Provider Questions and Answers
Louisiana Behavioral Health Partnership (LBHP)
Administration of Behavioral Health Benefits – Effective March 1, 2012

1. **Who is Magellan Health Services?** Magellan is a leading specialty health care management company that delivers innovative solutions in collaboration with government agencies, health plans, corporations and their members nationwide. Magellan specializes in managing behavioral health care, as well as diagnostic imaging, and specialty pharmaceutical services and providing pharmacy benefit administration, and partners with clients, providers, members and other stakeholders within health care communities. Magellan currently manages behavioral health care for 32 million individuals, including individuals in public programs in the states of Arizona, Florida, Iowa, Nebraska, and Pennsylvania.

   Effective March 1, 2012, Magellan will manage behavioral health services under contract to the Office of Behavioral Health in the Department of Health and Hospitals (OBH/DHH). This managed care system is known as the Louisiana Behavioral Health Partnership (LBHP) and includes services to adults, adolescents, and children served by OBH and children served by the Office for Juvenile Justice (OJJ), Department of Children and Family Services (DCFS), and Department of Education (DOE), including the Coordinated System of Care (CSoC).

2. **What is the Louisiana Behavioral Health Partnership (LBHP)?** The LBHP is the behavioral health program for those adults and children eligible for Medicaid (listed above). It will be managed by Magellan Health Services, who will be overseen by the Office of Behavioral Health in the Department of Health and Hospitals. The program includes behavioral health care providers statewide who provide mental health and substance abuse services for adults and children. The goal of the LBHP is to improve the quality and accessibility of these services for eligible Louisianans, and to do so collaboratively with care providers and families.

3. **What experience does Magellan have in implementing transitions to behavioral health managed care?** Magellan has extensive experience managing effective implementations for a large number of public behavioral health managed care systems in states such as Arizona, Iowa, Nebraska and Pennsylvania. These implementations included executing new and innovative managed care systems. Magellan has the depth of experience, competencies and capacities to implement a successful managed care transition that is tailored to the needs and objectives of DHH and Louisiana stakeholders.

   It is our goal to establish a managed care program that will meet and exceed expectations. Transformation of the behavioral health system in Louisiana will be based upon leveraging the strengths of the existing system with pivotal identified issues and opportunities for change. This transformation will be a learning process requiring ongoing modifications, adjustments, and refinement.

4. **Why is this change to the behavioral health care system happening?** The citizens of Louisiana deserve quality, timely behavioral health care that provides voice and choice. The elected leaders of Louisiana advocated for these changes and the Louisiana Behavioral Health Partnership was born. The LBHP will go live on March 1, 2012 and will be managed by Magellan Health Services, in partnership with local, community-based behavioral health care providers. We are committed to…
    - Resiliency: Believing that all people have qualities that enable us to rebound from adversity, trauma, tragedy, or other stresses and to go on with life with a sense of mastery, competency and hope.
    - Recovery: Believing that all people living with behavioral health conditions have the capacity to learn, grow and change, and can achieve a life filled with meaning and purpose.
    - Cultural Competency: Working to provide care and services that recognize the diverse backgrounds of the individuals and families served, and using strategies that acknowledge and respect the behavior, ideas, attitudes, values, beliefs and language of an individual or group of people.

5. **Who verifies agency credentials?** Magellan credentials providers every 3 years, in accordance with NCQA requirements. The credentialing process includes: Primary Source Verification (PSV) and Regional Network Credentialing Committee (RNCC) review. Magellan will process all credentialing applications within 180 days or in accordance with applicable state or client company guidelines. Re-credentialing is completed every 3 years.

6. **Are any special licensures or credentials required in order to provide outpatient substance abuse services?** Individual practitioners can practice within their allowable scope of practice. Licensed addiction counselors will be eligible to participate in the LBHP and may deliver substance abuse services to Medicaid-eligible members within their scope of practice. Licensed addiction facilities must employ staff as defined by their license standards as a substance abuse facility. The Office of Behavioral Health has certifications requirements that some provider types are required to complete. Please review the certification documents located on the procurement Library on the DHH website at http://new.dhh.louisiana.gov/index.cfm/page/538. And, make sure you complete that process as quickly as possible as well. The good news is that outpatient substance abuse services, which were not previously funded through the Medicaid program, now will be, effective March 1.

7. **Does an organization or provider need to be enrolled in Medicaid?** Providers will be issued a number through a data transfer process that Magellan and Louisiana Medicaid have worked out. No action from the provider is necessary.

8. **Will LPCs and LCSWs who are ACE-certified through Medicaid be able to apply for a provider number?** Yes, the new waivers in Louisiana allow LPCs and LCSWs to participate in the Medicaid program through a contract with Magellan. Providers who do not already have a Medicaid ID number do not need to apply through Medicaid. That process is going to be handled by Magellan through data transfer with the State. The only thing that any provider in the system needs to do is comply with our credentialing application—get us the data we need to complete that process—and then through the transfer of data back and forth between us and the State, you will be automatically issued the Medicaid ID number that we need to have issued for you. So you don't need to take any special steps to obtain a Medicaid ID number.

9. **Will Magellan have a targeted case management service area within Louisiana?** Magellan will cover behavioral services for the entire state of Louisiana

10. **When will member handbooks be distributed?** The member handbook will be available on the MagellanofLouisiana.com website on March 1, 2012. We will begin to print and distribute the English version throughout the community/state in March.

11. **Do adults seeking behavioral health services need to go through Magellan to receive services or can they refer themselves directly to a provider?** Individuals can go directly to a provider for services. The provider is then responsible to contact Magellan for any necessary authorizations.

12. **Will the initial assessment be conducted by the provider or practitioner?** For children in CSoC and adults in the 1915(i) waiver, there will be an independent assessment and plan of care developed by an independent assessor who cannot be the treatment provider. For other individuals, the provider will conduct the initial assessment and develop the treatment plan.

13. **Who will decide length of treatment (days of IOP, days of inpatient, etc.) - the assessor or current providers?** For children in CSoC and adults in the 1915(i) waiver, the assessor will recommend the length of treatment. For other individuals, the provider will make this recommendation. Magellan will review recommendations and authorize care utilizing the Louisiana Behavioral Health Partnership Service Authorization Criteria.

