

COMMONWEALTH OF VIRGINIA

*Department of
Human Resource Management*

**Cost Alliance and Key Advantage
Member Benefits Plan Handbook**

for the

Employee Assistance,

Mental Health and

Substance Abuse Program

Administered by



In cooperation with SENTARA Mental Health Management

Effective July 1, 2000

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Your benefits include the following:

- 1-800-775-5138 (TDD Service 1-800-828-1120 VA Relay Center) — A toll-free number to receive assistance or answer questions 24 hours a day, 7 days a week, from anywhere in the United States
- Help in emergency or crisis situations by trained professionals
- Comprehensive mental health and substance abuse services in a variety of settings
- A four-visit Employee Assistance Program to assist all qualified members in your household with the problems and stresses of daily living
- A Care Management Team ready to understand your needs and assist you in finding the most appropriate, medically necessary treatment
- A national network of facilities and professionals who have gone through Magellan's detailed and rigorous credentialing process for their specialty
- Referrals to credentialed providers who can help with your specific situations and who can assist in coordinating your care
- Preauthorization of **all** services is required to receive full network benefits
- If you are covered by **Key Advantage**, and you refer yourself to a provider, the service must be medically necessary to receive 75% of the network allowable charge.

If you are covered by **Cost Alliance**, there is no coverage for self referring to a provider. Only life threatening or urgent care services would be covered to an out of network provider.

- Continuous contact by our Care Management Team with you and your provider to check on the effectiveness of your treatment
- Individual case management services to offer extra assistance and benefits in complex situations
- Claims filing by referred providers and direct payment to referred providers
- A continuous quality improvement program that asks everyone to participate

Your 24-Hour Help Line

We at Green Spring Health Services, Inc., d.b.a. Magellan Behavioral Health (hereinafter “Magellan”) are in the business of coordinating mental health and substance abuse benefits, as well as Employee Assistance Programs. This is all we do and because it is our focus, we can offer personalized service and follow-up on every call.

You can reach us any time of the day or night. Our toll-free number, 1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center), is the only number you need to remember. By calling this number, you reach our highly trained and confidential professionals who can help you begin the referral and preauthorization process or just answer eligibility questions. We are available for crisis or routine calls.

Who will take your call?

Client Service Representatives

When you call our toll-free number, one of our Client Service Representatives (CSR) will answer the phone. They will collect some general information from you, such as your name, address and employer. They will then refer you to either a Care Manager or an EAP Specialist who will work with you throughout your treatment.

Care Managers

Our Care Managers coordinate mental health and substance abuse care. They include experienced clinically trained psychiatrists, psychologists, social workers, and psychiatric nurses. Most have five years or more of mental health and substance abuse experience, are licensed by the state, and have advanced degrees in their specialty.

Our Care Manager acts as your advocate and as the central point of contact to coordinate all of your care. This person will be in frequent contact with you and your providers to help increase the effectiveness of your treatment.

EAP Specialists

Our Employee Assistance Program (EAP) Specialists are experienced, clinically trained mental health and substance abuse professionals. They include psychiatrists, psychologists, social workers, master’s level therapists and EAP professionals. All EAP Specialists have at least five years experience in providing mental health, substance abuse, and EAP services. They are licensed by the state and have advanced degrees in their specialty.

Your 24-Hour Help Line continued

The Importance of Calling

Your call to our toll-free number is very important for the following reasons:

- **You can get immediate assistance.** Whether you just have a question about your eligibility for a service or you are in an emergency situation, the person answering the phone can help you. Our phones are staffed 24 hours a day, 7 days a week with highly trained professionals in a variety of specialties.
- **You'll be referred to the appropriate provider.** Our Care Managers and EAP Specialists will talk with you on the phone to understand your needs. At the end of this initial assessment, you will be referred to a provider or to a community resource who can help you with your specific situation.
- **You need approval on all services.** To receive the highest level of reimbursement under this plan, we must approve your provider and the services that you receive before you receive them. If you are in **Cost Alliance** and you decide to refer yourself to a provider, your care will not be covered. If you are in **Key Advantage**, your care may be covered at 75% of the network allowable charge. Your insurance makes payments to you (or your provider) based on allowable charges, and you are responsible for the balance.
- **Your care will be coordinated.** Our Care Manager or EAP Specialist stays in contact with you and your provider. The goal is to make sure that you are receiving the help that you need and that it is working. We make sure that nothing is missed in your treatment and that you are aware of treatment alternatives that may be more effective.

