Magellan Healthcare, Inc.*

Provider Handbook Supplement for Connect Nevada: Strengthening Youth, Empowering Families

Revised January 2025

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Magellan HEALTHCARE®

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Welcome

Welcome to the Connect Nevada: Strengthening Youth, Empowering Families (Connect Nevada) Provider Handbook Supplement. This document supplements the Magellan National Provider Handbook, addressing policies and procedures specific for the Connect Nevada program. Use this provider handbook supplement in conjunction with the Magellan National Provider Handbook (and Magellan organizational provider supplement, as applicable). When information in this supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, the policies and procedures in the Connect Nevada supplement prevail.

Covered Services

The Nevada Care Management Entity (CME) provides a youth-guided and family-driven, strengths-based approach coordinated across child-serving agencies and providers for youth ages 3 through 20. Youth may be Medicaid enrolled/eligible or under-/uninsured. Intensive care coordination and high-fidelity wraparound services are provided by CME internal staff while assessments, evidence-based intensive home-based treatment, youth peer support services, as well as emergency and planned respite services, are provided by credentialed and contracted network providers. Respite services may also be provided by family members/friends, following a self-directed model. These services are intended to be alternatives to costly residential and hospital care for children and adolescents with moderate to severe behavioral health needs. Children and youth with complex behavioral health needs often receive fragmented care through multiple service systems. This approach results in poor outcomes and increased costs. Coordinated care management is intended to:

- Decrease use of emergency room care
- Decrease use of inappropriate out of home placements
- Reduce duplication of efforts across the system
- Increase positive outcomes
- Reduce cost.

The goal is for youth and families to remain united in the home and in the least restrictive setting while receiving behavioral health services. Research has revealed the longer a youth remains in out-of-home placement, family reunification becomes more challenging, resulting in the increased possibility of relinquishment. The Nevada Division of Child and Family Services (DCFS) is charged with serving and safeguarding the most vulnerable youth and families in the state and ensuring that service delivery is directed towards their safety and wellbeing. In partnership with its sister agencies, DCFS is committed to System of Care values and principles to guide the organization of services and supports for children,

youth, and families, including best practices for partnering with youth and families and for coordinating care across systems and providers.

Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our Nevada website at www.MagellanofNevada.com (or the sites of Magellan's contracted vendors, as directed) to get quick and easy access to information and answers to questions you may have about Magellan and the Connect Nevada program.

You can reach us at the Magellan Nevada Care Management Entity at the following number:

- Nevada Youth and Families, and Provider Services Line: 1-833-396-4310.
- Email: NevadaProvider@MagellanHealth.com.

Or, you can call our Magellan National Provider Services Line at 1-800-788-4005.

Connect Nevada youth and families can contact Magellan toll-free at: 1-833-396-4310; TTY: 7-1-1; 8 a.m. to 5 p.m. PT.

For reporting fraud, waste and abuse, contact any of the following:

- Magellan's Corporate Compliance Hotline at 1-800-915-2108, or email Compliance@MagellanHealth.com.
- Magellan's Special Investigations Unit Hotline at 1-800-755-0850 or email SIU@MagellanHealth.com.

Network Provider Training

Our Philosophy

Magellan is committed to promoting quality behavioral healthcare services to youth and families of the Connect Nevada: Strengthening Youth, Empowering Families program (Connect Nevada).

Our Policy

In support of this commitment, providers must complete required trainings prior to caring for youth and families. Magellan's comprehensive provider education and training strategy supports the provider learning journey through new provider orientation, ongoing education, and annual training. We utilize a blended approach of self-directed and leader-led trainings. We look forward to working with you in the delivery of quality behavioral healthcare services to the Connect Nevada program.

What You Need to Do

Your responsibility is to complete required trainings and attestations before providing services to Connect Nevada youth and families. Magellan has developed training courses approved by the state. You can access these training courses and submit an attestation form at the end of the training for proof of participation.

New Provider Orientation

Magellan's training is intended to complement this Nevada Provider Handbook Supplement and the Magellan National Provider Handbook. New provider orientation training provides information from Magellan in the following areas: network, contracting, authorization procedures, claims submission, quality and compliance, cultural competency, Magellan's systems, and provider data management. We designed it for providers who are new to Magellan; however, it also has proven to be a helpful

overview for more tenured providers who want to refresh their knowledge of Magellan's policies and procedures. We share it with providers during the contracting process. You can also view it at any time by visiting the Magellan of Nevada provider training page or by contacting a member of our team.

Assessments

Assessors are fully licensed mental health clinicians or licensed mental health interns under the supervision of a fully licensed mental health clinician. Assessors will conduct the Independent Behavioral Health Assessment (IBHA) and the Child and Adolescent Needs and Strength (CANS) tool for each youth.

The Praed Foundation and Magellan of Nevada have partnered for online training and certification on the Collaborative Training website referenced below, which is required for all assessors. This online training and certification covers the Nevada CANS 3.0 used in the Connect Nevada program. Providers trained and certified in using the CANS assessment tool can access and use the NV CANS 3.0.

- All assessors must complete the CANS training and certification by going to https://www.TCOMTraining.com. First time users will sign up under Regional Designation "Nevada" and Agency "Magellan CME."
    - How-To Guides on registering can be found at https://praedfoundation.org/resources/tcom-training/.
- The CANS certification is valid for one year, starting upon certification date, and must be renewed annually. Providers will receive a recertification reminder 60 days prior to the expiration of their current certification. To recertify for CANS, providers should go to http://www.TCOMTraining.com, hover on "Training" and click "Courses". You may need to press "Load More" to find the Magellan CANS and locate the course "Nevada CME CANS 3.0". Failure to maintain an active certification may result in a disruption to services. Assessors must ensure CANS recertification is completed promptly to remain in compliance.
- The IBHA and CANS are entered by assessors into Magellan's Outcomes and Assessments System application through a single sign-on via Availity Essentials (Magellan Healthcare of Nevada > Assessments tile). Providers must assign an "Organization

Administrator" who will be responsible for ensuring all affiliated assessors within the group have the appropriate user access to the system. Assessors must review the demo videos and step-by-step guides located on the Magellan of Nevada provider training page.

Intensive Home-Based Treatment

Intensive Home-Based Treatment (IHBT) may include a wide array of evidence-based treatment models with demonstrated fidelity and outcomes. Providers will need to demonstrate fidelity to the specific model(s) and be certified by the respective training/certification entity or demonstrate the ability to adopt the Bruns et al. 2021 *Program and Practice Standards*. More information on IHBT can be found here on the Magellan of Nevada website.

Respite

Individuals delivering respite care are paraprofessionals at least 21 years old, have a valid driver's license, at least two years of work/personal experience with children, and have access to a qualified mental health clinician to provide backup support and/or consultation.

- Magellan will provide access to the required respite training during the contracting and credentialing process. The training and attestations must be completed by each respite care individual prior to delivery of services.

Youth Peer Support

Youth peer support specialties are individuals ages 18 through 29 who have lived experience as a youth/young adult who has navigated mental health/substance use service systems.

- Youth peer support specialists (YPSS) must hold certification with the Nevada Certification Board, other approved licensing board, or must be working towards certification. YPSS who are not yet certified must take the foundational Nevada peer certification training, Peer Support Specialist 101:Self Paced online course.

What Magellan Will Do

Magellan's responsibility is to offer comprehensive training to give network providers specific information on the delivery of behavioral

healthcare services to youth and families of the Connect Nevada: Strengthening Youth, Empowering Families program.

Types of Providers

Our Philosophy

Magellan is dedicated to recruiting and retaining individual practitioners and institutional providers with the behavioral healthcare credentials to provide responsive, effective care and treatment for children, youth and young adults. Magellan's network of providers includes those in private practice, practitioners in group practices, and provider organizations including facilities and agencies.

Our Policy

Magellan's contracted Connect Nevada provider network includes the following categories:

- **Individual Practitioner** – a fully licensed clinician who provides behavioral healthcare services and bills under their own Taxpayer Identification Number.
- **Group Practice** – a practice with multiple licensed clinicians, licensed interns under supervision, and/or paraprofessionals contracted with Magellan as a group entity, and as such, bills as a group entity for the services performed by its Magellan-credentialed clinicians.
- **Organization** – a facility or agency licensed and/or authorized by the state in which it operates to provide behavioral health services. Examples of organizations include but are not limited to freestanding behavioral health facilities, community mental health centers, and agencies. Please refer to the Organizational and Facility Providers Handbook Supplement for additional information about facility/organizational providers, including credentialing criteria.

What You Need to Do

Your responsibility is to:

- Ensure your contract with Magellan is appropriate for your provider practice type.
- Providers who choose to contract for IHBT using an evidence-based practice (EBP), must show current certification or submit a plan that outlines specific steps/timeline for EBP training and certification.

What Magellan Will Do

Magellan's responsibility is to:

- Provide you with information and guidance to ensure your contractual relationship with Magellan is appropriate to your provider practice type.

Contracting with Magellan

Our Philosophy

Magellan's provider agreements protect youth and families, providers, and Magellan by defining:

- The rights and responsibilities of the parties;
- The application of Magellan's policies and procedures to services rendered to youth and families;
- The programs/services available to youth and families;
- The provider network for youth and families' use; and
- The reimbursement for covered services.

Depending on a provider's type of practice and location, Magellan will issue a provider agreement with applicable addenda and exhibits.

Our Policy

Magellan network providers participating in the Connect Nevada program are required to have an executed Magellan Network Provider Agreement agreeing to comply with Magellan's policies, procedures and guidelines in order to bill Magellan for the provision of covered services.

Services must be provided directly by an independently licensed clinician for all youth unless you have an executed Supervisory Protocol Addendum with Magellan. The Supervisory Protocol addresses the requirements that must be followed when non-credentialed practitioners employed by your practice provide services. Non-credentialed practitioners include individuals who: 1) may be unlicensed, 2) are working towards independent licensure, or 3) are working towards an advanced healthcare degree.

Credentialed and/or non-credentialed practitioners delivering services must be submitted on the staff roster and have an NPI in order to submit claims for services. Any fully licensed practitioners added to the staff roster after the contract is executed must be credentialed prior to service delivery.

What You Need to Do

Your responsibility is to:

- Read, understand, and sign a Magellan Network Provider Agreement;
- Return your signed Network Provider Agreement, addenda and exhibits (as applicable) required for specific services to Magellan for contract execution, which may be signed electronically;
- Comply with the terms of the Magellan Network Provider Agreement, including the policies and procedures contained within this handbook;
- Honor reimbursement provisions for covered services rendered to youth and families;
- Accept your Magellan contracted rates for services rendered on an ad hoc basis to Magellan youth and families with health plans for which you are *not* contracted;
- Notify Magellan and/or confirm any changes in administrative practice information;
- Complete required trainings and/or certifications and attest here on the Magellan of Nevada website prior to service delivery;
- After the provider agreement is executed, maintain the staff roster on Magellan's Provider Data Change Form accessed via Availity Essentials (Magellan Healthcare of Nevada > Provider Practice Information).