14. **Where will the 250 children per region in the CSOC Program come from? For example, already in OJJ, DCFS, etc. or at home at risk of being removed?** Children in CSoC will be children who are in out-of-home placement or at risk of out-of-home placement. The CSoC program is being implemented in a staged manner throughout the state, and there will not be 250 children per region identified for CSoC on March 1, 2012.

15. **Will children be required to go through CANs to receive services?** In order to receive CSoC services, the member will receive a Comprehensive CANS through an independent assessor.

16. **Are there plans to expand Medicaid to addiction services?** All individuals with Medicaid coverage are eligible to receive substance use disorder treatment.

17. **Will adults with a substance use disorder be eligible for Medicaid?** Medicaid eligibility is not dependent on diagnosis.

18. **Do I need to wait for Magellan to send referrals or can I accept them independently?** Providers can accept referrals but need to contact Magellan for authorization of services to be rendered.

19. **How will Magellan handle pre-approval for courts on behalf of client ordered into treatment?** A court order does not establish medical necessity. Magellan authorizes based on the medical necessity of the services requested.

20. **We currently use Interqual criteria for behavioral health. Will this be applicable criteria for inpatient psychiatric care and use with clinical advisor?** Magellan will review recommendations and authorize care utilizing the Louisiana Behavioral Health Partnership Service Authorization Criteria.

21. **Will there be a claims interface? Will Magellan come to an agency to provide claims training? Magellan should receive claims only for dates of service of** March 1, 2012 and

beyond.

- ***Clinical Advisor*** requires no software on the desktop, supports all clinical interactions necessary with the patient, and also provides standard office functionality such as scheduling and claims processing.

- **Electronic Claims submission** via www.MagellanHealth.com/provider or through a clearinghouse. When submitting claims electronically, use submitter ID # 01260 for all except Emdeon 837I which is submitter ID# 12X27

- **Paper Claims** - Mailing address:
  Magellan Health Services
  Attention: Claim Department
  P.O. Box 2064
  Maryland Heights, MO 63043

22. **What will be the role of OBH in the Magellan provider network?** Each funding agent (Medicaid, OBH, DCFS, OJJ, DOE, etc.) is responsible for determining member eligibility based upon their mandates. OBH also oversees Magellan's contract as the state management organization.

23. **How will the regional office work with FSOs peer specialists in terms of training, technical assistance and funding?** Family Support Training will be developed to ensure the specific needs of the FSO providers are addressed. Ongoing training will include, but will not be limited to:

    - Fundamentals of Providing Family Driven Services
    - Opportunities for Coaching/Mentoring
    - Observations using any pre-established protocols

24. **Are Magellan committees formed regionally? Where do we send applications to be part of the Magellan committees?** Magellan is committed to promoting stakeholder voice in the design and development of our quality program. Design and development occur primarily through our Louisiana Care Management Center QI committee structure. As stakeholders, providers are invited to participate in all Louisiana QI committees.
    - Quality Assurance/Performance Improvement Committee
    - Utilization Management Committee
    - Member Services Committee
    - Regional Network Credentialing Committee
    - Network Strategy Committee
    - Family, Member, Stakeholder Advisory Committee
    - Race and Equity Committee

25. **Will clients receiving Medicaid and Medicare qualify for services through 1915i?** As of March 1, 2012, new members must complete an Independent Evaluation to qualify. Independent Plan of Care (POC) will be developed and submitted for approval. Authorization will be good for 3 months. For subsequent authorizations individual services approved based on plan of care (POC). Authorization is good for 3 months. POC must be updated at least annually.Although members who have both Medicare and Medicaid may be eligible for services in the LBHP, Medicaid will be the payor of last resort.

26. **Will claims be sent to Magellan based on diagnosis or provider type? For example, if a pediatrician sees his/her patient and diagnoses ADHD or depression, will these claims go through Magellan?** Magellan is responsible for managing behavioral health services delivered by behavioral health providers. If a pediatrician diagnoses and treats for ADHD, the claims will be paid by the CCN or Medicaid FFS. This would be considered a physical health service based on the provider delivering the care. If a psychiatrist provides the treatment, the claim will be submitted to Magellan.

27. **It is our understanding that upon approval of our credentialing application, a "point person" will be assigned to our agency. We further understand that the point person will call us to finalize the contracting process. How can we find out who our point person is, and obtain contact information?** Providers have already had outreach from the person assigned to get the contract completed. If you are not sure who your contact is, email us at LAProviderQuestions@MagellanHealth.com to request the name of the network coordinator who is handling your credentialing and contracting.

28. **Where can we find detailed instructions on how to make referrals (e.g., process for making a referral, phone numbers, any documents we need to prepare, etc.)? When will we be allowed to begin making referrals?** Provider processes and procedures will be included in the Louisiana provider handbook supplement, which is currently in development and will be posted on www.MagellanofLouisiana.com in the *For Providers* area. It depends on the type of care being referred, but generally you can contact Magellan at 1-800-424-4399 to make a referral. Members also can self-refer to routine outpatient services or check the website to locate a provider. This web functionality will be available on www.MagellanofLouisiana.com in the future.

29. **Can Case Conference be provided by an LMHP employed by an MHR agency?** It is expected that MHR, CMHCs and other provider types that have a psychiatrist on staff would not utilize the Case Conference service. Treatment team meetings are an expected part of these service provider types. Case Conference is intended for use to coordinate treatment with other providers outside of your agency not within an agency or organization.

30. **Or is Case Conference only for independent LMHPs to provide?** Please see list of allowable provider types, both LMHPs and organizations are included in that list.

31. **If a non-licensed person works in a community mental health center are they required to provide 51 percent of their services off-site? If so, what does that involve?** Yes. A non-licensed bachelor's- or master's-level individual can only provide services under the Community Psychiatric Support and Services or Psychosocial Rehabilitation codes. Please see these service descriptions for the parameters of service delivery, including the requirement of 51 percent of Psychosocial Rehabilitation services in the community.

32. **Does "eligible for DHH services" for children mean that the local providers will use the eligibility criteria used by the OBH community mental health clinics? If yes, where do we get those criteria?** Yes. You will need to consult with DHH to determine OBH non-Medicaid eligibility; however that will be determined in the same way as in the past.

33. **I am in private practice and already have a contract with Magellan. Do I need a new contract to provide services through LBHP?** No.-You only need an addendum to your existing contract. Please email Magellan at LAProviderQuestions@MagellanHealth.com or call 1-800-788-4005 to request this addendum.

