Magellan HEALTHCARE℠

Weekly Provider Q&A Session 2nd Quarter 2016

Type	Provider	Issue/Agenda Item	Response/Outcome/Updates
Claims	Western Tidewater	We billed the assessment for an individual that went from a CCC to Magellan when the assessment was billed to the CCC. We can't bill another assessment once they switched to Magellan. Are you honoring those initial assessments that were originally billed to the CCC?	If the member has CCC coverage and you did an assessment while the member was in CCC, and then they switched to Medicaid, Magellan needs the CCC assessment date and we can have the claim reviewed. Please contact our customer service center at 1-800-424-4046 to resolve.
Claims	Western Tidewater	Regarding codes 90791 and 90792. We are billing both and receiving denials for one code. Are we to forward the claim information to you?	For procedure codes 90791 and 90792 some providers were questioning billing for one code and getting a denial for the other code. Only one code --- either one or the other--- is allowed once during a 12 month rolling period by provider. By provider, means at the tax I.D. level. Only one agency will be able to bill one code during a 12-month period.
Claims	Colonial Behavioral Health & Southside CSB	I know when a member has regular Medicare and Medicaid and makes a payment, we would bill the deductible coinsurance directly to Medicaid but in this case we have a member who has picked up one of the Humana plans that is a Medicare replacement. The primary portion of the claims is billed to Humana, but I am receiving a denial from Magellan when I am try to bill for secondary. When there is a Humana Medicare replacement plan who should I bill the secondary to pick up that?	There are 3 reasons when Magellan will pick up after Medicare. Those reasons are: (1) If someone has maxed their benefits through Medicare. If they have maxed the benefit, Magellan needs the Medicare Explanation of Benefit (EOB) on file that shows the member has maxed the benefit. (2) When the code is considered a "Medicare bypass" code, which processes no differently than what it has always been. These codes are not covered by another carrier and will not require Coordination of Benefits (COB) processing. (3) The third reason is when the provider is not covered by Medicare or contracted with Medicare. The current process today is if your provider does not participate with Medicare, we ask that you send Magellan a letter on your letterhead with the provider's name and NPI number stating that this provider does not participate with Medicare.
Clinical	Middle Peninsula Northern Neck CSB	The 99211 code does not require the presence of the physician but does the physician have to be in the building? We have not started using the code yet but I wanted to make sure we are correct that the physician does not have to be in the building.	In reviewing the Mental Health Clinic Manual Chapter 2, page 1, a physician does not necessarily need to be an employee of the clinic or utilized on a full time basis or present in the facility on hours that services are provided. It also states that although the physician does not have to be on the premises when the patient is receiving services, they assume professional responsibility for the services provided and assure the services are medically appropriate.

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Clinical	Virginia Beach CSB	I want to get some clarification on the monthly PSR progress note. We have a program that runs on Saturday. So if somebody's note were due on that Saturday, you are saying that the whole month has to be done on that Saturday?	Psychosocial rehabilitation monthly progress notes are due on the 30th day of treatment. If the 30th day falls on a weekend, providers should complete the note on the workday prior to the weekend. If a program is open on the weekend and the 30th day is on the weekend then the note is due on the weekend. Please refer to the CMHRS provider manual, Chapter 6, page 14 under "Psychosocial Rehabilitation Documentation Requirements". Magellan encourages you and your clinical team to determine how you want to handle that as a program/organization. The note is due on the 30th day.
Clinical	Chesapeake CSB	I want to ask about the minutes from the call. Our QA person received the minutes about a month ago. I have only received one so far and I want to know if you are going to continue that or has that stopped or what is the status? So you are planning quarterly?	Minutes from this call have never been posted or sent out by Magellan. Magellan is working on posting a written Frequently Asked Questions (FAQ) from the Friday Provider Call, which will be posted quarterly. The FAQ will include/cover questions for the benefit of a wide audience.
Clinical	Hallmark Youth Care Center	I have a question concerning continued stay authorizations. If we submitted a case for continued stay authorization and this is level C RTC 7 days prior to the last covered day, what is the latest day that Magellan can review that case?	Magellan has 3 business days to review a service authorization from the date of submission. Magellan bases the timeframe on when the authorization is submitted and not when the member's authorization ends. There is a possibility that Magellan may have to pend the authorization if all the information we needed is not included in the submission. This would delay the authorization decision. You have at least 30 days prior to the end date of a current authorization to submit and we encourage submitting as early as possible to avoid a lapse in service for the member.
Clinical	Prince William County	One of our clinical directors asked me to ask this regarding case management. If a case manager accompanies a client to the doctor appointment would that – speaking with the doctor, etc – is that billable case management? While they are in the doctor's office while speaking to the doctor about the client's condition, etc or do we have to subtract that time during the doctor's visit.	Refer to the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapter 4 on page 79. It states that case management includes activities that are intended to positively impact a member's mental health condition. Also on page 80, it states that those activities include linking the individual to needed services and supports specific to the Individual Service Plan (ISP). It also states that case management activities include coordinating services and treatment planning with other agencies and providers. On the same page, page 80, it states that case management counseling is defined as problem-solving activities designed to promote community adjustment and improve functional capacity. If a case manager