What Magellan Will Do

Magellan's responsibility is to:

- Submit a Magellan Network Provider Agreement to providers identified for participation in the Magellan Connect Nevada provider network;
- Indicate our customers, products or lines of business covered by the agreement based on the reimbursement schedules provided;
- Execute the agreement, amendments, and/or addenda, when applicable, after it has been signed and returned by the provider, and the provider has successfully completed the credentialing process and met contractual requirements. The effective date of the agreement is the date Magellan signs the agreement, unless otherwise noted;
- Provide a copy of the executed agreement via an email notification.

Wraparound, Recovery, and Resiliency

Our Philosophy

Recovery has as many definitions as there are people who experience it. Magellan defines recovery this way: 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. We define resiliency as having qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence, and hope.

Our Policy

Magellan staff is trained in wraparound, recovery and resiliency values and practices to refer youth and families to providers able to offer services and supports that promote individual recovery and help build resiliency. Magellan assesses network practices, programs, and training needs on an ongoing basis to ensure a culture of recovery and resiliency is accessible for youth and families.

What You Need to Do

Your responsibility is to:

- Understand and apply core elements of recovery and resiliency to service delivery.
- Understand and integrate best and promising practices related to recovery and resiliency programs and initiatives.
- Receive regular training on aspects of recovery and resiliency.
- Ensure that service plans are person-centered and strengths-based.
- Understand and integrate different cultural aspects of recovery and resiliency when delivering services.
- Coordinate care with the Magellan care coordinator and actively participate in the Child and Family Team process.

What Magellan Will Do

Magellan's responsibility is to:

- Provide ongoing education to deliver services that maximize opportunities for individual recovery and development of personal resiliency to youth and families.
- Provide tools and technical assistance to improve recovery and resiliency programs and practices.

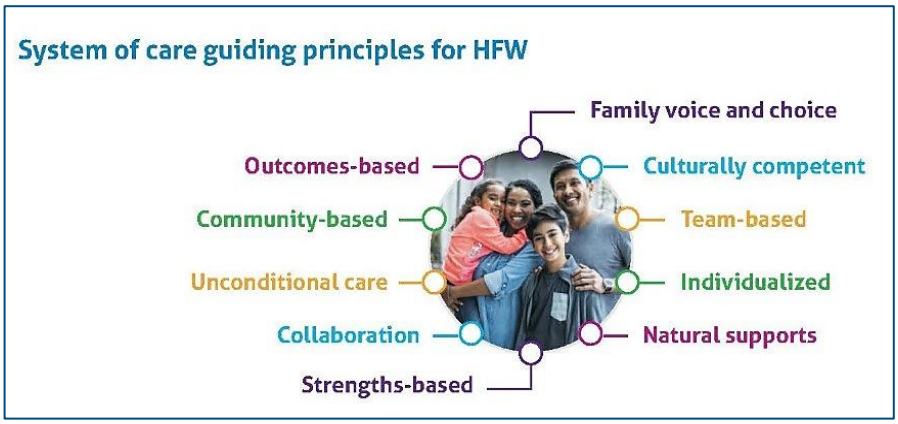
Care Coordination Overview

Our Philosophy

The goal of Magellan's care management program is to improve clinical and functional outcomes, to enhance system efficiencies, and to foster resiliency in youth and their families.

Our Policy

Magellan will provide three levels of care management; youth will be referred to a level of care management based on their individual circumstances and functional impairments.



High Fidelity Wraparound (HFW): Wraparound is an intensive, individualized, team-based care planning process used to achieve positive outcomes by providing a structured, creative, team-based planning process that addresses child/youth and family needs.

The cornerstone of the wraparound process is that it is driven by the goals, perspectives and preferences of the child/youth and their family as they work side by side with the wraparound facilitator and the other members of the Child and Family Team. The Child and Family Team is charged with identifying any underlying needs that would lead to a better understanding of the child/youth's behavior and provide support to the family as they reach their goals.

Through this team-based collaborative approach, a single Plan of Care (POC) is developed that focuses on the strengths of the child/youth, family, and other team members rather than the deficits. This single comprehensive plan encompasses both formal and informal services. During the regularly scheduled Child and Family Team meetings, the

plan is reviewed, and changes are made as needed so that the child/youth and family achieve their goals.

High Fidelity Wraparound includes the following phases:

- Phase One: Engagement and Team Preparation
    - HFW facilitator shares information about the wraparound process.
    - Youth and family share their story, including their goals for the program.
    - Youth and family share their culture, values, traditions and beliefs.
    - Youth and family identify who should participate in their team.
- Phase Two: Initial Plan Development
    - HFW facilitator holds the first Child Family Team (CFT) meeting.
    - CFT identifies strengths and needs.
    - CFT develops action steps to address needs.
    - CFT assigns action steps and follow-up tasks.
- Phase Three: Plan Implementation
    - Youth and family share accomplishments and what has been going well.
    - CFT determines if the current plan is meeting the participant's needs.
    - CFT adjusts the plan to address areas where the plan isn't working.
    - CFT assigns new action steps and follow-up tasks.
    - Between meetings, the HFW facilitator follows up with team members on the actions, ensures clear communications between team members, and adjusts the plan if needed.
- Phase Four: Transition
    - Transition planning occurs throughout the process.
    - CFT brainstorms follow-up options to support the youth and family outside the formal wraparound process.
    - The HFW facilitator creates a transition plan based on participant goals.
    - CFT agrees to the transition plan and commits to follow-up action steps.

- Final celebration meeting to review strengths and accomplishments.

Intensive Care Coordination (ICC): ICC is a model of care management utilizing the same principles and interventions as HFW; the primary difference is that the program is delivered telephonically or via telehealth, and overall intensity of contacts may be fewer. ICC facilitators are trained in HFW. ICC will follow the same phases as HFW including developing a care plan with a variety of action steps to address the identified needs.

Care Coordination (CC): Care Coordination is a lower intensity care management program focusing on connecting youth and their families to services and support within the community. Care coordinators are trained in HFW and will complete an assessment, based on youth and families' voice and choice, in developing a care plan with action steps. Care coordination is primarily a telephonic intervention with the youth and family; however, it may include team planning meetings with other support partners such as providers, school personnel, juvenile or child welfare, and youth peer support as needed. The family is eligible for additional services offered through the CME such as respite and youth peer support.

What You Need to Do

Your responsibility is to:

- Advocate for and take part in the wraparound process for youth and families enrolled in the Connect Nevada program.
- Participate in care planning and the provision of therapeutic services to those eligible.

What Magellan Will Do

Magellan's responsibility is to:

- Collaborate with providers to help tailor care to each child/youth's needs, ensuring that the individual's culture, preferences and goals are considered. This includes ongoing case reviews and authorizations for High Fidelity Wraparound.

Before Services Begin

Our Philosophy

Magellan wants youth and families to receive the most appropriate services and experience the most desirable treatment outcomes. Thus, we strive to connect youth with practitioners who best fit their needs and preferences, including provider location, service hours, specialties, spoken language(s), gender and cultural considerations.

Our Policy

We help youth and families optimize their benefits by reviewing and authorizing the most appropriate services to meet their behavioral healthcare needs. Magellan conducts timely reviews to evaluate the youth's clinical situation and determine the medical necessity of the requested services.

What You Need to Do

Your responsibility is to:

- Obtain authorization for IHBT, respite and/or youth peer support services before rendering care to a referred youth via the Magellan of Nevada Payer Space in Availity Essentials.
- Ensure that an authorization/consent form is obtained by the youth or their legal guardian, in order to share information, in order to promote care coordination between you and the CFT team, including the primary care physician (PCP) as appropriate. This practice is governed by the Health Insurance Portability and Accountability Act (HIPAA) which outlines when and how a provider can share patient information.
- Participate in **regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports** as a best practice, but at a minimum have **monthly contact with the Magellan care coordinator working with the youth and family**.

What Magellan Will Do

Magellan's responsibility is to:

- Operate a toll-free telephone line to respond to provider questions, comments, and inquiries. That number is 1-833-396-4310.
- Make decisions about prior authorizations within contractual guidelines and timeframes, including responses to expedited

preauthorization requests from Magellan care coordinators on behalf of Child and Family Teams.

Concurrent Review

Our Philosophy

Magellan believes in supporting the most appropriate services to improve healthcare outcomes. We look to our providers to notify us if additional services beyond those initially authorized are needed, including a second opinion for complex cases.

Our Policy

Magellan's care coordinator will request additional services and/or units as part of the care planning process. Care plans are reviewed and updated at least every six (6) months but can be reviewed more frequently based on need.

What You Need to Do

Your responsibility is to:

- Notify the Magellan care coordinator for the youth if, after evaluating and treating the youth, you determine that additional services are necessary. The Magellan care coordinator is the primary contact.
- If you are not aware of the designated care coordinator, contact Magellan at 1-833-396-4310 to be connected with a care coordinator.
- Be prepared to provide the Magellan care manager or physician advisor with an assessment of the youth's clinical condition, including any changes since the previous clinical review.

What Magellan Will Do

Magellan's responsibility is to:

- Be available 24 hours a day, seven days a week, 365 days a year to respond to requests for authorization of care.
- Promptly act on requests from Child and Family Teams, via Magellan care coordinators, for expedited preauthorization.
- Promptly review your request for additional days or visits in accordance with the applicable medical necessity criteria.
- Have a physician advisor available to conduct a clinical review in a timely manner if the care manager is unable to authorize the requested services.
- Respond in a timely manner to your request, verbally and in writing, for additional days or visits.

- Operate a toll-free telephone line to respond to provider questions, comments, and inquiries. That number is 1-833-396-4310.
- Review the complete treatment request and issue the authorization or Notice of Action within 14 calendar days.

Youth and Family Access to Care

Our Philosophy

Magellan believes that youth and families need timely access to appropriate mental health and substance use services from an in-network provider 24 hours a day, seven days a week.

Our Policy

We require in-network providers to be accessible within a timeframe that reflects the clinical urgency of the youth's situation.

What You Need to Do

Your responsibility is to:

- Confirm receipt and acceptance of a referral within 4 business days. If you are unable to accommodate a referral, notify your Magellan care coordinator as soon as possible.
- Respond to telephone messages and/or emails in a timely manner.
- Notify your Magellan care coordinator with any challenges in contact the youth or caregiver as soon as possible for assistance.
- Ensure that youth and families know how to access care 24 hours a day, seven days a week.
- Inform youth and families of how to proceed, should they need services after regular business hours.
- Provide coverage for your practice when you are not available, including but not limited to an answering service with emergency contact information.
- Consistently adhere to the following access to care standards:

Behavioral health service	Timeliness standard
Provide **emergency services** when necessary to evaluate or stabilize a potentially life-threatening situation	Immediately
Provide access to an appointment in **an emergent situation that is *not* life-threatening**; an emergency occurs when the youth's clinical situation could result in serious jeopardy to their health and wellbeing	Within 1 hour of referral from Magellan
Provide access to an appointment in an **urgent clinical situation**; an urgent situation occurs when the youth's	Within 48 hours of referral from Magellan

clinical situation will likely get worse if not seen in a timely fashion	
Provide appointment access for **routine clinical situations**	Within 14 calendar days of receipt of authorization
Provide access to an appointment **after youth's discharge from an inpatient or residential stay**	Within 7 calendar days of receipt of authorization

- Contact Magellan immediately if you are unable to see the youth within these timeframes.
- Provide outreach to youth who do not follow up with recommended services.