34. **The service definitions listed in the manual for children are for CSoC youth. Are those the same service definitions that will be used for youth eligible for the listed state agencies?** The first five services of Chapter 1 in the Service Description Manual are for youth found eligible for CSoC. All other services in the Manual are available to all other children and CSoC-eligible children.

35. **Will licensed professionals employed as W-2 or 1099 employees by an MHR agency be able to credential through the provider agency to provide "Outpatient Therapy by Licensed Professionals" and bill the service through the agency's Taxpayer ID / NPI numbers?** Licensed professionals as defined in the service description manual as employees, either W-2 or 1099, are not required to complete individual credentialing applications. They will be included in the (licensed professional) staff roster submitted by the organization. If that individual licensed clinician also works in a separate individual or group practice, unaffiliated with the mental health rehab provider, that provider will need to complete individual credentialing in order to bill for services delivered in the private practice.

36. **There is a workforce development shortage in the addictions field. Are you going to give addiction providers time to get their current staff licensed?** Unlicensed staff providing addition services now would be working within licensed substance abuse residential programs. That can continue under the authority of the existing license through Louisiana Addictive Disorder Regulatory Authority. In order to provide substance abuse services as an independent clinician within the scope of practice, individuals will need to be licensed. Due to Medicaid regulations, services can only be billed under the Provider Qualifications listed in the Service Description Manual.

37. **On one of your presentation charts there is no X on the OBH Adults column and LMHP row. I thought LMHPs could deliver services to OBH adults.** That section of the chart refers to non-Medicaid adults within OBH clinics. OBH adults will be referred to OBH clinics as they have in the past

38. **Does the LBHP apply to clients who have both Medicare and Medicaid?** A Medicare-eligible member will use Medicare as their primary funding source for behavioral health care needs. If members have both Medicare and Medicaid you will bill Magellan for the services after Medicare is billed.

39. **Will the LOCUS instrument still be used to determine eligibility for MHR services?** Yes.

40. **If an agency is enrolled with Magellan, are all licensed clinicians automatically credentialed to provide services listed under the "Licensed Clinician" section of the provider manual or is additional credentialing needed?** Licensed clinicians working for an organization under one Taxpayer ID number are included in the credentialing and contracting of that organization. A separate credentialing and contracting process is not needed for clinicians working in a licensed OBH clinic, CMHC, or certified mental health rehab organization See service manual for complete list

41. **Can I obtain a copy of past webinars/presentations on your website?** We post provider webinars and forum presentations to www.MagellanofLouisiana.com, in the For Providers/Training & Events area.

42. **Will Magellan re-issue PAs for recipients in the MHR program and will those PAs reflect the arbitrary cuts (e.g., all new adults coming in at Medium Need, etc.) enacted back in November?** No. We are not reissuing prior authorization. We have a transition plan to allow

services to continue at the same intensity and frequency as was authorized prior to March 1, 2012.

43. **Will there be a specific CPT Code provided for the MHR services and medical diagnosis?** HCPS codes for mental health rehab services are provided in the service description reimbursement schedule attachment in the LBHP procurement library: http://new.dhh.louisiana.gov/index.cfm/page/538

44. **How do we handle those calling in for services before March 1, 2012?** For mental health rehab services, contact DHH. Magellan is not responsible for services until March 1, 2012.

45. **We have clients that are in our treatment center but do not have Medicaid as of March 1, 2012. Do I bill Magellan?** It depends. If you are referring to commercial contracts insurance, not managed by Magellan, you do not need to contact us. If you are referring to members who are not eligible for Medicaid but are eligible for OBH funding, you would contact Magellan.

46. **"How will we work to build more services to meet the continuum of care neeeds"?** It will be a cooperative effort between local companies, providers and Magellan when thre are good ideas which can be built upon.

Youth Residential-Related Questions

1. **Can non-LBHP children (OJJ/DCFS) be placed in the same facilities as LBHP children?** Please refer to your licensing authority document for guidance on restrictions of placement in your specific facility.

2. **Can a residential provider have varying levels of group homes on the same property, not in the same building?** The guidelines set for the Therapeutic Group Home type state that this facility must be a residential home in a residential neighborhood setting, so would not allow another type on the same property. The remaining residential types could be on one campus unless the organization's structure classifies it as an Institution for Mental Diseases (IMD).

3. **Will our number of transitional living beds reduce the number of NMGH beds that we have?** The total number of beds regardless of type will be counted toward an institution's total bed count.

4. **Can an agency that runs a non-medical group home on a campus owned by a parent organization also run a transitional home (independent living house for children aging out of care) in a separate area (with a different address), owned by the agency and not the parent organization?** The total number of beds regardless of type and location will be counted toward an institution's total bed count if that provider is considered a "single institution" as defined in the Institution for Mental Diseases (IMD) definition.

5. **What is the full array of service for Medicaid and where is the information available?** The full array of services for the Louisiana Behavioral Health Partnership is available in the Services Description Manual found in the SMO Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/538/n/225.

6. **What is the length of stay for NMGH?** There is no length of stay dictated for the Basic Non-Medical Group Home nor the Mothers with Infants sub-type. There is a 60-day length of stay limit on the Diagnostic and Assessment NMGH sub-type.

7. **What is the rate for room and board? Will they pay for room and board for the NMGH with option to provide other services on-site?** Only the room and board rate will be paid to NMGHs. Other behavioral health treatment services will be paid directly to those qualifying treatment providers for services provided on-site or off-site of the NMGH. The NMGH room and board rates were recently released by DCFS and OJJ and will soon be available on the website.

8. **Has Magellan received my credentialing application?** Please send inquiries regarding your credentialing and contracting process with Magellan to LAProviderQuestions@MagellanHealth.com or call 1-800-788-4005.

9. **When will the data be available on the CANS assessments so as to determine the actual balance and need of PRTF, TGH, NMGH, and TFC beds in various regions?** As part of Magellan's provider network development, data will be gathered throughout the coming year to determine the service capacity needs by region for each service.

10. **Although Magellan begins managing services on March 1, 2012, youth will reportedly be transitioned over time to appropriate placements. Providers are being told to continue services with youth in placement. How does Magellan plan to pay for services rendered if the amount of need is more than, or less than, the agency's pre-determined classified rate? During this period of transition, will the financial payment follow the child's level of need or the services actually provided by agencies?** Only behavioral health services outlined in the Service Description Manual will be paid by Magellan beginning March 1, 2012. Mechanisms are being developed to avoid the disruption of treatment for youth on March 1 while adhering to the requirements and standards outlined in the Service Description Manual.

