

IBHP Provider Handbook Supplement

Revision log – updated April 1, 2026

Date	Section	Previous Content	New Content
4/1/26	Entire Document	References to the Center of Excellence (CoE)	All references have been removed.
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Federal Data Collection Requirements	<p>To ensure compliance with federal requirements, providers must complete assessments at the following intervals throughout treatment:</p> <ul style="list-style-type: none"> • At admission to services (mental health and SUD) • At any change in level of care <ul style="list-style-type: none"> ○ For SUD services, levels of care include: <ul style="list-style-type: none"> ▪ 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- 	<p>Content Added:</p> <p>To ensure compliance with federal requirements, providers must complete assessments at the following intervals throughout treatment:</p> <ul style="list-style-type: none"> • At admission to services (mental health and SUD) • At any change in level of care <ul style="list-style-type: none"> ○ For SUD services, levels of care include: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ State psychiatric hospital ▪ State Mental Health Authority funded/operated community-based program

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		<ul style="list-style-type: none"> Intensive Outpatient <ul style="list-style-type: none"> ▪ Ambulatory – Detox ○ For mental health services, levels of care include: <ul style="list-style-type: none"> ▪ State psychiatric hospital ▪ State Mental Health Authority funded/operated community-based program ▪ Residential Treatment Center ▪ Other psychiatric inpatient ▪ Institutions under the justice system • For mental health members who do not experience a level of care change, an annual update is required. • For both mental health and SUD members, a discharge from services requires data collection as well. 	<ul style="list-style-type: none"> ▪ Residential Treatment Center ▪ Other psychiatric inpatient ▪ Institutions under the justice system <ul style="list-style-type: none"> • For mental health members who do not experience a level of care change, an annual update is required. • For both mental health and SUD members, a discharge from services requires data collection as well. • Note: TEDS data is not required for braided funding, e.g. members with both Medicaid and other state funding.
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	<p>Authorization Processes</p> <p>Please use the Outpatient Care Authorization Request Form, found on MagellanofIdaho.com, when submitting a paper NOA.</p>	<p>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.</p>
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	<p>Services Requiring Prior Authorization</p> <p>The following services had an update in the Medical Necessity Criteria column</p> <ul style="list-style-type: none"> • Psychological/Neuropsychological Testing • Parenting with Love and Limits (PLL) 	<p>IBHP-Supplemental MNC</p> <p>Magellan Care Guidelines for IBHP</p>

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		<ul style="list-style-type: none"> • Wraparound • CBRS (Skill-Building/Community-Based Rehab Services) • Adult Peer Support • Youth Peer Support • Family Support • Recovery Coaching • IHCBS – Multisystemic Therapy, Multidimensional Family, Functional Family Therapy, and Family Program • Basic Housing Essentials • Adult Safe and Sober Housing • Enhanced Adult Safe and Sober Housing • Child Care for SUD 																																			
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4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	Preservice: Standard	For standard authorization decisions, Magellan will provide the decision notice as expeditiously as the member's health condition requires, not to exceed 14 calendar days following receipt of the request for service.	Preservice: Standard	For standard authorization decisions, Magellan will provide the decision notice as expeditiously as the member's health condition requires, not to exceed 14 7 calendar days following receipt of the request for service.
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	Language Removed		Requesting a Prior Authorization In some instances, the NOA may result in an immediate authorization.	
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	Preservice: ASAM levels of care 4.0, 3.7, & 3.5 Notification of admission (NOA) is required to be submitted within 24 hours of admit. Magellan will provide a decision notice within 3 calendar days of receipt of a completed request.		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.	
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	Preservice EPSDT requests Magellan will review and render a decision on requests for services that fall under EPSDT for medical necessity within 14 business days of receipt of a completed request and medical history information.		Magellan will review and render a decision on requests for services that fall under EPSDT for medical necessity within 14 business 7 calendar days of receipt of a completed request and medical history information.	
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	Concurrent: Standard Magellan will provide the decision notice within 7 calendar days upon the receipt of the completed request.		Magellan will provide the decision notice within 14 7 calendar days upon the receipt of the completed request.	

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4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Before Services Begin	Expedited Authorizations	Expedited/Urgent Authorizations
4/1/26	SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN Member Access to Care	Language Added	<p>Access to care standards and definitions:</p> <ul style="list-style-type: none"> • Non-life-threatening emergencies/Critical Behavioral Health Need: For situations such as suicidal ideation requiring stabilization but without imminent danger, appointments <u>should be offered within 6 hours from the time of the request.</u> • Urgent behavioral health appointments: For conditions that are serious but not immediately life-threatening, appointments <u>should be offered within 48 hours of the request.</u> 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 <u>within 10 business days</u> from the date of the request. Examples include initial intake assessments and ongoing outpatient therapy for stable conditions.
4/1/26	SECTION 4: THE QUALITY PARTNERSHIP Youth Empowerment Services (YES) System of Care	Language updated	<ul style="list-style-type: none"> • Coordinate ongoing with the TCOM COE competency center for training and education to assist providers in delivering YES services that maximize youth and family voice, choice, and strengths.
4/1/26	SECTION 4: THE QUALITY PARTNERSHIP Fraud, Waste, and Abuse	Language Added	<p>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</p>

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			<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>