What Magellan Will Do

Magellan's responsibility is to:

- Communicate the clinical urgency of the youth's situation when making referrals.
- Assist with follow-up service coordination for youth transitioning from inpatient to an outpatient level of care.

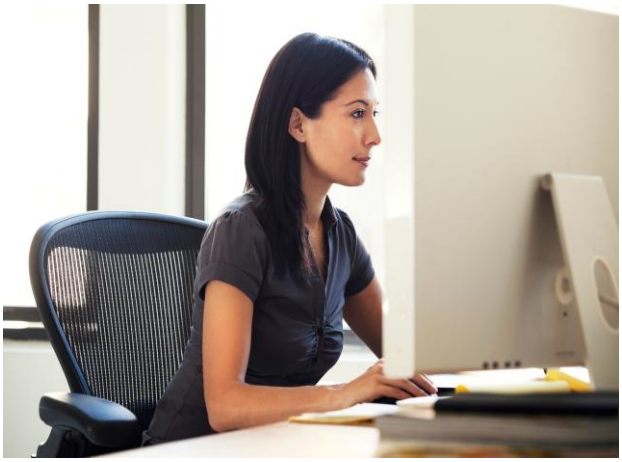
Telehealth

Our Philosophy

Youth and families must have timely access to appropriate mental health services from an in-network provider 24 hours a day, seven days a week. Telehealth is an acceptable channel to improve access under certain circumstances. During a natural disaster or national/regional crisis, Magellan follows Centers for Medicare and Medicaid Services (CMS) and state guidance.

Our Policy

Magellan defines telehealth as a method of delivering behavioral health services using interactive telecommunications when the youth and the behavioral health provider are not in the same physical location. Telecommunications must be the combination of audio *and* live, interactive video.



What You Need to Do

Your responsibility is to:

- Comply with state requirements regarding telehealth, including but not limited to N.R.S. 629.500-515. Telehealth is not intended to replace in-person service delivery or provider choice based on recipient preference. The provider must adhere to applicable state laws when delivering telehealth services, which may include various types of care such as therapy, medication monitoring, evaluation, crisis intervention and consultation.

- Complete Magellan's telehealth services provider attestation if you are interested in providing behavioral health services via telehealth.
- Meet the specific requirements outlined in the telehealth services attestation surrounding the provision of telehealth services, including the ability to provide all telehealth sessions through secure and HIPAA-compliant technology.
- Direct questions to NevadaProvider@MagellanHealth.com or call our national Provider Services Line at 1-800-788-4005.

What Magellan Will Do

Magellan's responsibility is to:

- Answer your questions about the delivery of and payment for telehealth services, including proper coding requirements. (See the Provider section on www.MagellanofNevada.com for additional information.)
- Ensure that telehealth does not replace provider choice or recipient preference for in-person service delivery. Telehealth is not an alternative to meeting provider network access requirements.

Websites

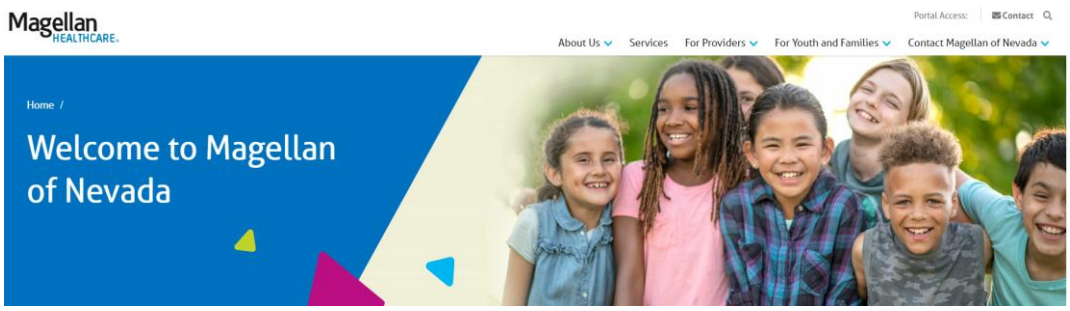
Our Philosophy

Magellan is committed to reducing administrative burdens on our providers by offering web-based tools for retrieving and exchanging information.

Our Policy

The Magellan of Nevada website, www.MagellanofNevada.com, is where providers can find up-to-date information about the Connect Nevada program. This website (and those of our contracted vendors, as applicable) will be continually updated so providers have easy access to information, web-based trainings, handbooks and other helpful material to assist you with navigating your way around Magellan. We encourage providers to use this website (and those of our contracted vendors, as directed) often as a self-service tool for supporting the provider's behavioral health practice.

In addition, Magellan Connect Nevada providers can sign in to the Availity Essentials provider portal to perform a variety of secure transactions, such as requesting authorization, submitting claims and more.



What You Need to Do

To realize the benefits of the Magellan provider website (and those of our contracted vendors, as directed), you should:

- Have access to a personal computer, internet service provider and current web browser software;
- Visit our website frequently to ensure you have the most recent information take advantage of new capabilities and resources; and
- Provide us with feedback on any difficulties you may experience using our online resources, or on ideas you have for enhancements.

What Magellan Will Do

Magellan's responsibility is to:

- Maintain operation of online services on a 24 hour per day, seven day per week basis;
- Inform users of service problems if they occur, e.g., via email and website notices;
- Use your feedback to continually improve our website capabilities; and
- Provide online access to the following information and applications via the Magellan of Nevada website, Availity Essentials, or those of contracted vendors:
    - Authorization status;
    - Clinical documents such as medical necessity criteria;
    - Provider-specific news regarding the Connect Nevada program;
    - Procedural updates on provider topics such as billing, records management and training opportunities;
    - Claims submission;
    - Claims inquiry and online explanation of payments (EOPs);
    - Electronic funds transfer (EFT) signup;
    - Cultural competency tools for providers and staff;
    - Online demos and step-by-step guides to help providers navigate website applications;
    - Comprehensive library of clinical practice information; and
    - Other tools and information beneficial to Magellan providers serving Connect Nevada youth.

Medical Necessity Criteria

Our Philosophy

Magellan is committed to the philosophy of providing treatment at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment while meeting the individual patient's biopsychosocial needs.

Our Policy

Magellan will utilize medical necessity guidelines for the following services as approved by DCFS.

Respite

1. Respite is intended to provide temporary relief for family/ caregivers from the ongoing responsibility of caring for a youth with behavioral health needs.
2. The use of respite services should be outlined in the Plan of Care.
3. Emergency respite is meant to provide immediate stress relief for family/caregivers to prevent a crisis or any negative physical or emotional effects.
4. Service settings are based either in the youth or provider's residence or in a non-institutional location.
5. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/caregivers and natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.
6. Respite is limited to eight (8) hours per month per youth. If there is a need to exceed this limit, service must be prior authorized.
7. Respite is provided by one provider to one youth at a time.

Intensive Home-Based Treatment (IHBT)

1. IHBT is provided to children and youth who are experiencing social, emotional, and behavioral difficulties and need more intensive services to increase stability across settings and help prevent out-of-home placement. These services are also integral when youth are returning to the community following long-term placement.

2. IHBT includes a flexible array of services to meet the assessed needs, including behavior management, therapy crisis response and intervention, and parent education and training.
3. The average length of services is typically 3-6 months, with a service intensity expected to be 2-5 sessions per week for a duration of 4-8 hours per week.
4. IHBT evidence-based modalities include but are not limited to:

    1. **Multisystemic Therapy (MST)**:
        - Multisystemic Therapy (MST) is an intensive family and community-based treatment that addresses the multiple causes of serious behavioral health needs of children and adolescents. (https://www.mstservices.com/)
        - MST focuses on reducing delinquent and antisocial behavior by addressing the core causes and viewing the youth as part of a larger system including family, peers, school and community.
        - Serves youth ages 12-17 years old.
    2. **Multidimensional Family Therapy (MDFT**):
        - MDFT is an integrated, comprehensive, family-centered treatment for adolescents. MDFT simultaneously addresses substance use, delinquency, antisocial and aggressive behaviors, mental health symptoms, and school problems.
        - Providers are required to have an MDFT certification from MDFT International and follow the guidelines as set by MDFT International. (https://www.mdft.org/)
    3. **Functional Family Therapy (FFT):**
        - FFT is a prevention/intervention program for youth who have demonstrated a range of maladaptive behaviors and related syndromes.
        - Provider agencies are required to have an FFT site certification from FFT, LLC and follow the guidelines set by FFT, LLC Family Center Treatment (FCT). (https://www.fftllc.com/)
    4. **Family Centered Treatment (FCT):**
        - FCT is effective in working with families with

experiences of multiple primary trauma types: exposure of victims of violence, neglect, emotional, physical and sexual abuse, abandonment, losses, complex trauma and domestic violence. It includes families with the effects of multiple placements including adoption disruption, secondary trauma from medical complexities.

- Provider agencies are required to have FCT certification through Wheels of Change. (http://www.familycenteredtreatment.org/)

5. **Family Check-Up**
   - FCU is a brief, strengths-based intervention for families with children ages 2 through 17. The intervention aims to improve parenting skills and family management practices with the goal of improving a range of emotional, behavioral, and academic child outcomes.
   - Providers must complete training to become a qualified Family Check-Up practitioner.
6. **Parents as Teachers**
   - PAT is an early childhood parent education, family wellbeing, and school readiness home visit model based on the premise that all children will learn, grow, and develop to realize their full potential.
   - Parent educators must meet minimum educational requirements and have undergone supervised work experience with young children and/or parents.
7. **Parent Child Interaction Therapy**
   - Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment for young children ages two to seven with emotional and behavioral disorders. PCIT places emphasis on improving the quality of the parent-child relationship and changing parent/child interaction patterns.
   - Providers must complete a minimum of 40 hours of in-person training with a certified trainer, and hold at least a master's degree and be an independently licensed mental health service provider.
8. **Triple P Positive Parenting Program (Triple P)**

- Triple P Positive Parenting is a parenting program designed to prevent and treat behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential.
- Providers are required to have training and certification through the Triple P (https://www.triplep.net)

9. **Family Behavior Therapy (FBT)**
    - FBT is an evidence-based treatment which utilizes innovative, easily learned, behavioral therapies to accomplish performance of goals within a family context. FBT focuses on optimizing thoughts and behaviors through performance programming that typically consist of 12 to 16 outpatient sessions of approximately 60 to 90 minutes that are scheduled to occur across 4 to 6 month period.
    - Providers are required to have training and certification through FBT (https://familybehaviortherapy.faculty.unlv.edu/training/)

Youth Peer Support

1. Youth Peer Support Specialists are trained and certified to deliver youth-driven and youth-led peer support in person, by phone, or via telehealth to individuals and/or groups.
2. Youth Peer Support Specialists are young adults ages 18 through 29 with personal experience participating in the system of care. They may be members of the Child and Family Team.
3. Youth Peer Support Specialists lean on their own lived experience to mentor a youth and help them learn positive coping skills that can be successfully applied to the team process and other areas of their life.
4. The service limit is 12 hours per month for no more than 6 months.

