Weekly Provider Q&A Session 3rd Quarter 2016

Type	Issue/Agenda Item	Response/Outcome/Updates
Clinical	The DMAS Medicaid Memo dated June 30, 2016 on page 3 states changes to mental health skill-building services (MHSS) will no longer require a service specific provider intake (SSPI) every 6 months. That function was replaced with a service review by an LMHP to ensure the individual continues to meet medical necessity criteria. "Service Review" is in quotes. Does that mean it will need a special form to require face-to-face with documents needed? Are there elements that are required to be addressed or documented in the "service review"?	There is not a specific form for the service review at this six-month period. Every six months, the LMHP type must review services and document the continued need for the service and any individual's medical records. This is conducted face-to-face with the member. This information can be found on page 63 in Chapter 4 of the Community Mental Health and Rehabilitative Services (CMHRS) manual. When completing services reviews, providers should include any information that indicates how the member is continuing to meet medical necessity criteria for the service and also document how the member continues to benefit from the service. How specific agencies choose to document this information should be discussed internally. Providers can do a full SSPI, but it is not necessary. The questions included in a SSPI may be a good starting point to do a service review on the member. Please refer to page 63 in Chapter 4 of the Community Mental Health and Rehabilitative Services (CMHRS) manual for additional required activities.
Clinical	I was recently informed that the mental health skill-building units have been extended to 520 units for the year instead of the usual 186 units. Is this correct? I was informed that they have 520 annually and it is broken to 260 every 6 months. So, when we submit a request for an authorization for continued stay, do we have 520 units?	The annual unit limit for MHSS is now 520 units. There is a weekly limit of 10 units and a daily limit of 2 units. For Mental Health Skill Building Services (MHSS), the annual limit is 520 units. Providers shall request the amount of units that are clinically appropriate based on the member's need. Keep in mind for mental health

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	Should we be requesting 260 units if we want another 6 months?	skill-building services, the authorizations are a maximum timespan of six months, so providers would not use 520 units in that 6 month time span. That is the maximum allowed for that time. It is based on individual need and not every member require that level of units.
Clinical	If a member calls Magellan to end an authorization, is there any form of communication sent to the provider?	Magellan will make one attempt to contact the provider to inform them of the discharge. If the provider contact does not answer the call, we will leave the information in a voicemail message, so long as the voicemail is clearly identified as "confidential". This marks the importance of making sure providers notify Magellan with up to date contact information and also setting up a confidential voice mail in order for staff to leave messages with Protected Health Information (PHI).
Clinical	How do I add units to an existing MHSS authorization? What are the current limits on MHSS?	Magellan will not automatically increase the units on existing approved authorizations. However, providers can call in for additional units when clinically appropriate. Providers would need to be able to justify the need for additional units, including why the additional units are needed as it relates to medical necessity criteria. This is because not all members will require additional units to manage their mental health symptoms. Providers are welcome to request additional units on the subsequent authorization request. If providers feel it is medically necessary to manage a member's current symptoms on the current authorization, providers may contact a Magellan care manager at 1-800-424-4046 to request additional units. As a reminder, the annual unit limit for MHSS is now 520. There is a weekly limit of 10 units and a daily limit of 2 units.
Clinical	Can a psychiatric evaluation or psychological evaluation from a previous provider that states the member has previously been hospitalized satisfy the requirement for documentation of a higher level of care?	Providers can use discharge summaries to document evidence of a prior higher level of care by contacting the prior provider and providers can also use telephone contact. If providers are going to call the prior provider to get the information regarding higher level of care, the documentation should include the following minimum elements: the name and title of the caller, the name and title of the professional who was called, the name of the organization that the professional works for, the date and time of the call, the specific placement provided, the type of treatment previously

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		provided, the name of that treatment provider, and the date of that previous treatment. Family member or member statements regarding prior treatment record history will not suffice and reports based on self-reports will also not suffice for this criteria.
Clinical	Please clarify the period for completion of the monthly progress note for psychosocial rehabilitation (PSR). Are daily notes for PSR still required?	The monthly progress note is due on the 30th day of treatment. This is not a calendar day but is based on the member's 30th day in treatment. If the 30th day falls on a weekend or day they are closed, then the note would be due on the workday prior to the weekend or prior to closing. For instance if providers are looking at a member's treatment period from Friday, August 7th and move forward 30 days that takes providers to Sunday, September 6th, providers note would need to be completed and in the record by providers last business day Friday, September 4th. If something did occur over the weekend prior to the end of the 30 days providers could simply add an addendum note into the record taking account of anything that occurred after providers had already written the monthly note. Daily PSR notes are still required. Daily documentation is needed to support the time billed for the day of programming. Please refer to the CMHRS Manual, Chapter 6 page 14 that covers daily documentation. In short, daily documentation should include a summary of daily activities and group activities and include impressions of each member in the activity.
Clinical	Is a SSPI required for a new crisis intervention registration after the first seven days?	An SSPI is not required for additional crisis intervention registrations. However, it would be good practice to constantly evaluate a member in such a high level of care to determine risk, progress, obstacles to discharge, and whether or not they continue to need this high level of care prior to requesting another registration.
Clinical	For case management services, are individual service plans (ISP)s required to be signed and dated by the member and provider no later than 15 days following the quarterly review?	Yes. Within 15 days of the end of the quarter, a signed and dated copy of the ISP is required to be in the member's medical record for case management. The signatures must include both the member and the provider.