11. **When will "freedom of choice" to select a therapist or provider be realistically added for youth and families in care? Currently, residential providers are being asked to continue services, which includes therapy. This question regarding a realistic timeline has a significant impact on financial planning and employee retention or repositioning, therefore more information in this area would be helpful.** Mechanisms are being developed to avoid the disruption of treatment for youth on March 1, 2012, while adhering to the requirements and standards outlined in the Service Description Manual.

12. **What is the general clinical plan to transition youth to new placements or select therapists when freedom of choice actually becomes part of the equation? Describe more fully the parameters and frequency of choice.** The freedom of choice will be afforded to a youth and family through the Child and Family Team process under the Wraparound Facilitation. Please refer to the Wraparound Facilitation portion of the Service Description Manual for a thorough description.

13. **What are the anticipated dates for moving children out of their current placements so that providers can prepare the youth and staff?** Children will not be moved on March 1, 2012; they will stay in their current placements.

14. **I have heard someone from Magellan say they have a one-year, two-year, and three-year plan as to how to implement CSoC. Can the plan be shared with us?** We discussed a three-year overall plan in our forums in December. That presentation is available at http://new.dhh.louisiana.gov/index.cfm/page/1093.

15. **What training does Magellan plan to provide and when will it start?** Various in-person events and webinars have been held. Clinical Advisor system training began on Feb. 13, 2012

and intensive training will continue for three weeks. We will continue to provide training and support after March 1, 2012. Visit our Provider Trainings & Events page at www.MagellanofLouisiana.com/providertraining.

16. **Should agencies be contacting their FSOs and/or Wrap Around in order to be identified as a possible provider for their region?** To become a provider with Magellan for the LBHP, a provider should contact LAProviderQuestions@MagellanHealth.com or call 1-800-788-4005. Relationships should be developing between providers and the FSOs and WAAs within your regions.

17. **How soon will agencies know they have been certified through OBH?** Contact OBH to determine whether your certification has been completed.

18. **Will a non-medical group home be able to house both general non-medical and diagnostic and assessment beds?** Yes.

Louisiana provider webinar 2/3/12 – Q&A

Q: Regarding assessments being done by independent assessors – when a client calls or comes by our office, we have been directed to call Magellan. In doing so, if it rises to the level of them receiving an assessment by an independent assessor, will that assessment take place at the assessor's office, will it be at our office, or somewhere in the community – where would that take place?

A: Independent assessments will be conducted by providers who have signed up with us to be independent assessors. So, the independent assessors do need to be licensed mental health professionals. If you are interested in being on the independent assessment panel, please let us know during your contracting process.

We also are trying to identify those licensed professionals who may be interested and are reaching out to them.

Q: Do the people who are handling admissions for our various programs (e.g., residential, detox, outpatient, and an adolescent program), need to have a certain level of licensure?

A: You need to continue to follow the current licensing standards that you have now, in terms of staffing requirements and who is able to provide a specific service. The only caveat is if any new standards are identified in the Service Description Manual for those particular services, you need to check those and make sure you are compliant with those requirements as well. Consult the Addictions Services chapter.

Q: I'm also wondering about the independent assessment. Where is the independent assessment supposed to take place? Where will it actually occur? Where are we sending our possible patients to? Secondly, I need help finding the provider rates on the DHH website.

A: You will call Magellan if you have someone in your office who needs an independent assessment. We will locate an independent assessor, because the independent assessor cannot be the provider who is or is going to be the service provider. It must be someone independent from the person providing care. So, we will find an independent assessor and schedule that. It will occur in the independent assessor's office. It will not occur in Magellan's office. We are not providers, so we will not be providing any services in our own office. We are contracting with people to be independent assessors; the assessments themselves will occur in a provider office.

Where are the provider rates on the DHH website?
The provider reimbursement rates are in the DHH procurement library right at the very top, under the Service Description Manual itself. The link is titled "LBHP Services Manual Codes."

Q: After the independent assessor does the assessment, how is the client referred back to the agency? Will they have freedom of choice, or will you [Magellan] choose an agency that will follow that client?

A: The independent assessor develops a plan of care. After the independent assessment is done, the provider will recommend what he/she believes the individual needs in terms of treatment services. That will come back to Magellan and we will review it. We will authorize the services from that plan that are medically necessary. If the referral for independent assessment came from a provider (who cannot do the assessment itself), we would review that and, as long as you as the provider, provide the service that is now being authorized, we could send that person back to you for treatment.

Q: I'm already a provider with Magellan. I was told that all I would need to receive would be an amendment to my contract. Is that correct?

A: Yes, thank you for being a current Magellan provider; we don't need to credential you again. If you haven't already, you will soon receive the Medicaid addendum along with the appropriate reimbursement schedule for this program.

Q: I'm interested in becoming a provider. I'm an LPC and as I was going through the process, one of things I wondered is: According to the scope of practice, for example, I wouldn't do medication management, but would I be able to speak to any of these assessors regarding some of their clinical conclusions? What form will these reports take? How will I know as a provider that the person I'm getting the assessment from and I clinically agree?

A: The independent assessment is an assessment to determine whether the person is qualified for a 1915i waiver. So that assessment isn't really telling you clinically what to do for services; it's telling everyone that this particular member qualifies for the 1915i waiver and, therefore, some of the additional services that go along with that.

So if someone comes into your office and they are mildly depressed and you are going to provide therapy, then the assessment is not necessary. It is used for people who would be potentially eligible for rehabilitation services under the 1915i waiver.

Q: [Follow-up question.] So are those the only situations where an assessment would be necessary, or not?

A: It could also be for a child who may be eligible for the Coordinated System of Care.

Q: [Follow-up question.] So if someone comes into our office with, for example, general depression symptoms or anxiety or grief, we don't have to go through all that—we can just see if they fall under Magellan's scope of services, get an approval, and begin treatment, yes?

A: Correct.

Q: Where do I find the provider manual?
A: The Service Description Manual is published by DHH and is on the DHH website. Magellan's behavioral health provider handbook supplement for Louisiana providers is in development and will be posted on www.MagellanofLouisiana.com before March 1.

Q: Do we have to complete the organization certification with OBH before we can be credentialed by Magellan?