Independent Behavioral Health Assessment (IBHA)/Child and Adolescent Needs and Strengths (CANS) Evaluation

1. An evaluation completed by a psychologist, licensed mental health professional, or licensed mental health intern under the supervision of a licensed clinician, who is certified in CANS.
2. The youth must be present during the IBHA and CANS assessment.

What You Need to Do

Your responsibility is to:

- Review and be familiar with the full description of the medical necessity guidelines located at www.MagellanofNevada.com.
- Keep apprised of medical necessity guideline changes via communications posted on the website.
- Ensure the youth being evaluated is present during the assessment.
- Submit the completed IBHA and CANS within 14 calendar days of completion.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Make decisions about prior authorizations for services within contractual guidelines and timeframes.
- Magellan's care coordinator will identify service needs and intensity as part of the Child Family Team (CFT) process to ensure that each service supports and enhances the youth and family's overall goals.
- Magellan's care coordinator will submit the plan of care to Magellan's Utilization Department for medical necessity review.
- The Magellan care coordinator will notify providers of the utilization decision verbally, and the authorization details will be available on the Magellan provider portal.

A Commitment to Quality

Our Philosophy

Magellan supports the delivery of quality care with the primary goal of improving the health status of youth and families and, where the condition is not amenable to improvement, maintaining the youth's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. This includes identifying youth and families at risk of developing conditions, implementing appropriate interventions, and designating adequate resources to support the intervention(s).

Our Policy

Magellan maintains an internal Quality Assurance Performance Improvement (QAPI) program that complies with state and federal standards specified in 42 CFR §438.200 and any other requirements as issued by DCFS. In support of our quality program, providers are required to be familiar with Magellan guidelines and standards and apply them in their work with youth and families.

What You Need to Do

To comply with this policy, your responsibility is to:

- Understand federal and state Medicaid standards applicable to providers.
- Comply with federal and state laws, regulations, the contract, and all other quality management requirements, including a procedure for formal review with site visits.
- Adhere to clinical practice guidelines as appropriate.
- Provide feedback and recommendations to improve Magellan's performance.
- Support youth and their families/caregivers in submitting grievances and complaints, appeals, feedback, and recommendations to improve Magellan's performance.
- Participate and cooperate fully in any monitoring and site reviews conducted by Magellan to ensure they provide services in settings that are home- and community-based, as applicable.
- Participate in quality reviews and/or quality improvement activities as requested by Magellan and DCFS.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Operate a toll-free telephone line to respond to provider questions, comments, grievances and complaints, and inquiries. That number is 1-833-396-4310.
- Establish a QAPI program based on a model of continuous quality improvement using clinically sound, nationally developed, and accepted criteria.
- Form a QAPI committee that meets the following requirements:
    - Be chaired or co-chaired by Magellan's medical director.
    - Include the appropriate Magellan staff representing the various departments of the Magellan organization, including but not limited to grievance, complaint, and appeal staff and the Program Integrity Compliance Officer responsible for fraud, waste, and abuse monitoring activities.
    - Implement a written QAPI program description and work plan which complies with DCFS requirements as specified in our contract and reviewed and approved by DCFS annually.
    - Ensure that the written QAPI work plan includes:
        - Objectives for the contract year, inclusive of associated action steps and timelines.
        - Metrics and associated benchmarks for the wraparound agency scorecard.
        - A plan to evaluate ongoing implementation of High Fidelity Wraparound in accordance with NWIC standards inclusive of best practice indicators.
        - Submit an annual QAPI evaluation to DCFS that includes, but is not limited to, results of QAPI activities and findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of care.
- Ensure that QI processes are data-driven, including the continual measurement of clinical and non-clinical processes. These are driven by the measurement and the re-measurement of effectiveness and continuous development and implementation of improvements as appropriate.

- Have sufficient mechanisms in place to assess the quality and appropriateness of care furnished to youth and families with special healthcare needs.
- Collect data on race, ethnicity, primary language, gender, age, and geography (e.g., urban/rural).
- Identify and address health disparities between population groups, such as but not limited to, quality of care, access to care, and health outcomes.
- Develop a performance scorecard for services offered by the Connect Nevada program to include comprehensive data on a variety of measures.
- Take appropriate action to address service delivery, provider, or other QAPI issues as they are identified.
- Have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, subcontractors, youth and their families/caregivers, and providers, and use the feedback and recommendations to improve performance.
- Disseminate information about findings and improvement actions taken and their effectiveness to DCFS and other participating agencies, youth and their families/caregivers, providers, committees, and other key stakeholders, and post the information on the Magellan of Nevada website in a timely manner.
- Ensure that the ultimate responsibility for the QAPI is with Magellan and shall not be delegated to subcontractors or network providers.
- Participate in the DCFS quality committee meetings and other meetings as directed by DCFS, e.g., quarterly Utilization Management/Care Management Committee meetings to include Wraparound Steering and Population Health Equity workgroups.
- Participate in the review of quality findings and act as directed by DCFS. Magellan will submit requested materials to DCFS prior to the scheduled meeting date.
- Collect data, perform data analysis, and report data for the performance measures identified in the Connect Nevada Quality Improvement Strategy (QIS) prepared by DCFS and in accordance with the frequency identified in said document and the methodology approved by DCFS.

- Ensure that an appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal or state regulations.
- Monitor and evaluate corrective actions taken to ensure appropriate changes have been made promptly.
- Submit quarterly reports that summarize monitoring activities, findings, corrective actions, and improvements for specialized behavioral health services.
- Survey youth and families annually to assess their satisfaction with quality, availability, and accessibility of care and experience with their providers and Magellan.
- Cooperate fully in quality reviews conducted by DCFS or its designee and ensure full cooperation of our network providers.
- Use quality review findings to improve the QAPI program and take action to address identified issues in a timely manner, as directed by DCFS.

Cultural Competency

Our Philosophy

Magellan is committed to the provision of services that are responsive to the unique cultural, ethnic, and linguistic characteristics of the population we serve. We define cultural competency as a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups and the sensitivity to know how these differences influence relationships with youth and families. This requires a willingness and ability to draw on community-based values, traditions, and customs to devise strategies to better meet culturally diverse needs of youth and families, and to collaborate with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

We believe that all people the Connect Nevada program serves must receive equitable and effective treatment in a respectful manner, recognizing individual spoken language(s), gender, and cultural aspects.

Our Policy

Magellan staff receive training in cultural diversity and sensitivity to refer youth and families to providers who are appropriate to their needs and preferences. Magellan continually assesses network composition by actively recruiting, developing, retaining, and monitoring a diverse provider network compatible with the youth population.

What You Need to Do

Your responsibility is to:

- Provide Magellan with information on languages you speak.
- On your credentialing application, provide Magellan with any practice specialty information you hold.
- Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact. Oral and ASL interpretation services are provided at no charge. Youth and

families must be provided with information instructing them on how to access these services.

- In general, any document that requires the signature of the behavioral health recipient, and that contains vital information regarding treatment, medications, or service plans, must be translated into their preferred/primary language if requested by the behavioral health child/youth recipient or their guardian.
- Collect youth demographic data, including but not limited to ethnicity, race, gender, sexual orientation, and religion. Ensure that supervision of direct care staff is provided in a culturally sensitive manner that represents the cultural needs and characteristics of the staff, the service area, and the population being served.
- Involve the youth and family throughout the planning and delivery of services. Ensure that services are delivered in a culturally and linguistically competent manner, respectful of the youth and family receiving services, appropriate to youth and families of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups, and appropriate for age, development and education.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Provide ongoing education to deliver responsive services to people of all cultures, races, ethnic backgrounds, religions, and those with disabilities.
- Provide language assistance, including bilingual staff and interpreter services, to those with limited English proficiency during all hours of operation at no cost to the recipient.
- Provide easily understood youth and family materials, available in the languages of the commonly encountered groups and/or groups represented in the service area.
- Monitor gaps in services and other culture-specific provider service needs. When gaps are identified, Magellan will develop a provider recruitment plan and monitor its effectiveness.
- Monitor cultural competence and linguistic needs, including the youth and family 's prevalent languages(s) and sign language.
- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural

health beliefs and practices, preferred languages, health literacy, and other communication needs by collecting youth and family demographic data, including but not limited to ethnicity, race, gender, sexual orientation, and religion, so that the provider will be able to respond appropriately to the cultural needs of the community being served.

- Annually assess the cultural competence of providers through the network development evaluation and plan.
- Annually assess youth and family satisfaction of the services provided as it pertains to cultural competence.

Youth Safety

Our Philosophy

Within the Connect Nevada program, the Magellan Quality Assurance Process Improvement program prioritizes a focus on patient safety that includes oversight of quality-of-care concerns that may occur at programs and facilities. This activity may support assessments of provider performance concerns, and compliance with regulatory and Magellan standards of services delivered. Our staff may conduct administrative, compliance and clinical reviews.

Our Policy

Magellan monitors the safety of Connect Nevada youth receiving treatment from our providers. Monitoring includes but is not limited to youth and family feedback, performance indicator reviews, site visits, treatment record reviews and surveys.

What You Need to Do

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures. Providers must permit access to any and all portions of the medical record which resulted from a youth's admission, or the services provided. Magellan's utilization review program and/or quality improvement program may include on-site review of covered services, and shall permit Magellan staff on-site access.

Treatment Record Reviews (TRRs) and/or on-site visits may be conducted at minimum:

- On occasions when Magellan determines it is necessary, including but not limited to, clinical reasons, grievance and complaint investigations, and customer requests.

What Magellan Will Do

Magellan of Nevada's responsibility is to evaluate TRRs/site visit findings and may send a written report to the provider. This report may include the following information:

- The findings from the site visit.
- Recommendations for improvement, if needed.
- A request for a corrective action plan to improve care or services, if indicated.

- These findings are reviewed by DCFS and the applicable Magellan Regional Network Credentialing Committee as part of the provider's credentialing and recredentialing process.

Provider Input

Our Philosophy

Magellan of Nevada believes that provider input concerning our programs and services are a vital component of our quality improvement efforts.

Our Policy

Magellan obtains provider input through provider participation in various workgroups and committees of the Connect Nevada Program. We offer providers opportunities to submit feedback through participation in our quality programs, or via requests for feedback in provider publications.

What You Need to Do

Your responsibility is to comply with this policy:

- Provide input and feedback to Magellan to actively improve the quality of care provided to youth and families.
- Participate in quality improvement and utilization oversight activities if requested by Magellan.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Actively request input and feedback regarding youths' care.
- Operate a toll-free telephone line to respond to provider questions, comments and inquiries. The number for our Connect Nevada Customer Experience Associates is 1-833-396-4310.
- Establish a multi-disciplinary Quality Oversight Committee to oversee all quality functions and activities.
- Maintain a health information system sufficient to support the collection, integration, tracking, analysis and reporting of data.
- Provide designated staff with expertise in quality assessment, utilization management, and continuous quality improvement.
- Develop and evaluate reports, indicate recommendations to be implemented, and facilitate feedback to providers and youth and families.
- Conduct provider satisfaction surveys annually.