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			is taking a member to a doctor's appointment and is present throughout the appointment, this activity should be tied to the individual's ISP and aimed at improving the member's functioning or mental health condition. Documentation should include interventions or problem solving activities that are taking place to help this member and demonstrate how the case manager is needed in this appointment to link the member to this provider or coordinate care.
Network	Unidentified	I have a question about the provider emails/ Provider Notifications email blast, how do we get on the distribution list?	Magellan's email distribution list is updated monthly. Providers can send in an email to VAproviderquestions@magellanhealth.com and Magellan will update the list. Refer to the tips posted on the 2016 Provider Communication page to ensure emails are not sent to your junk/spam mail.
GAP	Prince William County	I have a GAP question. One of our directors emailed me to say there will be a change in the GAP income levels come July 1st she said it would move from 60% to 80%. Is that correct?	Correct. This change in GAP eligibility of household income going from 60% to 80% federal poverty level went into effect July 1, 2016. Please review the Provider Communication from 7/7/16 titled "GAP Eligibility" posted on the Magellan of Virginia website under "Providers" and "2016 Communications".
GAP	Region 10	We are having a lot of our GAP recipients reach the point where they are having to reapply for coverage – renew their coverage - and I understand that they are getting letters mailed to their addresses but we are never seeing those letters. It not being clear to us how we should proceed with helping them with their GAP coverage. One particular point is whether those folks who had GAP and it come to an end if we need to do a new SMI screening and submit it to Magellan. Do we need to do a new SMI assessment? Is that part of the renewal application? Will that also be the case if someone had GAP coverage for 12 months, it lapsed and 2 or 3 months go by and then they reapply would we need to do a new SMI screening and submit to Magellan? One other question since you are on the line. Some of our customers are getting calls from Cover VA telling them that for their application to be completed and considered they need an SMI	*A new Serious Mental Illness (SMI) assessment is not required. The only requirement is the financial part* *. A GAP SMI assessment is good for 1 year from the date of the screening for consideration for eligibility. A new screening would not be needed if the date of the screening is less than a year from the 2nd eligibility application.* ***Cover VA Representative Response:*** *If there is an issue with a SMI assessment already submitted to Magellan, but then they contact GAP unit at Cover Virginia and the SMI has not been received by Cover Virginia, the Cover Virginia worker can check our report to make sure that there is no incorrect information that was transmitted*

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		screening done. We have actually done the screenings and sent them to Magellan. It is causing a lot of confusion for our consumers and staff. In those cases where we have already submitted the SMI screening to Magellan and yet Cover VA is saying they don't have it is there anything we can do to relay it over to Cover VA or is it up to the customer. Okay! So it is up to the consumer or an authorized rep to call and get this resolved. In the past week or so, I have had 4 or 5 of our case managers tell me that their consumers have gotten calls from Cover VA saying it wasn't done which I know we have done and sent to Magellan. Our case managers were confused as what to do. I told them that the consumer had to call Magellan or Cover VA and say no it has been done it just needs to be sent over. I told them consumer because I as the fiscal administrator person can't call myself and say so that was what I thought.	*over. Sometimes the last name and first name are transposed and sometimes the date of birth or social security number might be incorrect. There is a report that Cover VA can check. Also, what you can also do if there is a situation where you know it has been sent, the Cover VA contact person email is raynette.adams@xerox.comCover Virginia is asking their workers to check that report on a daily basis just to make sure that nothing was missed. Hopefully, it will get better with time.* *Once it has been received by Cover VA from Magellan, the information is uploaded to the application. If you know it has been sent but it is not showing up in the Cover VA system, there might be an error somewhere that will require additional research.* *Cover VA staff have been instructed if there is a situation - if they cannot locate the SMI, an additional contact is raynette.adams@xerox.com.* ***Magellan Response:*** *Letters are mailed to address on file, so if the member moves, they should notify COVER VA of their new address. It is also important for providers to call and notify Magellan if they input data incorrectly on SMI Screening form at 1-800-424-4046.* ***Additional Resource:*** *DMAS/COVER VA Presentation on Renewal Process:* *GAP Re-enrollment Training*
GAP	Mount	Do you all have any answers for the SMI	**Below refers to the original Magellan response given during the call.*

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	Rodgers CSB	assessments due to the overlapping of their insurance? If they lose coverage and they get coverage again and we have to get the screen all over. We don't have any follow up as far as that is concerned at this time? It has been denied previously when we tried to put the second SMI date. If they lost coverage. It states that either they have an SMI listed but they need the second SMI. Have you found a way for us to enter the second date?	Magellan is working on reconfiguring the system to allow a second date for the SMI screening for a member that has lost insurance coverage and is rescreened. The system has not been edited at this moment. **This process has since been updated. Please see the updated Magellan response with additional clarification below:* A provider can only submit one SMI screening per member in a 365-day period. CoverVA will keep the information on file for one year. If the member's diagnosis changes or other information is changed, providers need to contact Magellan and speak with a GAP care manger. Magellan will then communicate this information to DMAS. If the screening period is greater than 365 days, the assessment is allowed to be entered systematically on www.Magellanhealth.com.provider