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Clinical	Can providers clarify the supervision requirements for QMHPs?	Magellan encourages all providers to review Chapter 4- Provider Participation Requirements, pages 12-13 of the CMHRS Manual to review specific qualifications for QMHPs. Also, page 6 of Chapter 6 of the CMHRS Manual “Utilization Review and Control” section, provides additional information regarding requirements for documentation. Please view the following regulation 12VAC30-50-130 for clarification on specific levels of care and 12VAC35-105-20 to view the QMHP definitions. Magellan recommend that providers consult with their licensing board and/or the Department of Behavioral Health and Developmental Services (DBHDS), which may have specific requirements and guidelines for supervision.
Clinical	Can a certified pre-screener conduct an SSPI for crisis stabilization services? Can a Virginia Preadmission Form be used in lieu of doing a SSPI for Crisis Stabilization?	On page 61 Chapter 4 of the CMHRS manual, it states that a certified pre-screener can conduct the face to face SSPI, as long as it meets the requirements of an SSPI outlined on pages 15-16 of the same manual and it is signed by an LMHP, LMHP-supervisee, LMHP resident or LMHP-RP within one business day. The SSPI should be completed prior to initiating the crisis stabilization service and help drive the development of the ISP. On page 61 Chapter 4 of the CMHRS Manual states, “An LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a Certified Pre-Screener, shall conduct a face-to-face service-specific provider intake. If the intake is completed by the pre-screener it must be signed off by an LMHP, LMHP-supervisee, LMHP-resident or LMHP-RP within one business day.” Details for what must be included in the SSPI are on pages 14-17. There is no provision for allowing a Virginia Pre-admission form to be used in lieu of the SSPI. All required elements are required to be addressed to qualify for reimbursement.
Clinical	Can a QMHP-E provide MHSS?	Per regulations effective August 1, 2016, Mental Health Skill-Building Services can be provided by a QMHP-E, assuming they are being supervised as required by all QMHP-E staff. Please refer to Chapter 2, page 12 of the CMHRS Manual for details regarding supervision of QMHP-Es.
Clinical	Documentation of Medical Necessity	Magellan reviews for medical necessity for all levels of care. For all services, when providers are submitting a request to Magellan it is the provider’s responsibility to document thoroughly how the member meets the medical necessity criteria for that level of care. Documentation for

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		medical necessity would include answering questions on the service request authorization thoroughly, which would reflect a member's current symptoms and behaviors. Medical Necessity Documentation should also be in the member's medical record. Examples of documentation for medical necessity would include the Service Specific Provider Intake, progress notes, and Individual service Plan however this list if not exhaustive. Care Managers will continue to review for medical necessity criteria when requests are submitted to Magellan. Please keep in mind that authorization is not a guarantee of payment. Providers must be able to substantiate medical necessity in the member's record or may be subject to retraction even when there is an authorization in place.
Clinical	Can the "Virginia Preadmission Screening Form" be used as the assessment in lieu of the SSPI for Crisis Intervention when the member presents voluntarily for hospital admission and an ECO/TDO is not required?	On page 56 of the Community Mental Health and Rehabilitative Services manual it states that "During Emergency Custody Order (ECO) related Crisis Intervention services, CSBs may use the *DMH 224 -Preadmission Screening Report* to document the required elements of the service specific provider intake." There is no provision for using the preadmission screening report if the member is not under an ECO.
Clinical	If goals on an ISP have been met, are we required to keep them listed on the ISP?	Information regarding requirements for ISPs can be found on page 17 of the CMHRS Manual. There is no specific requirement to keep goals that have been met on the ISP, but providers do want to make sure that the ISP reflects that the goal has been met along with the date met. Whenever revising the ISP, new goals may be added to reflect the member's needs, however, it would be important to maintain documentation in the member's record of the previous ISP goals.
Clinical	Can a licensed physician who is not a psychiatrist provide crisis stabilization services?	On page 8 of the CMHRS Manual, Chapter 2 page 8 states "Crisis Stabilization services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a certified prescreener". An LMHP is defined on page 11 as "a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist". Therefore, a licensed physician who is not a psychiatrist can provide the service. From a clinical perspective, it would be important to