Complaint and Grievance Process

Our Philosophy

To achieve a high level of youth and family satisfaction and care, Magellan believes in providing a mechanism for providers and external agencies to express grievances and complaints related to care, service, confidentiality, policy, procedure, payment, or any other communication or action by Magellan.

Our Policy

Magellan maintains a Provider Grievance and Complaint System for providers to dispute Magellan's policies, procedures, or any aspect of Magellan's administrative functions. Magellan defines a provider grievance and complaint as the following:

- Any verbal or written expression originating from a provider and delivered to any employee of Magellan that voices dissatisfaction with a policy, procedure, payment, or any other communication or action by Magellan.
- An expression of dissatisfaction about any matter other than an adverse benefit determination. Examples include:
    - Dissatisfaction with quality of care.
    - Dissatisfaction with quality of services provided.
    - Dissatisfaction with aspects of interpersonal relationships such as rudeness of a provider or a network employee or failure to respect a youth's rights regardless of whether remedial action is requested.
    - Dissatisfaction with network administration practices. Administrative grievances are generally those related to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

What You Need to Do

To comply with this policy, your responsibility is to:

- Assist the youth and family in filing a grievance or complaint.
- Submit grievances and complaints to Magellan using one of the five available mechanisms:

1. Call Magellan at 1-833-396-4310; TTY: 7-1-1; 8 a.m. to 5 p.m. PT.
2. Fax to 1-888-656-9795.

3. Access the Magellan of Nevada website and complete the online grievance and complaint form.

    - On the website, navigate to "For providers/ Resources/Forms/Complaints and Grievances." A form is provided on the website. Enter your information in the boxes and click "Submit" when you are finished.
4. Email a written grievance and complaint to: NevadaAppealsGrievances@MagellanHealth.com. If emailing protected health information to Magellan or DCFS, use secure email.
5. Mail a written grievance and complaint to the following address.

Connect Nevada: Strengthening Youth,
Empowering Families Program
Attention: Magellan of Nevada
Appeals & Grievances Department
P.O. Box 2188
Maryland Heights, MO 63043

- Notify us if you or your representative(s) want the opportunity to present your grievance and complaint in person. We will assist you with the next steps.
- Provide pertinent information to assist in investigating your grievance and complaint, such as relevant contact information (e.g., name, provider name, phone number, email, etc.), the subject of the grievance and complaint, and a description of the concern.
- Follow procedures for escalating a grievance and complaint. This process is in place for both in-network and out-of-network providers to dispute Magellan's policies, procedures, or any aspect of Magellan's administrative functions. The escalation procedures are also accessible via the Magellan of Nevada website in the "Grievances and Complaints/Issue Escalation and Resolution" section.

Procedures include:

- Seek resolution with Magellan of Nevada using a three-tier process that has been developed for escalation and resolution:

  Tier 1: Contact your Magellan network management specialist by phone, email, or by calling the toll-free provider line at 1-833-396-4310.

  Document the name of the representative(s) with whom you speak or communicate, along with the time and date, and provide that information as issues are escalated.

  Tier 2: Contact your Magellan network management specialist by phone, email, or by calling the toll-free provider line at 1-833-396-4310 and request to speak to our network management director.

  Document the name of the representative(s) with whom you speak or communicate, along with the time and date, and provide that information as issues are escalated.

  Tier 3: You may file a grievance and complaint directly with DCFS if you feel you have exhausted Magellan's provider grievance and complaint system. Email the written grievance and complaint to DCFS/Magellan Quality Improvement at dcfsmglnqi@dcfs.nv.gov. If emailing protected health information to DCFS, use secure email.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Operate a toll-free telephone line to respond to providers' grievances, complaints, questions, comments, and inquiries. That number is 1-833-396-4310 (Customer Experience Associates) or 1-800-788-4005 (National Provider Services Line).
- Maintain a designated Magellan staff person with authority to administer and oversee the Provider Grievance and Complaint System.
- Have authorized, dedicated provider support staff, called network management specialists, for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider grievance and complaint, and resolve problems. Magellan will ensure our network management specialists are trained to distinguish between a provider grievance and

complaint, and a youth and family grievance and complaint in which the provider is acting on the youth's behalf.

- Allow providers to consolidate grievances and complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual youth or payment claims included in the bundled grievance and complaint.
- Provide written acknowledgement of provider grievance and complaint within five business days of receipt.
- Thoroughly investigate each provider's grievance and complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying Magellan's written policies and procedures.
- Resolve and provide written notification of the grievance and complaint resolution to the provider within thirty (30) calendar days of receipt. If unable to resolve in thirty (30) calendar days, Magellan will provide written notification to the provider of the reason the issue has not been resolved; however, the issue must be resolved within ninety (90) calendar days.
- Ensure a Magellan executive with the authority to require corrective action engages in the provider grievance and complaint escalation process, as necessary.
- Give providers (or their representatives) the opportunity to present their cases in person if requested.
- Operate a system to capture, track, and report the status and resolution of provider grievances and complaints, which includes associated documentation, whether the grievance and complaint is received by telephone, in person, or in writing.
- Submit a performance report of provider grievances and complaints to DCFS including the issue in the grievances and complaints.
- Address any aberrant trends identified, either internally or by DCFS, that require corrective action by Magellan.

Magellan of Nevada's responsibility to youth and families is to:

- Ensure Magellan staff are educated concerning the importance of the grievance and complaint procedure, the rights of the youth, and how to instruct a youth to file a grievance and complaint.
- Assist youth and families in completing forms and taking other procedural steps. This includes, but is not limited to, providing

interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

- Refer youth and families who are dissatisfied with Magellan, its subcontractors, or its network providers in any respect to the Magellan staff authorized to review and respond to grievances and complaints that require corrective action.
- Maintain a website in which a grievance and complaint can be submitted electronically.
- Ensure timely due process by eliminating barriers such as:
    - Failure to inform youth and families of their due process rights.
    - Failure to log and process grievances, complaints, and appeals.
    - Failure to issue a proper notice including vague or illegible notices.
    - Failure to inform of continuation of benefits.
- Allow the youth or a representative or provider acting on the youth's behalf with the youth's written consent, to file a grievance and complaint either orally or in writing, including online through the Magellan of Nevada website.
- Grievances and complaints can be filed at any time. Once received, Magellan will:
    - Acknowledge the grievance and complaint in writing within five (5) business days from date of receipt, except in instances where the resolution of the grievance and complaint occurs on the same day the grievance and complaint is received. Although the requirement to acknowledge the grievance and complaint in writing is waived in this instance, Magellan will report the grievance and complaint on our quality tracking log.
    - Make a good faith effort to resolve the concern at the time of the initial call or involve a supervisor or designee to resolve the issue.
    - Thoroughly investigate each youth's grievance and complaint using applicable statutory, regulatory, and contractual provisions, collecting pertinent facts from all parties.
    - Resolve the grievance and complaint and provide written notification of the resolution to the grievant within thirty

(30) calendar days. Provide written notice to the youth and family of the resolution of a grievance and complaint via a letter to the originator of the grievance containing, at a minimum:

1. Sufficient detail to foster an understanding of the resolution.
2. Whether grievance and complaint was a quality-of-care issue.
3. A contact name and telephone number to call for assistance or to express any unresolved concerns.

- Make every effort to ensure that no punitive action will be taken against any youth or family who files a grievance and complaint.

- When a grievance and complaint involves a quality of care (QOC) concern, Magellan will:
  - Conduct follow-up with the youth, family/caregiver, and/or custodial state agency, if applicable, to determine whether the immediate behavioral healthcare needs are met.
  - Refer grievances and complaints with quality-of-care issues to the Magellan peer review/credentialing committee, when appropriate.
  - Refer or report the grievance and complaint quality of care issue(s) to the appropriate regulatory agency, child, or adult protective services, and DCFS for further research, review, or action, when appropriate.
  - Notify DCFS and the appropriate regulatory or licensing board or agency when the provider agreement with a network provider is suspended or terminated due to quality-of-care concerns.

Critical Incident Reporting

Our Philosophy

Magellan of Nevada defines a critical incident as an unexpected occurrence involving a child, youth, or young adult, providers, or contractor staff that poses an actual risk of physical or mental harm to themselves or others. This encompasses events hindering access to medical care by the provider or agency, potentially resulting in detrimental effects like death or serious disability during or after behavioral health treatment.

Furthermore, Magellan identifies critical incidents as unexpected events related to its services that could have caused serious harm, loss, or damage, such as death or serious injury, to individuals receiving services through Magellan or a third party. The organization is dedicated to early identification of potential or existing risks to eliminate or mitigate them for the wellbeing of Connect Nevada youth and families, as well as Magellan itself.

Our Policy

Critical incidents include but are not limited to:

- Homicide or attempted homicide by a child or youth served by the Connect Nevada program.
- A major injury or major trauma that has the potential to cause prolonged disability or death of a child or youth that occurs in a facility licensed by the state of Nevada to provide publicly funded behavioral health services.
- An unexpected death that occurs in a facility licensed by the state of Nevada to provide publicly funded behavioral health services.
- Abuse, neglect, or exploitation (not to include child abuse).
- Violent acts allegedly committed by a child or youth to include:
    - Arson
    - Assault resulting in serious bodily harm
    - Homicide or attempted homicide by abuse
    - Drive-by shooting
    - Extortion
    - Kidnapping
    - Rape, sexual assault, or indecent liberties
    - Robbery

- Vehicular homicide
- Unauthorized leave of an individual with mental health challenges, particularly those with a history of offenses such as sexual or violent behavior, from a mental health facility or secure Community Transition Facility that accepts involuntary admissions. These facilities include Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities.
- Any event involving a child or youth served that has attracted or is likely to attract media attention.

Magellan requires providers to submit written notification to Magellan within 24 hours of becoming aware of a reportable critical incident, including the use of restraints and/or seclusions.

What You Need to Do

To comply with this policy your responsibility is to:

- Complete Critical Incident training as part of new provider orientation.
- Know the definitions of reportable incidents. Definitions and instructions on how to file critical incidents are accessible on the Magellan of Nevada website.
- Ensure all provider staff comply with state and/or federal regulations for mandated report of child or adult abuse, neglect, exploitation, and extortion.
- Comply with the youth's right to be free of restraints and seclusions during the course of the delivery of services. Magellan does not permit (or prohibits) the use of restraints during the course of the delivery of services.
- Notify Magellan within 24 hours of the discovery of a reportable incident involving a youth, whether it occurs at the provider's location or at another location.
- Under Nevada Revised Statutes NRS Chapter 432B, reporting is required. Report any incidents of child or adult abuse, neglect, exploitation, and extortion to Magellan and the appropriate regulatory body (e.g., Division of Child and Family Services, Child Protective Services, Aging, and Disabilities Services Division, police, etc.) as soon as possible or within 24 hours.

    a. Division of Child and Family Services website:

https://dcfs.nv.gov/.

b. Clark County call 702-399-0081 or submit a report online: https://redrock.clarkcountynv.gov/dfswebform.
c. Washoe County (Reno and surrounding area) call 833-900-7233.
d. Division of Child and Family Services: For all other counties, call 833-571-1041, or 833-803-1183 after hours, weekends, and holidays.
e. If it is an emergency, call 911 to report to your local law enforcement agency.

