can share with our providers to enhance their service to members. They also provide valuable information for us to share internally allowing us to improve overall service to members.

Examples:

- Treatment that seems inappropriate for member's age diagnosis etc.
- Treatment that appears inconsistent with standards of good practice.
- Provider actions that could potentially harm the health, wellbeing or recovery of the member.

Who Can report:

- Anyone can report a QoCC
- They may be identified by Magellan care management staff or maybe referred to Magellan by someone in the community (a member, family member, providers or concerned citizens).
- Community members reporting QoCC's have the option to remain anonymous.

How to submit a QoCC

- Orally through Member services or in writing
- The are typically referred from the complaints department, the critical incident department, the care coordination staff and the Special investigations unit, or the medical director.
- Determinations are based on the actual harm or risk for the harm to the member.

The QoCC process is designed with member safety as a priority, and the goal is to support providers in improving service quality.

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) 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 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 service plan (PSCP) 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 competency center 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 (TTY 711) 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 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 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 (TTY 711) 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 a standard or expedited appeal either orally or in writing.
    - Maintaining a website (Magellan Healthcare 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 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 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 Magellan/IDHW 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.

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.
13. **Facility equipment failure** that interferes with member care**.**
14. **Evacuation or temporary closure**, suspension, or relocation of services (e.g., disaster, accident, illness) or any facility or provider related event that will substantially interfere with care.

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 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.
- Last date of service

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.

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 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.

Payment Integrity Prepayment Review

To support payment integrity and ensure accurate claims processing, we conduct prepayment reviews on selected claims. As part of this process, providers may be required to submit medical records or

other documentation before a claim can be adjudicated. Prepayment review focuses specifically on verifying coding accuracy and confirming that the documentation submitted supports the codes billed. This process helps maintain a consistent, compliant, and reliable claims payment environment. Prepayment review is also an important component of our efforts to reduce FWA. When documentation does not fully support the billing submitted, we cannot validate that the claim meets applicable program and regulatory requirements. Requesting medical records allows us to confirm that documentation is complete, coding is accurate, and billing practices align with established standards. This proactive approach helps prevent improper payments and supports the integrity of the healthcare system.

Information obtained through prepayment review is also used to identify common billing errors, documentation gaps, and recurring patterns. We use these insights to provide education and guidance to providers, with the goal of supporting improved compliance and reducing future billing issues. This collaborative approach reinforces our commitment to assisting providers in meeting program requirements and supporting the state's broader FWA prevention initiatives.

Providers are required to comply with requests for medical records or other documentation as part of their contractual and regulatory obligations. Submission of documentation that supports the codes billed is a fundamental component of the claims process. Failure to provide the requested information may delay claim processing or result in claim denial, as we cannot validate payment without adequate documentation. Timely cooperation ensures accurate reimbursement and contributes to a transparent and compliant payment environment.

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.

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

Non-Medicaid Holds/Commitments Billing

If an individual is on an involuntary hold or under an involuntary commitment, waiting for inpatient mental health program in an emergency room or higher level of care, Magellan will pay for routine and extraordinary medical care and behavioral health services. Magellan will pay behavioral health services based on the Magellan IBHP Rates and physical health services at 35% of the total cost of services.

Hospitals should complete the below items and submit to the following email address: IBHPPrecommitmentServices@MagellanHealth.com.

1) Emergency Room Precommitment Services Invoice (download via this link)
2) Proof of commitment
3) Medical record for the individual while they were in the emergency room

When emailing protected health information (PHI) to Magellan, use secure/encrypted email. Please use a separate form for each individual.

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.

When submitting EOB information electronically, to ensure the proper processing of claims requiring coordination of benefits, Magellan recommends that providers validate the patient's membership number and supplementary or primary carrier information for every claim. All sum of paid amounts (AMT02 in loop 2320) and all line adjustment amounts (CAS in 2320 and 2340) must equal the total charge amount (CLM).

If the claim was adjudicated by another payer identified in the 2330B loop, the AMT – Payer Paid Amount and AMT – Remaining Patient Liability must be completed. Primary and secondary coverage for the same claim will not be processed simultaneously. Claims that contain both primary and secondary coverage must be broken down into two claims.

File the primary coverage first and submit the secondary coverage after the primary coverage claim has been processed. Submitters can be assured that the primary coverage claim has been processed upon receipt of the EOP or ERA. A secondary coverage claim that is submitted prior to the processing of its preceding primary coverage claim will be denied, based on the need for primary insurance information.

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 at 1-855-202-0983.

After Your Claim Is Processed: Understanding Reconsiderations and Disputes
After a claim has been processed, there may be times when additional review or action is needed. This is known as post-claim adjudication. Post-claim adjudication includes activities such as reconsiderations and disputes. These processes help ensure claims are paid correctly and in accordance with plan guidelines.

Submitting a Claim for Reconsideration
If you believe that Magellan has processed or denied your claim incorrectly, you may submit a **claim dispute** for reconsideration. Here are a few steps to follow prior to your submission of the claim dispute to ensure timely review and resolution.

Step 1: Review of the explanation of payment (EOP)

- Confirm the member information, dates of service, procedure codes, diagnosis codes, and billed charges.
- Review the reason codes and remarks explaining how the claim was processed.
- Verify coordination of benefits (COB), authorization, and eligibility details, if applicable.

After you have reviewed the EOP and the issue appears to be due to missing, incorrect, or updated information, or the primary carrier EOB needs to be submitted.

Step 2: Submit a corrected or reconsideration request - ***This is not a dispute, please follow standard claim submission processes.***

- Submit a corrected claim with the appropriate correction indicator.
- Include all required supporting documentation (e.g., Primary carrier EOB, proof of timely filing, proof of authorization).
- Please follow the documented claim resubmission process. This can be found on page 70 of the IDHW Magellan provider handbook.

If you disagree with the processing after review of the EOP or after you have submitted a correction/reconsideration you can submit a claim dispute.

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.

Submitting a Claim Dispute

A claim dispute is a request to review whether a claim was processed correctly based on applicable benefits, authorization, eligibility, provider participation, coding, and billing requirements. **This review is not a guarantee of payment**.

How to file a Dispute

Disputes may be submitted electronically via Availity Essentials. Any other submission type (e.g. fax or mail) will be rejected and not processed.

Requests must include, at a minimum:

- Member name and identification number
- Date(s) of service
- Magellan 9-digit claim number
- Reason for the dispute
- Any applicable supporting documentation related to claim processing (primary carrier EOB, proof of timely filing, proof of authorization)

Note: Medical records should not be submitted with claim dispute or reconsideration requests, as only administrative claim processing issues are reviewed through this process. If medical records are the only documentation submitted, the dispute will be rejected and not processed.

Any claim dispute received without sufficient information to review will be rejected. All claim dispute determinations are final and not subject to appeal.

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. To minimize denials, if Magellan receives a claim and the date of service is 7-1-24, we will apply an admit date of 6-30-24.
- 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	Ph. D. Psychologist
AH	Ph. D. Clinical 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.