Using our toll-free number whenever you have questions or need assistance ensures that you get full use of your benefits and the appropriate level of care for your situation.

Everything is Confidential

Any and all information relating to your health care history, diagnosis, condition, treatment, or evaluation is kept confidential. We comply with State and Federal laws and regulations concerning confidentiality.

Finding a Provider

The Network of Providers

We draw upon our national network of 50,000 professionals and several thousand facilities to provide you the services that you need. In Virginia, we currently have over 1,500 providers, but are constantly expanding the network. All providers are reviewed according to a detailed selection and credentialing process. We also review their performance in our network every two years.

The network of providers includes:

- psychiatrists
- doctoral level psychologists
- master's and doctoral level social workers
- master's level psychiatric nurses
- master's level employee assistance specialists
- facilities offering a range of services in various settings:
 - acute hospital
 - rehab care
 - partial hospital

EAP Resources

Our Employee Assistance Program (EAP) Specialists draw upon the resources of the EAP Network Affiliates. We are fortunate to have one of the largest EAP-specific networks in the country. All EAP Network Affiliates must first be credentialed for our mental health and substance abuse network mentioned above. They must also meet the detailed educational and experience criteria to provide EAP services.

Receiving a mental health or EAP Referral

You must call our toll-free number, 1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center), to receive a referral to a provider before you receive any services. This process ensures that you get a provider that is most appropriate for your needs.

When we refer you to a provider

When we refer you to a network provider, you are ensured that the provider has had experience and training in helping people in your situation. The referral also means that our Care Managers and EAP Specialists can work with your provider to speed the authorization process and to identify treatments that may be effective.

Using a referred network provider means that we reimburse at the highest rate available. You are not financially responsible for amounts (except for copayments) that a provider may charge over and above Magellan Behavioral Health's reimbursable rate. The provider also files claims for you and receives our payment directly. The referred provider is responsible for working with our staff to receive the necessary continued authorizations for your treatment. At any time, you may request a referral to another provider.

Finding a Provider continued

When you refer yourself

If you do not use a provider to whom we have referred you, you are self-referring. **If you are in Key Advantage** and you self refer, you, rather than the provider, are responsible for initiating the authorization process for services with Magellan Behavioral Health. Our reimbursement may be at the out-of-network rate for medically necessary services. You are also responsible for paying your provider directly and obtaining partial reimbursement from Magellan Behavioral Health and are responsible for the difference between the provider's charge and what Magellan reimburses. **If you are in Cost Alliance**, there is no coverage for self-referring to a provider.

Receiving Approval for Your Care

What is preauthorization?

Preauthorization is the process of referring you to the appropriate provider and reviewing your treatment plan against our medical necessity criteria. We preauthorize so that you get the most effective treatment from a credentialed provider.

Are the services medically necessary?

During preauthorization, all services are reviewed to determine if they are medically necessary. This review makes sure that the prescribed treatment is:

- appropriate for the patient's needs,
- provided in the least intrusive manner, and
- believed to be the most effective treatment available for the individual patient.

Our Care Managers and EAP Specialists use their clinical experience to evaluate the needed level of care based on this medical necessity criteria. Our Physician Advisors perform the same type of review on all inpatient admissions. This review makes sure that treatment is consistent with the patient's diagnosis. This ensures that everyone is working in the best interest of the patient.

What must be preauthorized?

All services must be preauthorized by calling our toll-free number, 1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center). This includes initial visits to providers, elective inpatient admissions, and emergency admissions. We also must preauthorize any additional visits in excess of those we initially preauthorized.

When care is not preauthorized

When you self-refer or receive services that are not approved by Magellan Behavioral Health, we check to see if the services are medically necessary when we receive the claim. If the services are medically necessary, we will reimburse at the out-of-network rate for **Key Advantage**. There is no out-of-network reimbursement for **Cost Alliance**.

If you don't agree with a decision

Any time you do not agree with one of our decisions, you may ask for an appeal. Our Physician Advisors or peer advisors will review the situation and confirm or reverse the original decision. If you do not agree with this second opinion, you may make a second-level appeal.

In a second-level appeal, you or your provider sends a written request to Magellan Behavioral Health with a copy of your medical records. The medical record is reviewed by an appeals panel, whose background is appropriate to your case. The panel communicates the final decision on the case to you and your provider.