- Participate in the investigation of any critical incident and complete corrective actions as needed.

Providers can use the Magellan Critical Incident Reporting Form located on the Magellan of Nevada Payer Space within Availity Essentials of a form of your choice including the required fields:

- The date you became aware of the incident
- The date of the incident
- A description of the incident
- The name of the facility where the incident occurred, or a description of the incident location
- The name(s), age(s), gender, and address of child(ren) and/or youth(s) involved in the incident
- The name(s) and title(s) of facility personnel or other staff involved
- The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement
- The whereabouts of the child or youth at the time of the report if known (i.e., home, jail, hospital, unknown, etc.) or actions taken by you or Magellan to locate the child or youth
- Actions planned or taken by you or Magellan to minimize harm resulting from the incident
- Any legally required notifications made by you or Magellan.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Review incidents to ensure that immediate youth safety issues are resolved.

- Initiate investigations of critical incidents and require corrective actions as needed.
- Track and trend incidents to identify and address systemic youth safety issues.
- Report individual-level remediation actions taken for critical incidents involving substantiated abuse, neglect, exploitation, and death to DCFS.

Individual Critical Incident Resolution and Closure: Magellan will submit follow-up reports using the DCFS Incident Reporting System and close the case within forty-five (45) calendar days after the critical incident was initially reported.

Appeal Procedures

Our Philosophy

Magellan supports the right of youth and families, and their providers acting on the youth's behalf, to appeal adverse benefit determinations.

Our Policy

Magellan maintains an appeal process in accordance with applicable federal, state and contract requirements.

Magellan defines an adverse benefit determination as the denial, reduction, suspension, delay, or termination of a request for admission, availability of care, continued stay, or other healthcare service upon review by Magellan of the information provided that the requested service does not meet Magellan's requirements for medical necessity, appropriateness, healthcare setting, and/or level of care or effectiveness.

An appeal is defined as a review by Magellan of an adverse benefit determination. Specific examples include:

- The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service not including claims denied in whole or in part due to not meeting the definition of a "clean claim" (e.g., with no defect or impropriety).
- The failure to provide services in a timely manner as defined by the DCFS.
- The failure of Magellan to act within the timeframes provided regarding the standard resolution of appeals.

What You Need to Do

Your responsibility is to:

- Have knowledge of Magellan's procedures for filing an appeal.
- Support youth and families in filing an appeal on their behalf.
- Appeal by phone, fax, email, or mail as detailed below:

1. Access the Magellan of Nevada website and complete the online appeal request form. Help the youth file the appeal at www.MagellanofNevada.com. Navigate to "For Providers>Authorizations and Claims" and under the section titled "Clinical/Medical Appeals" click the link to the **Appeal Request Form**. Enter your information in the boxes and click "Submit" when you are finished.

2. Call Magellan at 1-833-396-4310.
3. Fax the Request for Appeal form to 1-888-656-9795.
4. Send the Appeal Request Form via secure (encrypted) email to NevadaAppealsGrievances@MagellanHealth.com.

5. Mail the Appeal Request Form to:

Connect Nevada: Strengthening Youth, Empowering Families Program
Attention: Magellan of Nevada
Appeals & Grievances Department
P.O. Box 2188
Maryland Heights, MO 63043

- Obtain and submit the youth's written consent when filing an appeal on behalf of the youth and family. Magellan will only process an appeal filed by a provider on behalf of the youth if the provider has obtained and submitted the written consent of the youth, legal guardian, or authorized representative with the appeal request.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Ensure Magellan's staff are educated concerning the importance of the appeal procedures, the rights of the youth and family, and how to instruct the youth and family to file an appeal.
- Ensure timely due process by eliminating barriers such as:
    - Failure to inform youth and families of their due process rights.
    - Failure to log and process grievances, complaints, and appeals.
    - Failure to issue a proper notice including vague or illegible notices.

    - Failure to inform of continuation of benefits.
- Allow the youth, a representative acting on the youth's behalf, or network provider, with the youth and families' written consent, to request an appeal either orally or in writing.
- To process an appeal:
    - The appeal must be requested within sixty (60) calendar days from the date on the Notice of Denial letter.
    - Magellan will maintain a website in which an appeal can be initiated via an electronic appeal form.
    - Assist youth and families in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
    - Send a written acknowledgement of the appeal request within five (5) business days of receipt.
    - Provide the youth and family reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
    - Provide the youth and family an opportunity to examine their case file, including treatment records, other documents and records considered during the appeals process, and any new or additional evidence considered, relied upon, or generated by Magellan in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the date by which Magellan must resolve the appeal.
- Ensure that the individuals who make appeal decisions:
    - Were not involved in any previous level of review or decision making, nor a subordinate of any such individual.
    - Have the appropriate clinical expertise, as determined by DCFS, in treating the youth's condition or disease.
    - Consider all comments, documents, records, and other information submitted by the youth and family, or youth's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
    - Not take any punitive action against the youth/family or any provider that requests or supports an appeal.

- Resolve an appeal and provide written notice, as expeditiously as the youth's health condition requires, but no later than the timeframes established below:
    - For standard resolution of an appeal and notice to the affected parties, the timeframe is thirty (30) calendar days from the day the appeal is received.
    - For expedited resolution of an appeal and notice to affected parties, the timeframe is 72 hours (3 calendar days) after receipt of the appeal.
    - At the request of the youth and family or if Magellan believes that there is need for additional information and the delay is in the youth's interest, Magellan will extend the timeframe for completing appeals by up to fourteen (14) calendar days.
- Provide written notice to the youth and family of the resolution of the appeal, which complies with state and federal regulations, and DCFS requirements, and includes the results of the resolution process and the date it was completed.
- Allow an expedited review process when the youth or the treating provider, on behalf of the youth, indicates that the time it would take to complete a standard appeal would seriously jeopardize the youth's life, health, or ability to attain, maintain, or regain maximum function.
- The youth, the youth's representative, or the youth's provider acting on their behalf and with the youth's prior written consent, may file an expedited appeal either orally or in writing.
- Expedited appeals will be completed, and written notification sent within 72 hours of receipt of the appeal request.
    - In addition, Magellan will make reasonable efforts to provide oral notice to the youth and family within 72 hours of receipt of appeal request. In cases in which Magellan denies a request for expedited resolution of appeal, Magellan will:
        - Resolve the appeal within thirty (30) calendar days from the date the appeal request is received and inform all parties of Magellan's resolution in writing.
        - Not record the denial of a request for expedited resolution of appeal as an adverse

benefit determination or require a Notice of Adverse Benefit Determination.

- Continue the youth's benefits while an appeal request is under review as bulleted below. A provider may not request continuation of benefits for the youth unless:
  - The youth and family files the appeal in a timely manner in accordance with 42 CFR§438.420(c)(1)(ii) and (c)(2)(ii);
  - The appeal involves the termination, suspension, or reduction of previously authorized services;
  - An authorized provider ordered the services;
  - The period covered by the original authorization has not expired; and
  - The youth and family files in a timely manner for continuation of benefits.

- Provide the information specified in 42 CFR §438.414 about the grievance, complaint, and appeal system to all subcontractors and network providers at the time they enter a provider agreement or subcontract.
- Make retrospective review determinations within thirty (30) calendar days of receipt of sufficient medical information necessary to make a determination if the provider had no way of knowing that the youth was eligible for services under Magellan.
- Requests for retrospective reviews must be submitted to Magellan no later than 180 days after the date of service.
- Not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission, or the provider misrepresented the youth's health condition.

Youth and Family Rights and Responsibilities

Our Philosophy

Magellan expects providers to share Connect Nevada youth and family Rights and Responsibilities (below) with them. We expect to see evidence in their record that you have shared this information with youth and families. Rights and Responsibilities also need to be posted in a visible area within your office.

Our Policy

Youth Rights

Connect Nevada youth have the right to receive the care they need. They should expect to:

- Be treated with respect, recognizing their dignity and need for privacy, by Magellan staff and network providers.
- Have easy access to information about Magellan, its services, and the providers that treat them, when they need it.
- Family choice: Freedom to choose the Magellan behavioral health network providers that they want for treatment. They may change providers if they are unhappy.
- Get emergency services when they need them from any provider without Magellan's approval.
- Get information that they can easily understand from their providers and be able to talk to them about treatment options, without any interference from Magellan.
- Make decisions about their treatment. If they cannot make treatment decisions independently, they have the right to designate someone else to help them make decisions or make decisions for them. They may refuse treatment or services unless they are required to get involuntary treatment under the Mental Health Procedures Act.
- Talk with providers in confidence and have their information and records kept confidential.
- See and get a copy of their medical records and ask for changes or corrections to records.
- Ask for a second opinion regarding their care.

- File an appeal if they disagree with Magellan's decision that a service is not medically necessary for them. (Information about the process can be found under Appeal Procedures.)
- File a grievance and complaint if they are unhappy about the care or treatment they have received. (Information about the process is found in the Complaint and Grievance Process section.)
- Be free from any form of restraint or seclusion used to force them to do something, to discipline them, or as a punishment.
- Get information about services that Magellan or a provider does not cover because of moral or religious objections and about how to get those services.
- Exercise their rights without it negatively affecting the way the DCFS, Magellan, or network providers treat them.
- Request case files prior to any proceedings. There is no cost to file.
- Receive a list of advocacy organizations that can assist them.

Youth and Family Responsibilities

Youth and families also have responsibilities to Magellan staff and providers. They are as follows. Youth and family need to:

- Provide, to the extent they can, information needed by their providers.
- Inform their provider of the medicines they are taking, including over-the-counter medicines, vitamins, and natural remedies.
- Be involved in decisions about their healthcare and treatment.

- Work with their providers to create and conduct their treatment plans.
- Tell their providers what they want and need.
- Take their medications as prescribed and tell their provider if there is a problem.
- Keep their appointments.
- Learn about Magellan coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless Magellan approves an out-of-network provider.
- Respect other patients, provider staff and provider workers.
- Report fraud and abuse to the State of Nevada Department of Administration Division of Internal Audits Fraud Hotline.
    - Call: 775-687-0150
    - Email: jaudits@finance.nv.gov
    - Report Medicaid fraud: https://ag.nv.gov/About/Criminal_Justice/Medicaid_Fraud

What You Need to Do

Your responsibility is to:

- Review the Youth and Family Rights and Responsibilities with youth and/or family members in your care at their first appointment.
- Give youth the opportunity to discuss their rights and responsibilities with you.
- Review with youth in your care information such as procedures to follow if a clinical emergency occurs, confidentiality scope and limits, complaint/grievance/appeals processes, treatment options, and medication.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Make the Youth and Family Rights and Responsibilities policies available.
- Make the Youth and Family Rights and Responsibilities policies available in languages and formats that youth and family members can understand.