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		ensure that the professional providing the service is practicing within their knowledge base and scope of practice.
Clinical	The DMAS Psychiatric Services Manual states that no more than three outpatient therapy sessions can be provided in a seven-day period. How is a seven-day period defined?	The reference to a seven-day period on page 28 of chapter 4 of the psychiatric services manual is referring to any seven-day period, not a calendar week. So for instance, if the member has outpatient individual therapy on Wednesday, family therapy on Thursday and Group therapy on Friday, the provider would not be able to get paid for outpatient therapy again until the following Wednesday. Please refer to the additional specific service limits on pages 28 and 29.
GAP	Does a nurse practitioner meet the requirements for a diagnostic evaluation completed in the last 12 months in order to use the limited screening for GAP?	A licensed mental health professional (LMHP) is defined in Chapter 2 of the Community Mental Health and Rehabilitative Services (CMHRS) Manual. Nurse Practitioners are not included in qualifications for an LMHP and therefore, do not meet requirements for a diagnostic evaluation completed in the last 12 months.
GAP	Clarification on Magellan case management provider communication Is a new registration required if the member's eligibility changes from GAP coverage to straight Medicaid?	Effective September 1, 2016, the Mental Health Case Management (H0023) registration forms will add a GAP modifier code in order for providers to specify when the service provided is GAP case management. If the registration is for "GAP Case Management Low Intensity", the provider will select H0023 UB. If the registration is for "GAP Case Management High Intensity", the provider will select H0023 UC. Only one registration for the entire requested period will need to be submitted to Magellan, even if both Low Intensity and High Intensity services will be provided during the registration period. Providers are required to identify the appropriate modifier on the claim for the service provided in a specific month, either Low Intensity (UB modifier) or High Intensity (UC modifier). If a member's eligibility changes from GAP coverage to straight Medicaid or vice versa, a new case management registration would be required. Please note providers would have to discharge the first registration with Magellan prior to submitting the new registration. Providers can discharge the registration online by going to www.magellanofvirginia.com or calling Magellan directly. The secure provider web portal, www.magellanhealth.com/provider will be updated for all registrations submitted 9/1/16 or later with the new case management modifiers.

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	What if I have existing registrations prior to September 1st, 2016?	If providers have a previous registration with Magellan submitted prior to September 1st, providers do not need to resubmit and add modifiers to the registration. However, providers will need to designate a modifier when submitting claims.
GAP	Are we required to submit an authorization/registration discharge for GAP members when they discontinue services, as we currently do with Medicaid members?	There are no differences in submitting discharges for GAP members from other members. Prompt submissions for discharging members, including GAP members, will avoid a delay in members' access to services from another provider.
GAP	What should a provider do if they registered a member with GAP case management and then the member's eligibility was made retroactive as fee-for- service Medicaid?	Registrations prior to September 1, 2016 did not include the modifier, so a new registration does not need to be submitted. Post September 1, 2016, if there is a change in eligibility to fee-for service, providers will have to discharge the GAP case management registration and submit a new case management registration without the modifier. For claims submission, if a member was in a GAP plan and claims were paid and the member now has fee-for-service eligibility that is retroactive, the provider would need to submit a corrected claim removing the GAP modifier. There is a rate difference in payment for GAP case management and fee-for-service case management, which would require a corrected claim in order to adjust the payment accordingly.
Network	How do I sign up to receive the Provider Notices?	If providers want to be on our distribution list, please submit the contact information using the "contact us" link on www.magellanofvirignia.com or call 1-800-424-4536 to speak with a Network representative. If providers are already on Magellan's distribution list, but not receiving emails, please use the following tips to ensure delivery of our provider notices: • be sure to **ADD** Magellan Healthcare of Virginia / VAProviderQuestions@magellanhealth.com to email contacts • check spam | junk email folders

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		• check with internal IT support to ensure receipt of HTML-based emails/communications • check with IT support to ensure an internal firewall is not preventing mass email communications from coming through Please keep in mind, if the communication pertains to a specific service in which providers or the provider organization is not contracted, providers will not receive the notice. Magellan encourages providers to periodically check the communications page for Magellan provider notices.
Network	Clarification on Credentialing/Recredentialing Provider Communication	We have received a few questions regarding the provider communication from August 24, 2016, regarding credentialing and recredentialing requirements. There is mention to certain provider types subject to an application fee as well as newly enrolling providers or for existing providers adding new locations. The provider types are in scope for an application fee payment and referenced in the DMAS Medicaid Memo "Implementation of the CMS Affordable Care Act Provider Enrollment and Screening Requirements". This memo is dated March 7, 2014. To clarify whether the provider would be subject to the fee if there was an address change: If that location is already contracted/credentialed and is not changing any of the services that are licensed for that location, then it would not be applicable to the fee. **The fee is only applicable to newly enrolling locations for certain provider types outlined in the DMAS Memo.**

As a reminder, Magellan of Virginia hosts a weekly call each Friday beginning at 1 p.m. The call is open to all providers to address questions and issues. We encourage providers to visit the Friday Provider Call page on Magellan of Virginia's website to review weekly agendas with program announcements, questions to be covered during the call and quarterly FAQs. Providers may submit questions using the contact us link feature on the Magellan of Virginia homepage. Questions should be submitted by the close of business each Wednesday for discussion on Friday. Any questions that require more research will be held over and answered on a subsequent call. We look forward to your participation.