What Services are Covered

Inpatient & Outpatient Services

A broad range of mental health and substance abuse services are available for various conditions. However, if services are not considered medically necessary to treat the condition, we will not reimburse for those services.

When you use a provider to whom you have been referred by Magellan, the provider works with our Care Manager to ensure that the services you receive are covered under your contract. When you self-refer, **you** are responsible for making sure that the services you receive are medically necessary for your condition. Contact our Care Managers at **1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center)** to receive approval on the specific services that will be covered in your situation.

See also the EAP, Mental Health and Substance Abuse table in the Contract Provisions section (p. 14-15).

Levels of Care

We cover various settings, or levels of care, that you may need during your treatment. Our Care Managers approve the appropriate levels of care based on your diagnosis and our medical necessity criteria.

Acute Care

Acute care is the most intensive level of skills and services, provided in a psychiatric hospital setting or a detoxification unit. These facilities are licensed as hospitals and provide 24 hour medical and nursing care.

Partial Hospitalization

Partial hospitalization combines intensive treatment in a medically supervised setting, with the opportunity for the patient to return home or to another residential setting at night. Care includes individual, group, family, educational, and rehabilitation services. These programs usually offer services three to five times per week for more than several hours per day.

Outpatient Treatment

Outpatient treatment is the most frequently prescribed level of care provided on an individual, group, or family basis in an office setting. Therapists include licensed social workers, master's level psychiatric nurses, doctoral level psychologists, or psychiatrists.

What Services are Covered continued

Extra assistance: Individual Case Management

Patients who have a serious condition requiring inpatient care may benefit by receiving services that are not normally covered. The patient, family, provider, or our Care Manager can request or recommend that Individual Case Management (ICM) be started in order to receive extra-contractual benefits. These extra-contractual benefits replace the inpatient services typically prescribed for the condition.

After the patient has been referred to the ICM program, our Care Manager consults the patient and the attending physician on what treatment settings and types could replace inpatient treatment without a loss in treatment effectiveness. Everyone must agree to participate and sign an agreement letter, which lists the amount and type of approved care, for us to begin the ICM process. A copy of the agreement is sent to everyone involved.

All referred treatment alternatives are covered through a trade for unused inpatient benefits. If the trade is for benefits which are not covered in full, the patient does *not* pay a higher percentage of the cost of treatment. For example, if outpatient benefits require more cost sharing by the patient than inpatient benefits, the alternative benefits are made available at the cost sharing level associated with the inpatient benefits.

Employee Assistance Program (EAP) *What is an EAP?*

The Employee Assistance Program (EAP) is a confidential assessment, referral, and short term problem-solving service available to all employees and qualified members of their households. All Cost Alliance and Key Advantage participants are automatically enrolled in the program. The EAP helps you deal with problems affecting personal and work life, such as:

- Conflicts within the family and workplace
- Personal and emotional concerns
- Alcohol and substance abuse
- Financial and legal problems
- Elder and child care
- Career concerns and other challenges

What Services are Covered continued

How do you receive EAP benefits?

To access this program, call our toll-free number, **1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center)**. EAP Specialists are available 24 hours a day, 7 days a week. When you call, our EAP Specialists ask questions to determine what kinds of services you need. Their decision is based on matching your needs with EAP providers and available community services. EAP Specialists can also authorize mental health or substance abuse services when problems are complicated and meet the Magellan Behavioral Health medical necessity criteria.

When you need additional care

The EAP Specialist lets you know how many visits have been approved and follows up with the recommended provider. After you have used all of the preauthorized visits, the EAP Specialist works with you to make sure that you receive additional help if it is needed. You may be referred to another community resource or to a mental health and substance abuse provider.

Emergency Care

Whenever you have a crisis, call our toll-free number, 1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center), 24 hours a day 7 days a week. Our trained Care Managers and EAP Specialists stay with you on the phone to help you through the critical time. After assessing your needs, we refer you to the appropriate provider to help you immediately. We work to make sure that the level of care you receive is appropriate for your condition and is as unrestrictive as possible.

If hospitalization is required, our Care Manager preauthorizes an initial number of days. We monitor your care throughout the treatment, work with treating providers, and manage the aftercare plan. Physician advisors are available to assist if needed.

Inpatient Care ***Preauthorization of admissions***

All admissions must be preauthorized by calling our toll-free number, 1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center). If you are using a network provider, the provider calls for you. If you are using a self-referred provider, it is your responsibility to get the admission preauthorized.