A: No, you can do those things concurrently. To some extent we're going outside of what a normal sequence might be because of the compressed implementation timeframe. So you should be doing the OBH certification immediately if you're in the category of providers that needs to do that. You should also be concurrently working on your credentialing application. We don't want to let either of those processes slow the other down.

Q: Do you know the age range requirement for Medicaid as far as seeing children? Does it stop at age 18 for classification as a child or does it go up to age 20?

A: People under age 21, from a Medicaid perspective, are children.

Q: [Follow-up question.] So for addictions, which goes up to age 20, they would be treated in children and adolescent services, and 21 and above would go to adult services. Is that correct?

A: In this example a 20-year-old could be billed for under the children's defined Medicaid benefit, but the design of the programming needs to make clinical sense and must follow the licensure standards where the service is being provided.

Q: [Follow-up question.] Do you know the minimum age range that will be billable for a child, e.g., for children's services for a child that's receiving mental health treatment, would it be paid from the age of 0 to 6? Or would it start at age 5?

A: The issue is related to whether the services are medically necessary rather than the age of the child.

Q: [Follow-up question.] We're asking because on your credentialing application, it requests the age range.

A: On the credentialing application, we're trying to gather information on your competencies so that we can make accurate referrals. For example, if we have a referral for a 5-year-old child, through our credentialing data we would know that you only serve teenagers, and thus we wouldn't send that referral to you.

Q: [Follow-up question.] So our two programs: infant, child and family services, and early childhood supports and services, that fall under this…Would we just need to clarify on our credentialing application that we provide these services?

A: Our credentialing application is really asking clinicians to tell us what your practice specialty is. It has nothing to do with what the Medicaid eligibility standards are. So for credentialing, you should proceed with telling us what age children they serve, and that is independent of what the Medicaid eligibility is for particular groups.

Q: Does a provider have to be credentialed through Magellan to be able to get a Medicaid number?

A: Essentially, yes. To participate in this program of Medicaid through the Louisiana Behavioral Health Partnership, what has been established is that you will send your information to Magellan. As we get you credentialed and contracted, there will be files that are transferred back and forth between us and the State. When we send the file of our providers over, that is going to trigger the Medicaid ID number being issued. So essentially it's seamless and behind the scenes for you. In the past, to participate in Medicaid you would have to complete a Medicaid enrollment application. We've set this up in a way so

that you don't have to go through that process. Ultimately you will be given an MA ID number which is going to be, again, something that is transparent to you that is used for data transfer back and forth with the State so they know who the provider network is and what provider type you are.

Q: We sent in an application as an organization, so are we going to have to credential each provider?

A: No. When you are credentialing with us as an organization, you do not have to send us additional credentialing applications for your professional staff. In that scenario, we're handling you as an organization and credentialing you as such, and the only thing you're sending us about your staff is the staff roster.

Q: [Follow-up question.] So essentially they won't have a Medicaid number, right?

A: You will, as an organization. You get a Medicaid ID number, but you do not need to do anything about it because, again, we're doing that on the back end through data transfer processes.

Q: [Follow-up question.] What about master's level clinicians? Do they get paid under this new program? They weren't getting paid in the past.

A: Those licensed master's level clinicians, as defined in the Service Description Manual, who are eligible to participate can participate as independent clinicians. In that scenario, they would credential with us individually. There also may be licensed or unlicensed master's level professionals who work in organizations. In that scenario, they do not need to credential with us individually; they will be part of the organizational credentialing.

Louisiana provider webinar 2/8/12 – Q&A

Q: I'm in private practice and I already have a contract with Magellan. Do I need to have a new or different contract now?

A: You do not need a completely new contract. We will send you an addendum to include this product, the Louisiana Behavioral Health Partnership (LBHP) program, and it will include the rates for the services under the LBHP.

Q: Will I get the contract addendum automatically from Magellan?

A: Yes, we have mailed out all the addenda, so if you have not received one, please reach out to us and we will make sure that it gets to you.

Q: If I have clients who have coverage under both Medicaid and Medicare, are they part of the system or not?

A: Yes, they are part of the system.

Q: If a provider holds a conference call with a patient, would this be done through Skype (online video conferencing) or would it be a telephone interview?

A: This appears to refer to the case conference and the code that is available for providers to use to connect with other providers/professionals who might be involved with the case. That has traditionally been either a face-to-face meeting or phone call with the other provider. It is not a case conference with the member/client. Please refer to the Service Description Manual to get the specifics on how that case

conference should be used. Also, we should clarify as well that this service is not for every single eligible member; there are specific types of members for whom case conferences would apply.

Q: Regarding the intake process and the independent assessors: Are there established time frames for intakes, i.e., new referrals? What is the process for those referrals being approved in the Magellan system?

A: The precise time frames are still being worked out in terms of workflows. Magellan's routine access-to-care standard is typically seven days. We will soon be providing additional information about what the requirements are specifically for routine access to the independent assessments.

Q: Will the program allow for reimbursement of services via telehealth (telemedicine)? We are doing telemedicine currently, in the form of video conferences with doctors in another location.

A: Yes, the Service Description Manual indicates that under the category of "other licensed practitioner outpatient therapy," e.g., therapy provided by medical psychologists, licensed psychologists, LCSWs, LPCs, LMFTs, licensed addiction counselors and appropriately credentialed APRNs, telemedicine is an allowed option in terms of the mode of delivery for those services.

Q: Will the Clinical Advisor electronic behavioral health record generate a unique consumer ID number for each client?

A: The electronic behavioral health record will reside atop a master patient index. That index will have all the unique ID numbers from the feeder systems. So for all those systems that sent us eligibility data (e.g., Molina, OBH, OJJ, etc.), we will keep track of all their ID numbers and have a single consolidated lookup both on our website and in Clinical Advisor.

Q: In preparing a SAMHSA grant we have to use unique consumer ID numbers for patients. So for example, they may start in the program on Monday, then drop out of services after six months. If they then come back two years later, they need to have the same ID number. So we are considering using the Clinical Advisor ID number as long as it's a unique number that is between one and 11 characters.

A: It will be a unique number. We are still working out the exact assignment details and how it happens. We will be posting more information about this. But it will be a unique number; we have to track each person individually across the entire LBHP.