Site Visits

Our Philosophy

Site reviews are a joint responsibility of Network Management and Quality Improvement staff depending on the nature of the site visit.

Our Policy

Site visits may be conducted at minimum:

- On occasions when Magellan determines it is necessary, including, but not limited to, for quality reasons.

Magellan evaluates site visit findings and sends a written report to the provider. The report includes the following information:

- The findings from the site visit.
- Recommendations for improvement, if needed.
- A request for a corrective action plan to improve care or services, if indicated.

Site visit findings are reviewed by the Magellan Regional Network Credentialing Committee as part of the provider's credentialing and recredentialing process.

What You Need to Do

Your responsibility is to:

- Comply with requests for site visits.
- Provide information in a timely manner, including files as requested by the site visit reviewer.
- Be available to answer questions from the reviewer.
- Participate in developing and implementing a corrective action plan, if required.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Notify you in writing if a site visit is required.
- Advise you of what you need to do to prepare for the site visit.
- Notify you of the results of the site visit in a timely manner.
- Work with you to develop a corrective action plan, if required.

Treatment Record Reviews and Documentation

Our Philosophy

Magellan of Nevada is committed to ensuring that participating providers' behavioral health record documentation meets federal and state regulations as well as Magellan standards.

Our Policy

Magellan conducts routine treatment record reviews to monitor the behavioral health record documentation of providers against Magellan standards, and to measure network provider performance against important clinical process elements of Magellan-approved clinical practice guidelines. Magellan may also conduct treatment record reviews under special circumstances to investigate or follow up on quality-of-care concerns, critical incidents, or grievances and complaints about the clinical or administrative practices of a provider.

What You Need to Do

To comply with this policy, your responsibility is to:

- Ensure that record keeping practices are fully compliant with all requirements.
- Maintain administrative, personnel, and youth records for whichever of the following timeframes is longer:
    - Until records are audited, and all audit questions are answered; or
    - Six years from the date of the last payment period.
    - NOTE: Upon provider closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements, and copies of the required documents transferred to the new agency.
- Ensure all records, including administrative and youth records, must be the property of the provider and secured against loss, tampering, destruction, or unauthorized use.
- Safeguard the confidentiality of youth records and any information that might identify the youth or their families.

- Always make administrative, personnel, and youth records available to DCFS, or its designee, and appropriate state and federal personnel.
- Have a separate written record for each youth served by the provider.
- Have adequate documentation of services offered and provided to youth and families they serve for the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received. This documentation should be an ongoing chronology of activities undertaken on behalf of the youth.
- Ensure the organization of individual records and the location of documents within the record is consistent. Records must be appropriately thinned so that current material can be easily located in the record.
- Ensure that all entries and forms completed by staff in youth records is legible, written in ink (not black) and include the following:
    - The name of the person making the entry.
    - The signature of the person making the entry.
    - The functional title, applicable educational degree and/or professional license of the person making the entry.
    - The full date of documentation.
    - Reviewed by the supervisor, if required.
- Ensure service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered. The following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:
    - Name of youth.
    - Name of provider and employee providing the service(s).
    - Service provider's contact telephone number.
    - Date of service contact.
    - Start and stop time of service contact.
    - Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

- Ensure a sample of the service/progress notes for each youth seen by a non-licensed medical health provider (LMHP) is reviewed by an LMHP supervisor at least monthly, or more if needed.
- The signature of the LMHP attests to the date and time that the review occurred.
- Maintain a behavioral health record for each youth served which includes, minimally, the following:
    - Youth identifying information, i.e., name, identification number, date of birth (DOB), gender, and legal guardianship.
    - Primary language spoken by the youth and any translation needs of the youth.
    - Evidence that youth and family rights and responsibilities are reviewed.
    - Signed and dated releases for communication with all involved parties in the youth's care including other behavioral health providers, the Connect Nevada providers, and the youth's PCP/pediatrician, or documentation of refusal.
    - Services provided through the provider, date of service, service site, and name of service provider. Behavioral health history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first youth visit with or by a provider.
    - Treatment Plan and Plan of Care, if required.
    - Documentation of Child/Youth's Freedom of Choice & Consent Form (e.g., Freedom of Choice form).
    - The youth's most recent Independent Behavioral Health Assessment (IBHA) and Child and Adolescent Needs and Strengths (CANS) evaluation (as retrieved from the Connect Nevada program).
    - Referrals including follow-up and outcome of referrals.
    - Documentation of emergency and/or after-hours encounters and follow-up.
    - Other youth assessments as required by DCFS.
    - Signed and dated consent forms (as applicable), which could include other behavioral health providers, the

Connect Nevada program, and/or the youth's PCP/pediatrician.

- Documentation of advance directives, as appropriate.
- Documentation of each visit must include:
    - Date and begin and end times of service
    - Chief complaint or purpose of visit
    - Date and begin and end times of service
    - Diagnoses or medical impression
    - Objective findings
    - Youth's assessment findings
    - Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG)
    - Medications prescribed and compliance or non-compliance with medication if a prescriber
    - Health education provided
    - Interventions that are in alignment with youth's treatment plan and/or the plan of care
    - Progress towards measurable youth and family identified goals and/or barriers addressed, and
    - Name and credentials of the provider rendering services and the signature or initials of the provider, identified with correlating signatures.
- The provider's treatment record documentation must match all submitted claims and align with services billed on the claim (e.g., diagnosis, DOB, procedure code).
- Provide one (1) free copy of any part of the youth's record upon request.
- Ensure that documentation and/or records are maintained for at least six (6) years after the last good, service, or supply has been provided to a youth and family or an authorized agent of the state or federal government, or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by on behalf of the state or federal government.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Conduct Treatment Record Reviews or reviews of youth's medical and treatment records using a health professional to:
    - Verify that services for which reimbursement was made were provided to youth;
    - Identify and overcome barriers to care that a youth may encounter; and
    - Ensure that providers render high-quality healthcare that is documented according to established standards.
- Ensure that treatment record reviews address the following:
    - Quality of care consistent with professionally recognized standards of practice.
    - Adherence to clinical practice guidelines.
    - Youth's rights and confidentiality, including advance directives and informed consent.
    - Cultural competency.
    - Youth safety.
    - Compliance with critical incident reporting requirements.
    - Appropriate use of restraints and seclusion, if applicable.
    - Treatment planning components, including criteria to determine if the treatment plan includes evidence of implementation as reflected in progress notes and evidence that the youth is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the youth.

    - Continuity and coordination of care, including adequate discharge planning.
    - Family Support Organization (FSO) staff, particularly peer workers, are expected to follow and adhere to the Core Competencies set forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) for peer workers.
- Ensure that appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a needed service, or is out of compliance with federal or state regulations.
- Monitor and evaluate corrective actions taken to ensure that appropriate changes are made in a timely manner.
- Submit quarterly reports which summarize results of treatment record reviews and corrective actions taken for specialized behavioral health services.

Fraud, Waste, and Abuse

Our Philosophy

Magellan takes provider fraud, waste, and abuse very seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. We have made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law. For definitions, corporate policies and more information, see the Fraud, Waste, Abuse and Overpayment section of our National Provider Handbook.

Our Policy

Magellan does not tolerate abuse, fraud, or waste, either by providers, youth, families, or staff. Accordingly, we have instituted extensive fraud, waste, and abuse programs to combat these problems. Magellan's programs are wide-ranging and multi-faceted, focusing on prevention, detection, and investigation of all types of fraud, waste, and abuse in government programs and private insurance.

Abuse:

Abuse is defined as any practice that is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the Medical Assistance program, behavioral health managed care organization, primary contractor, a subcontractor, or provider, or a practice that results in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or agreement obligations (including the agreement, contracts, guidance issued in bulletins, and the requirements of state and federal statutes and regulations) for healthcare.

Examples include:

- Services that are billed by mistake.
- Misusing codes: A code on the claim does not comply with national or local coding guidelines; not billed as rendered.
- Billing for a non-covered service.
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session).

- Retaining and failing to refund and report overpayments (e.g., if a provider's claim was overpaid, they are required to report and refund the overpayment; unpaid overpayments are grounds for program exclusion).

Fraud:

Fraud is defined as any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable federal or state law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting.

Examples include:

- Intentionally billing for services that were not provided.
- Falsifying signatures.
- Rounding up therapy time spent with a youth.
- Altering claim forms.

Waste:

Waste means over-utilization of services or other practices that directly or indirectly result in unnecessary costs. Generally, waste is not considered caused by criminally negligent actions but rather the misuse of resources.

Examples include:

- Using excessive services such as office visits.
- Providing services that are not medically necessary.
- Ordering excessive testing.

What You Need to Do

Magellan of Nevada providers are expected to develop, implement, and maintain their own written Compliance Plans that adhere to applicable federal and Nevada state law and any applicable guidance on such plans issued by the United States Office of Health and Human Services Office of the Inspector General (HHS- OIG) or the Nevada Department of Health and Human Services (DHHS). All persons employed by or contracted with a Magellan-contracted provider will be governed under that provider's Compliance Plan, and the provider is responsible for the individuals' actions.

Federal False Claims Act

Providers must be familiar with and comply with the Federal False Claims Act. The False Claims Act (FCA) provides, in pertinent part, that:

a. Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a Member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages, which the Government sustains because of the act of that person.

b. For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Disclosure Requirements

Medicaid providers are required to disclose the following information regarding:

- The identity of all individuals and entities with an ownership or control interest of 5% or greater in the provider including information about the provider's agents and managing employees in compliance with 42 CFR 455.104;
- Certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455.105; and

- Including you, the provider, the identity of any individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider group or entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106.

How to Report Suspected Cases of Fraud, Waste, and Abuse

If you suspect that Medicaid fraud may be occurring, complete and submit one of the following forms, or call:

- Website: https://ag.nv.gov/Complaints/File_Complaint/ or
- Medicaid Fraud Control Unit (MFCU) website: https://ag.nv.gov/About/Criminal_Justice/Medicaid_Fraud/
- Email: mfcuintake@ag.nv.gov
- Fraud Hotline: State of Nevada Department of Administration, Division of Internal Audits: 775-687-0150

You may also mail the complaint to the Office of the Attorney General, Medicaid Fraud Control Unit, 100 North Carson Street, Carson City, NV 89701. Please call 775-684-1100 or 702-486-3420 if you have questions.