Our Care Manager and Physician Advisor review the need for an inpatient admission to determine if it is medically necessary. If so, our Care Manager refers you to a credentialed facility and certifies payment. If the admission is not medically necessary, it is not covered. In these circumstances, our Care Manager and Physician Advisor work with the provider to develop an alternative treatment plan.

What Services are Covered continued

Concurrent review of care

Throughout the initial authorized days, our Care Manager conducts a concurrent review. This means that our Care Manager keeps in contact with the attending physician to determine how treatment is progressing.

If you need to stay in the hospital longer than those days initially authorized, our Care Manager and Physician Advisor must authorize additional days. If additional days are not authorized, our Care Manager and Physician Advisor offer and arrange for alternative treatment.

Outpatient Care

Referral and preauthorization of outpatient services

All services must be preauthorized by calling our toll-free number, 1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center).

Our Care Manager conducts the initial assessment to determine if treatment is needed. If treatment is needed, our Care Manager refers you to a provider. Our Care Manager authorizes from one to three visits for an initial evaluation. If you are in **Key Advantage** and you decide to self-refer, our Care Manager still needs to authorize the number of visits; however, our reimbursement is not as high as if you had used the referred network provider. If you are in **Cost Alliance, there is no coverage for self-referring to a provider.**

Concurrent review of services

While you are receiving your initial visits, our Care Manager is monitoring your progress. If you need additional visits or alternative services, our Care Manager must authorize the services before you receive them.

When and How to File a Claim

When do you have to file a claim?

As a part of their agreement with us, all providers to whom you are referred file claims for you and our payment is sent directly to them. If you are in **Key Advantage** and you self-refer, you may have to file a claim. If you are in **Cost Alliance** and you self-refer, there will be no out of network reimbursement.. Please follow the steps below.

Claim Filing Period

You and your provider have until the end of the year following the year during which you received the services to submit the claim. For example, if the date you received services was July 1995, you have until December of 1996 to submit your claim. If you fail to submit your claim in this time frame, we do not make any payment.

Claim Filing Steps

	DESCRIPTION
1.	If you are in Key Advantage and you self-refer, you may have to file a claim. The provider may also ask you to pay the bill at the time you receive covered services. If this happens, pay the provider and submit a claim and/or an itemized bill to us for reimbursement. Call 1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center) for a claim form if you do not have one. Our payment is sent to you. If you are in Cost Alliance , there will be no out of network reimbursement.
2.	The itemized bill should be on the provider’s letterhead stationery and include: <ul style="list-style-type: none"> • a description of symptoms and treatment; • the charges for the services performed; • the date of service; • your name and membership number.
3.	Mail your completed information to: Magellan Behavioral Health Virginia/Commonwealth Claims P.O. Box 4600 Columbia, MD 21044-4600
4.	We send the payment for covered services directly to the subscriber. You will also receive an Explanation of Health Care Benefits (EOHB) anytime we review a claim. An EOHB is not a bill; it is documentation of the action we have taken on your claim.

When and How to File a Claim continued

Claim Review Procedure

After we receive a properly completed claim form, we usually process claims within 15 days. There may be instances where we need additional time and information to make a final decision about payment. If this happens, we will send you a notice explaining the reason for the delay. We will make a decision within 30 days of receiving the missing information.

Coordinating Your Benefits between Carriers

If you or members of your family have health insurance with another insurer in addition to the insurance you have with the Commonwealth of Virginia, we will coordinate the payment of your benefits with the other company. All health insurance programs will work together to provide you with the maximum benefit. This reduces duplicate payments and ultimately helps to control costs.

If you have more than one health insurer, one of the plans will provide “primary coverage” and the other will provide “secondary coverage.” First, the primary coverage will reimburse at their normal rate. The secondary coverage will then take into consideration what the primary insurance has paid. The secondary coverage will pay any difference between what the primary coverage paid and what is normally covered under the secondary coverage.

For more information on our coordination of benefits procedures, please consult your benefits administrator or our service representatives, at **1-800-775-5138 (TDD: 1-800-828-1120 VA Relay Center)**.