Q: Credentialing: We will be providing therapeutic group home services. We have sent in our credentialing application, and the staff roster includes our psychiatrist. Does the psychiatrist need to have an individual credentialing application, and if so, will the psychiatrist be able to limit the access to just the therapeutic group home residents?

A: If the psychiatrist is only going to provide services as part of the therapeutic group home, we will credential you as an organization. You do not have to credential the psychiatrist individually. We will send you contracts for the services that the psychiatrist can deliver as well as the room and board component. So you will credential with us as an organization.

Q: [Follow-up question] So the psychiatrist should not be billing separately under his/her Medicaid provider number, when he/she has seen the client?

A: We can set it up from a business perspective either way. It could be set up as an organization to bill or separately for the psychiatrist to bill. We would probably prefer to set it up as an organization that bills, but we would need to talk with you in some detail to be sure we're setting that up properly for you.

You can talk to one of our field network staff. You can send an email and we will follow up with you. The Magellan field network team is actively engaged in contacting every organizational provider. If that conversation has not already happened, we will make sure that it does.

Q: This is a question about mental health rehab recipients who are currently receiving services. We were told that as of March 1, their authorizations would be extended. How will we be notified of this extension?

A: We have been reviewing this issue as part of the Magellan provider forums we have hosted. We are going to stagger the time frames for the initial authorizations. That first one will occur sometime between March 15 and June 30. You will receive a call from Magellan between March 1 and March 14 to schedule the reviews, so it is important for you to be aware of how many people are in transitional services. The staggered time frame is based on members' birth month. We will plan to do four reviews per hour. So, if you have four members, for example, who were born between June 1 and June 30, those reviews will occur between March 15 and March 30. We will set up reviews ahead of time so you can be prepared for them, and we will go over those cases. We will try to schedule from March 1 and 14 all of your members who are in transitional care, even if members' birth dates aren't until the month of June. Until that review occurs, your members who are in treatment will receive the same services that they received prior to March 1. So you will be reimbursed for those services after March 1 until the first review occurs.

Q: What will the reviews entail?

A: The review will be based on the service authorization criteria to determine if the member requires a particular level of care. So for example, if psychosocial rehab services are proposed, we'll be reviewing that, and your member should have a current rating of high, medium or low. We will continue to use that rating scale. We are still working out the specifics with OBH. But, for example, if individuals in the high-level criteria category are getting 90 units per month, we would use that same number during the transition period.

Q: For those members who are not eligible for a particular service based on the criteria, would we have to immediately refer them out for other services?

A: Yes, we would work with you on determining that, for example, the case doesn't meet service authorization criteria and/or it is not considered medically necessary according to the State's definition, but it does meet medical necessity definition for some other type of service. Magellan wants to make sure this is a smooth transition, so we are not going to be overly strict with these criteria on the first review. So if the clinical features of the case fall somewhat in a gray area, we will authorize the service and help you understand why the case does or does not meet criteria. We will also help with the transition so that by the time of the next review, the person is able to move to the appropriate level of care as necessary. The only time we would not authorize a service on the first review would be in the case of a member for whom the proposed service is clearly not medically necessary.

Louisiana provider webinar 2/15/12 – Q&A

Q: We have a psychiatrist who hasn't billed in over a year. Do we bill through Medicaid? And if so, how far back can a physician file a claim?

A: If the provider has not billed in over a year, claims should be billed back through Medicaid. There is a 365-day, or one-year, timely filing limit. Also, you cannot bill Magellan for any services except for those

provided on or after the program start date of March 1, 2012. So any service that was provided before March 1 should be billed as you did previously.

Q: For our inpatient unit, I was requesting authorizations practically every day, for different patients. I would get multiple authorizations of two days or three days or four days. If a patient comes in to this short-term unit, am I going to have to get an authorization every day?

A: You do not have to obtain an authorization every day, but the authorizations will be for short periods of time. We want to be sure first of all that the person still clinically needs the inpatient level of care and could not be safely returned to services in their community. Secondly, we want to have a discussion at every review about the discharge plan. Discharge planning, in our view, begins at the time of admission. We want to make sure that members have a well-established plan for aftercare services in place when they are discharged. So we are going to be reviewing every two to three days depending on the status of the person's clinical condition and the plan for discharge.

Q: Are the reviews verbal or in writing?

A: All inpatient reviews are done verbally, i.e., telephonically. As we put a care plan together, you will have a much better understanding of exactly how services will be planned and when an additional authorization will need to take place. You'll be able to call us for that at 1-800-424-4399.

Q: Who can submit a request for authorization? Does the person need to be a clinician?

A: When we have a telephonic discussion about an individual who is in inpatient care, we would like to speak with someone who is able to have a clinical discussion with us. Our care managers are all licensed clinicians in the State of Louisiana, and they want to have a detailed clinical discussion about the client. What sometimes makes the review process more difficult is when we talk to staff people who don't know the clinical condition of the client, and they have to go back to other people to get information. So it's not so much that we care who we talk to, but that person has to be able to give us the information we need and engage in a clinical discussion. Otherwise the review may involve multiple calls or it may take a long time to complete. What we have successfully done previously is to give people ahead of time a list of the kind of information we are going to be asking, and that helps people to be able to prepare and do reviews so they don't have to go back and look up information.

Q: We originally thought providers would have to do the evaluation and the plan of care for the adult clients, but now we understand that all of that is going to be done through an independent evaluator for adults and for children. Correct?

A: The independent assessor will do the independent evaluation and the plan of care. That is only for people who are being evaluated for 1915i and CSoC services.

Q: Will the updates of the plan of care be done through the independent evaluator also?

A: Once the plan of care is completed, it will be good for a certain period of time, e.g., six months for children and three months for adults. After that, we will review the plan of care again, but it will be a review that does not go back for independent assessment and planning. Instead, we review the case to make sure that the services are still appropriate, and we may authorize additional care if needed. For adults, they have to be reassessed every year to make sure they still qualify as part of the 1915i population.

Q: How many units are available for clients when they are reassessed for mental health rehab (MHR) as of March 1? Their units expire at that time.

A: There is not a number of units. You will be able to continue billing according to the person's current plan of care, based on whether they've been assessed as being high, medium or low need. You will continue to provide the services at that level, and you will be able to provide and bill for that service until such time as we have done the next authorization which will be scheduled with you.

Q: So there are not a specific number of units allotted right at March 1; we'll just continue billing?