Reports made to Magellan can be submitted via one of the following methods:

- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com
- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com

Reports to the Corporate Compliance Hotline can be made 24 hours a Day, seven days a week. An outside vendor maintains the hotline. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

What Magellan Will Do

Magellan of Nevada's responsibility is to implement and regularly conduct fraud, waste and abuse prevention activities that include:

- Extensively monitoring and auditing provider utilization and claims to detect fraud, waste, and abuse.
- Actively investigating and pursuing abuse, fraud, or waste and other alleged illegal, unethical or unprofessional conduct.
- Reporting suspected abuse, fraud, or waste and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations.
- Cooperating with law enforcement authorities in the prosecution of healthcare and insurance fraud cases.
- Verifying eligibility for youth and families, and providers.
- Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/ Medicaid and other federally funded healthcare programs.
- Providing individual Explanation of Benefit notices to a sample group of the members who received services in a manner that complies with 42CFR§455.20 and §433.116(e).
- Making the Magellan Provider Handbook available to network providers.

Claims Submission

Our Philosophy

Magellan of Nevada is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements.

Our Policy

Magellan reimburses behavioral health and substance abuse treatment providers in accordance with reimbursement schedules for professional services. The reimbursement schedule(s) is attached to your Magellan provider agreement.

What You Need to Do

Your responsibility is to:

- Obtain authorizations before rendering services for:
  - Intensive Home-Based Therapy (IHBT), which may include but is not limited to:
    - Multisystemic Therapy (MST)
    - Multidimensional Family Therapy (MDFT)
    - Functional Family Therapy (FFT)
    - Family Centered Treatment (FCT)
    - Family Check-Up (FCU)
    - Parents as Teachers (PAT)
    - Parent Child Interaction Therapy (PCIT)
    - Triple P Positive Parenting Program (Triple P)
    - Family Behavior Therapy (FBT)
  - Emergency and Planned Respite
  - Youth Peer Support

- Submit claims electronically. See the Providers section on www.MagellanofNevada.com for information on this process.
- Submit a clean claim form for the services that you have provided through an approved clearinghouse or via paper claim. *Note:* A clean claim is a claim that has no defect or impropriety (including any lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment of the claim.

The postal address for Magellan of Nevada paper claims is:

Magellan Healthcare, Inc.
P.O. Box 1749
Maryland Heights, MO 63043

- You must submit claims for reimbursement within the limits required by the state. All claims for covered services provided to Magellan of Nevada youth and families must be received by Magellan in accordance with the following timelines.

  Claims – within **90** calendar days from the date of service or discharge.

  Corrected Claims – within **60** calendar days from date of Explanation of Payment (EOP) or Explanation of Benefits (EOB).

  Provider Claim Appeals – within **60** calendar days from date of the EOP/EOB.

  If Magellan does not receive a claim within these timeframes, the claim will be denied for payment.

  - When providing Intensive Home-Based Treatment, youth support or comprehensive assessments via telehealth, submit your claim with place of service being 10 if youth is in the home or 02 if the youth is elsewhere. Respite services are in-person only.
  - Bill using your contracted Taxpayer Identification Number.
  - Submit claims with the group or agency type 2 NPI (National Provider Identifier) as the billing provider and licensed or unlicensed staff type 1 NPI as the rendering provider.
  - Maintain up-to-date roster staff to avoid claim processing delays and/or denials.
  - Hold the youth/family harmless and do not bill the youth/family for any amount, including the difference between Magellan of Nevada's reimbursement amount and your standard rate. This practice is called *balance billing* and is prohibited.
  - Do not bill youth and families for missed appointments.
  - Contact Magellan of Nevada at 1-833-396-4310 if you are not certain which services require preauthorization, what your reimbursement

rate is, or for any questions that you have concerning claims payment.

- Refund any overpayments that you may identify by mailing a check and documentation of the youth identification number and date of service to:

Magellan Healthcare, Inc.
Recoveries Lockbox
P.O. Box 785346
Philadelphia, PA 19178-5346

Helpful Tips

The following suggestions will help expedite the processing of your claims:

- Use the appropriate billing, procedure codes, and modifiers.
- If submitting on paper, use the appropriate claim form (CMS-1500).
- Complete **all** required data on the form.
- Use the unit of service indicated on your Magellan contract.
- See "Elements of a Clean Claim," which is available within the appendix of Magellan's National Provider Handbook.

The following are common claims errors that may result in a denial. Check all your claims prior to submission to avoid delays due to these errors:

- Authorized units do not match billed units.
- More than one month of service is billed on one claim form.
- The youth's date of birth is missing.
- Procedure code and/or modifier(s) are incorrect.
- The diagnosis code is not an accepted code.
- Billed service and/or diagnosis is not permitted under the provider's license.

Resubmitting Claims

Claims with *provider* billing errors are called "resubmissions." Resubmitted claims must be received within 60 calendar days of the date of your Explanation of Benefits.

You can send resubmitted claims electronically via an 837 file. There is a specific indicator for an adjusted claim. When resubmitting on paper, the claim must be stamped "resubmission" (or otherwise noted on box 22 of Form CMS-1500) and include:

- The date of the original submission
- The original claim number, if applicable

- Box 22, resubmission code, of CMS 1500 form
    - 7, Replacement of Prior Claim
    - 8, Void/Cancel of Prior Claim

7	**Replacement of Prior Claim (See adjustment third digit)** - Use to correct a previously submitted bill. Provider applies this code to corrected or "new" bill.
8	**Void/Cancel of Prior Claim (See adjustment third digit)** - Use to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.

You may be able to correct/edit claims on the sites of our contracted vendors, as directed, on the same day; however, for claims corrections on a different day than submitted, you may only be able to amend certain fields. You may be required to submit a hard copy corrected claim, via postal mail as noted previously.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Process your claims promptly. In accordance with applicable law, Magellan will pay clean claims within 30 days of the date of receipt. Interest of 14.25 percent per year, or the amount required by applicable law, will be paid on clean claims not paid within the 30-day timeframe. Interest should be applied based on the Start and Stop time of the claim being received, finalized, and when the provider inquires about the claim. Clean claims, as defined in the provider agreement, are defined as claims that can be processed without obtaining any additional information from the provider or a third party.
- Provide a toll-free number for you to call for assistance: 1-833-396-4310.
- Respond to your claims questions and help resolve issues.
- Review our reimbursement schedules periodically in consideration of Medicaid changes.
- Include all applicable reimbursement schedules as exhibits to your contract.
- Communicate changes to reimbursement rates in writing prior to their effective date.
- Notify you in writing with instructions for refunds when Magellan identifies that an overpayment has been made.

Claims Disputes

Our Philosophy

Magellan of Nevada is committed to ensuring that providers have an avenue for redress of denied claims or payment matters. This further enhances our ability to accurately reimburse providers.

Our Policy

Magellan reviews provider-initiated disputes regarding payment of a claim, the denial of a claim, the recoupment of a payment of a claim and the imposition of sanctions.

What You Need to Do

Your responsibility is to:

- In a timely manner, file a claim dispute (provider claim appeal) if you are not satisfied with the payment of a claim, denial of claim, and recoupment of payment for a claim or the imposition of sanctions.
- Submit your claim dispute in writing within the required timeframe. Magellan of Nevada requires providers to submit claim disputes within sixty (60) calendar days of the date of the Explanation of Benefits. All claim disputes should be completed using the Magellan of Nevada Payer Space in Availity Essentials.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Enable you to file a claim dispute after receiving the Explanation of Benefits.
- Resolve the dispute and notify you in writing within thirty (30) calendar days of receipt of your claim dispute.
- Extend the timeframe for completing the review by up to thirty (30) calendar days at the request of the youth and family, provider, or Magellan.

National Provider Identifier (NPI) Numbers

Our Philosophy

Magellan complies with the Health Insurance Portability and Accountability Act (HIPAA) and its regulations regarding standard interface between healthcare organizations and providers. This includes provider attainment and use of the National Provider Identifier number.

Our Policy

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions since May 23, 2008. NPIs replaced all separately issued identifiers on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI was put in place so that each provider has one unique, government-issued identifier to be used in transactions with all health plans with which the provider conducts business. An NPI does not replace a provider's Taxpayer Identification Number (TIN). TINs continue to be required on all claims — paper and electronic. The NPI is for identification purposes, while the TIN is for tax purposes.

Important: claims that do not include a TIN will be rejected.

What You Need to Do

You must apply for and use your National Provider Identifier (NPI) on all electronic transactions submitted to Magellan. There are two different types of NPI numbers:

- Type 1 is for healthcare providers who are individuals, including physicians, psychiatrists and all sole proprietors. An individual is eligible for only one NPI.
- Type 2 NPIs are for healthcare providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.
- All staff providing services as the rendering provider for Assessments, Intensive Home-Based Treatment (IHBT), Emergency

and Planned Respite, and Youth Peer Support must have an NPI to render services.

Organizations can choose to enumerate subparts by taxonomy/ specialty, TIN, or site address; however, if you are an organization with a single-site address and multiple TINs, we prefer that you enumerate subparts at the TIN level. If you are an organization with multiple site addresses, we prefer that you enumerate subparts at the site address level. In other words, organizations should have one unique NPI for each rendering service location for billing purposes. An individual practitioner is assigned only one NPI (Type 1) regardless of the number of places where they may practice.

How to Apply

To apply for an NPI number, there are two different options:

- For the most efficient application processing and the fastest receipt of an NPI, use the web-based NPI application process. Log on to the National Plan and Provider Enumeration System (NPPES) and apply online at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Or, you may wish to obtain a copy of the paper NPI Application/ Update Form (CMS-10114) by contacting the Enumerator by phone at 1-800-465-3203 (TTY/TDD 1-800-692-2326); email customerservice@npienumerator.com; or mail at NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

How to Submit

Providers can submit their NPI to Magellan via email to NevadaProvider@MagellanProvider.com.

You can also submit your NPI by mail or fax, by sending us a copy of your NPI notification letter or email from NPPES.

Send to Magellan Healthcare, Inc., Attn: Data Management, PO Box 1899, Maryland Heights, MO 63043, Fax number: 314-387-5584.

The following are claims submission procedures specific to the NPI:

- For claims submitted via the ASC X12N 837 professional healthcare claim transaction, place the Type 2 NPI in the provider billing segment, loop 2010AA, and the Type 1 NPI in loop 2310B.
- On the CMS-1500 paper form (version 08/05), insert the main or billing Type 2 NPI number in Box 33a. Insert the service facility Type 2 NPI (if different from main or billing NPI) in Box 32a. Group providers only must also insert Type 1 NPIs for rendering providers in Box 24J.
- Organizations/facilities should complete the "Billing/Pay-To Provider Information" section, using the NPI associated with the rendering service location. Individual providers should complete the "Billing/Pay-To Provider Information" section with their own Type 1 NPI. The individual's NPI should be entered in that section only. Group providers should complete the "Billing/Pay-To Provider Information" section with the Group's Type 2 NPI. The "Rendering Provider Information" section should be completed using the rendering provider's Type 1 NPI.

What Magellan Will Do

Magellan of Nevada's responsibility is to:

- Be compliant with HIPAA's standard coding requirements.
- Accept only compliant codes in covered electronic transactions.
- Accept only covered electronic transactions that include an NPI.
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions.

National Correct Coding Initiative Edits

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are

reported. The NCCI contains one table of edits for physicians/ practitioners and one table of edits for outpatient hospital services. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include PTP code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service.

For more information, please visit: NCCI.CMS