A: Correct. Clients will follow their current plan of care and it will be assessed at the appropriate time. That is for adults receiving rehab services. For children receiving rehab services, we will be entering authorizations based on their current plan of care and the current authorizations. That will be entered into the system and, again, it will be good until the time that we do the next review. Please be aware that for children, we will be entering the information and you will not be able to exceed the current units.

Q: Who does the assessment for new clients beginning March 1? We have received several referrals since the transition period where we had to stop as of January 31.

A: If you believe they are going to qualify for 1915i waiver services, they go to an independent assessor on or after March 1, 2012. If they are not eligible or potentially eligible for the waiver services, then you could see them for an assessment at that point. You can give us a call at 1-800-424-4399 and we will provide an authorization.

Q: So only under the 1915i waiver will they be assessed by an independent assessor?

A: Correct, or CSoC. So it includes adults who may qualify for the 1915i waiver services, and children who may qualify for the CSoC services. So if you suspect that someone would qualify for one of those two waivers, we would refer them for an independent assessment. Otherwise you can assess them yourself and provide the appropriate treatment, with authorization as necessary.

Q: So we will continue to do the assessments as we have been doing them through OBH, e.g., completing our assessment packets, gathering all the information and submitting it for approval, right?

A: No, if the person is potentially eligible for waiver, they will go for an independent assessment. The independent assessor will submit that information to Magellan. We will review it and approve the recommended plan of care. If the person is not in a waiver service, then you do not have to complete paperwork other than to do the typical documentation of your assessment. For example, you would do an assessment, e.g., a 90801. Then if you are going to provide only outpatient therapy services, for example, you can provide up to 24 units of those for the member without an authorization, or medication management up to 12 a year. If it is any other service, you would call Magellan at 1-800-424-4399 and request an authorization for those services.

Q: So for medication management and individual therapy, we won't have to get a prior authorization?

A: Correct.-You get access to up to 24 individual, family or group sessions for that member per year. And you have access to up to 12 medication management sessions per year without an authorization. If you want to exceed that, you would need to call us to request authorization.

Q: For our clients who are already in care, from March 1-13 they will be transitioning to their next level of care and we'll be doing discharge planning. Will you contact us about those people?

A: For people who were in care and admitted prior to March 1, 2012 we will begin the reviews on March 6, 2012. For people who are in residential, halfway house, substance abuse rehab, we will begin those reviews on March 13, 2012. So it will depend on the type of care.

Q: What is the number we should call to get authorization?

A: The toll-free number is 1-800-424-4399.

Q: I've heard that referrals are going to come from Magellan. Is that right, or do we do it just as we would as if we have a private practice, e.g., for clients who have insurance, they come in and we just call you to get the authorization?

A: For the most part, that would be the case. We don't want to put any barriers in the way of members being able to access care. So they can walk in to a provider office and request care, or they can call us and we can make a referral if they don't know which provider they want to see—so there is really no wrong door for people to be able to access care.

Q: I need some clarification on MHR services. The 1915i and CSoC clients who are brand new as of March 1, 2012 and for whom we have gotten intakes…Do they have to go to an individual evaluator before they can start services with us?

A: Yes.

Q: If we have someone who is not providing direct service to a client and they are registered with Magellan, can they be an independent evaluator for us? For example, if they are serving in a supervisory role, are they allowed to do individual evaluations for the agency?

A: The person doing the independent assessment at the agency—if you have an individual who is qualified to and designated to perform independent assessments at your agency—cannot do assessments that apply to your agency, even if they are in the administration of your agency and are only doing independent assessments in your agency. CMS rules say that there needs to be another agency, another entity, not that clinician, not anyone else in your agency, who performs the independent assessments.

Q: So no one who works at this agency can do the assessment?

A: Correct.

Q: Is there going to be some type of plan of care available that we can see in terms of the clients who are already receiving services and who will be transitioned as of March 1, 2012? Will we be able to review some type of plan of care, or should we assume that whatever we're working on with them now in their individualized plan is going to continue until someone comes in to review us?

A: You will continue to provide care at the level that you're providing it at that point in time.

Q: So for an adult client who qualifies for a 1915i waiver, we will continue to treat them at the same level of care until Magellan says this person will or will not qualify to continue at this level?

A: Correct. And that will be done according to the transition review schedule, available within Part 2 of our in-person training presentation deck.

Q: Regarding the 24 and 12 individual sessions, does that pertain to us, or does that not apply to our program?

A: It is for licensed independent practioners who provide individual, group or family therapy, or medication management. So if you provide one of those services, then an individual can receive, in a year, 24 *combined* individual, group or family therapy sessions without a prior authorization. With medication management, they can receive 12 visits during the year.

Q: Does that pertain to rehab? We have individuals who are not licensed clinicians, e.g., they are master's or bachelor's level. Does that include those individuals who are already providing individual therapy under this program?

A: This pertains to people who qualify for the waiver now, or qualify for rehab services now, and will likely qualify for rehab services in the future. We were talking about those who do not qualify for the waiver. When we're talking about individual, group and family therapy, these services can only be provided by licensed practitioners, i.e., people who are licensed and allowed by their license to provide those services. What you might be talking more about are the services provided under rehab.

Q: We have licensed master's-level social workers who provide therapy, and we also have bachelor's-level social workers who do community support.

A: Correct. That would be billed under community support, not individual therapy. For individual therapy, it has to be independently licensed providers (LMHP) who provide independent services. It would have to be someone who could open up a private practice and be able to provide those services. Everyone else would be billed under your rehab service, such as community support.

Q: So no unlicensed individual can provide individual therapy?

A: Correct.

Q: We are an inpatient psychiatric hospital serving adolescents, children and adults. Our particular facility is not licensed to collect on adults; we are just licensed to collect on anyone younger than 21 or older than 65. Starting March 1, 2012 should our utilization review nurses, who previously called Molina to get authorization days, now call the 1-800-424-4399 number for authorization days with Magellan?

A: That's correct.

Q: Does Molina go away?

A: Molina will no longer provide that service.

Q: So they will in essence go away as of March 1, 2012 unless there is a client who is still in care February 28 or 29, 2012?

A: If, for example, they were admitted to the hospital on the 28th and they are still in the hospital as of March 1, then you would not do a review until we contact you on March 6 or thereabouts. Some of those people may have been discharged prior to that time, but we will be contacting you to ask if specific clients are still there, and if so, we will do a review.

Q: We bill by per diem, based on the number of authorized days we get. Will we still do that?

A: Yes.

Q: I saw something about electronic billing coming in the future.

A: Electronic billing is available to you but it does not change the payment methodology, which is a per diem charge for each day.

Q: Right now we bill on a UB-04 that we send to Molina. Should I do that with Magellan?

A: Correct.

Q: If a client comes in who doesn't have a Medicaid number, I actually input a Medicaid application. Does that have anything to do with Magellan?

A: No, that is a separate process.

Q: Regarding the Louisiana Medicaid website that I go to every day to check for active Medicaid numbers for new admissions, is that website going away?

A: No, that process will not change. You will continue to do that. Also, when you call in for your prior authorizations for inpatient care, we will also be checking eligibility. So we will be doing multiple checks of eligibility before that person gets an authorization.

Q: How will we be able to bill electronically? Is that on the Magellan website?

A: If you are not submitting claims via the Clinical Advisor system, you can find information on other electronic submission methods in the trainings we did in-person, available on the Magellan of Louisiana website in the Training & Events/Provider Forums section. There also is extensive information about submitting electronic claims on the Magellan provider website. Basically there are two ways you can submit an 837 file to Magellan and we will process it electronically.

1. You can submit claims individually through an application on the provider website called Claims Courier, which allows you to input an individual claim and do it electronically without having to do the 837 file preparation.
2. We have a whole section of our website dedicated to EDI testing, which is electronic data interface testing. Our IT specialists will work with providers to help them get set up to submit the 837 file to us.

We will want to work with you if you are only doing paper claims, to help you begin to submit electronically. We have the tools on our end to receive the claims, and we will need to provide some assistance in looking at your system and helping you get set up to submit electronic claims to us.

Q: So the software is not downloaded, but it's actually on the website?

A: Yes, it's our goal to get as many claims electronically as we can. So we'll be more than happy to work with you to make that transition happen.

Q: With regard to primary care physicians and community care referrals, will that still be in effect? There will be five different health plans that people who have Medicaid are going to be funneled into. Will we still have to call for referrals for that?

A: There are two separate programs going on. One is the BAYOU HEALTH plan for people's physical health care. Then there's the Louisiana Behavioral Health Partnership for people's behavioral health needs. So you will still be working with those five statewide health plans related to people's admissions

for physical health care needs. But you would work with Magellan for people who are admitted for psychiatric care.

Q: We completed the Clinical Advisor training. We did not see the billing portion of Clinical Advisor. When can MHR and MST providers get oriented to the billing portion of Clinical Advisor?

A: Soon we will present a three-hour training module that is strictly focused on billing. We will schedule web-based seminars to host and implement it as fast as we can statewide. Again, we will use the Magellan of Louisiana website in the For Providers/Training & Events section to announce the actual dates. We will invite providers to register for the training.

Q: If we would like to try to submit claims to you in between that time, we can use Claims Courier?

A: That's correct, or you could even send UB or HCFA forms to our mailing address in Missouri. By now there isn't much reason to do claims on paper because the Claims Courier process (on our provider website) is essentially filling out a claim electronically and submitting it directly into the system. So we encourage providers to use that or direct submit to Magellan, if you are not going to be set up on Clinical Advisor. Electronic methods are quicker and more efficient than paper claims, and it saves you a stamp. Also, cash flow and turnaround on payment typically is faster electronically than it is on paper claims. And in Clinical Advisor, anything you enter, such as progress notes, can be turned into claims and submitted later without having to key anything back in.

Q: This question pertains to authorizations for people who are not 1915i or CSoC, i.e., children. When we apply for reauthorization for them, will we be using the CANS authorization forms for that?

A: No, the CANS (Child and Adolescent Needs and Strengths) screenings are for children who are being evaluated to be part of the CSoC program.

Q: Is there a specific MHR assessment tool that Magellan requires providers to use for youth outside of CSoC?

A: No, there is not a specific tool.

Q: Do you have other recommendations for assessment tools?

A: Although we could make recommendations based on our prior experience, we do not want to do so at this point. If you are concerned that you are not getting what you need out of your current assessment tool, we would be happy to work with you.

Q: Would that be the same for the six-month reassessment, the individual service plan?

A: We may be talking about two separate things. The people who have standardized assessments are the people who are being evaluated for the 1915i waiver or CSoC. So, adults who are potentially going to be involved would have to have a LOCUS (Level of Care Utilization Scale), for example, and children would have to have a comprehensive CANS assessment. So beyond the 1915i and CsoC, there are no required assessments. You would do what you normally do in terms of an intake to determine people's clinical needs and the severity of their clinical condition, etc. If you want a recommendation for a tool, you may send a question to LAProviderQuestions@MagellanHealth.com and we can respond to it. But the relevance of us recommending an assessment versus you selecting your own tool really won't make a difference. Our only interest is to make sure we support the independent assessment (1915i and CsoC)

process. Other than that, the assessments you use are up to you. But we don't mind making a recommendation because we're here to help make everyone successful.

Q: Currently it is required that a psychiatrist participates in the assessment process for rehab. That will no longer be required, correct?

A: There would be no requirement for psychiatrists to participate in the initial assessment for the client, whether it is a child, youth or otherwise. But a licensed mental health professional who is credentialed and competent and practicing within the scope of their license can perform assessments, do mental status examinations, and render diagnoses within the scope of their practice. Of course you would need a psychiatrist or medical psychologist to prescribe any medications and do medication management reviews, etc.

Q: Can a nurse clinical practitioner provide medication management?

A: RNs are not approved providers for services within the LBHP. There are some limited exceptions to that, but for the most part they cannot provide medication management. Advanced practice registered nurses who meet qualifications to do behavioral health treatment can do that. If you have a nurse (e.g., an RN) who is not an APRN but who meets the other qualifications as a behavioral health specialist, anything they do in terms of working with the client would have to be incident to a psychiatrist visit.

Q: So APRNs can do medication management?

A: Only if they have a psychiatric certification.

Q: In reference to the 24 visits, if an MHR agency starts providing services under those 24 visits, how will we know if another independent provider is also providing services within that 24-visit time frame?

A: We recommend that you ask the client if they are or have been seeing another provider in the recent past. Secondly, call Magellan and we can help research that. We cannot tell you who specifically they saw, etc., but we can sometimes give you enough information for you to figure out that they may have already seen another provider and used up some of those sessions.