Call for assistance
1-800-775-5138
(TDD Service 1-800-828-1120 VA Relay Center)
24 hours a day, 7 days a week

When you are in need of:	Call our toll-free number to:
Crisis & Emergency Assistance	Receive help morning, noon, or night, any day of the week, from a professional trained to help you in your specific situation
Answers to your benefit questions	Receive an explanation of your mental health, substance abuse, and Employee Assistance Program benefits
Help understanding your situation and finding a provider	Discuss your needs with our Care Managers and EAP Specialists so that you can find the appropriate help
A provider referral	Receive a recommendation for a provider or to change your current provider
Approval to receive or continue care	Receive preauthorization for inpatient and outpatient services
Individual Case Management	Ask for assistance in finding alternative services to inpatient treatment
Filing a complaint	Register a complaint about any provider or treatment
A review on preauthorization decisions	Request an appeal of a decision not to approve certain services

Members' Rights and Responsibilities

Statement of Member's Rights:

- ◆ Members have the right to be treated with dignity and respect.
- ◆ Members have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- ◆ Members have the right to have their treatment and other member information kept private. Only by law, may records be released without member permission.
- ◆ Members have the right to easily access care in a timely fashion.
- ◆ Members have the right to know all about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- ◆ Members have the right to share in developing their plan of care.
- ◆ Members have the right to information in a language they can understand.
- ◆ Members have the right to have a clear explanation of their condition.
- ◆ Members have the right to a clear explanation of their treatment options.
- ◆ Members have the right to get information about Magellan's services and role in the treatment process.
- ◆ Members have the right to know the clinical guidelines used in providing and managing their care.
- ◆ Members have the right to information about provider work history and training.
- ◆ Members have the right to provide input on Magellan policies and services.
- ◆ Members have the right to know about advocacy and community groups and prevention services.
- ◆ Members have the right to freely file a complaint, grievance or appeal and to learn how to do so.
- ◆ Members have the right to know about laws that relate to their rights and responsibilities.
- ◆ Members have the right to know of their rights and responsibilities in the treatment process.

Statement of Member's Responsibilities:

- ◆ Members have the responsibility to treat those giving them care with dignity and respect.
- ◆ Members have the responsibility to give providers information they need. This is so providers can deliver the best possible care.
- ◆ Members have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- ◆ Members have the responsibility to follow treatment plans for their care. The plan of care is to be agreed upon by the member and provider.
- ◆ Members have the responsibility to follow their agreed upon medication plan.
- ◆ Members have the responsibility to tell their provider about medication changes, including medications given to them by others.
- ◆ Members have the responsibility to keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
- ◆ Members have the responsibility to let their provider know when the treatment plan no longer works for them.
- ◆ Members have the responsibility to let their provider know about problems with paying fees.
- ◆ Members have the responsibility to not take actions that could harm others.
- ◆ Members have the responsibility to report abuse.
- ◆ Members have the responsibility to report fraud.
- ◆ Members have the responsibility to openly report concerns about quality of care.

Contract Provisions

This section covers the benefits available to you under your Commonwealth of Virginia or Local Choice contract and the applicable rules.

EAP, MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

The table below describes covered services, explains the maximum number of days or visits available under this plan and the amounts that you are required to pay for medically necessary services. **All care must be pre-authorized and approved as medically necessary by Magellan Behavioral Health.**

Commonwealth of Virginia and Local Choice

Benefit Period is July 1 through June 30

**In-Network You Pay
(see below for
out-of-network)**

Inpatient/Partial Day Maximum Days of Care

Up to 30 days **total** per benefit period for **both** inpatient treatment **and** partial day services for non-biologically based mental illness. ***The 30-day limit does not apply to biologically based mental illnesses.**

Cost Alliance - \$100 per day with a \$500 maximum per admission.

Key Advantage - \$200 per admission.

Inpatient Hospital Services

90 days maximum lifetime benefits for inpatient services in a substance abuse treatment facility for non-biologically based mental illness. ***The 90-day limit does not apply to biologically based mental illnesses.** Inpatient hospital services may include:

- Semi-private room, meals, and general nursing services
- Prescribed drugs
- Mental health services

Emergency room services leading directly to admission

Readmission to partial day/inpatient services, separated by a period of not more than 90 days, will be considered part of the same treatment program.

Partial Day Program Services

Partial day services may include:

- Diagnostic services
- Mental health care services such as:
 - Outpatient detoxification
 - Individual psychotherapy
 - Group psychotherapy
 - Psychological testing
 - Counseling with family members to assist in the patient's diagnosis and treatment
 - Electroconvulsive therapy

Cost Alliance - \$100 per day with a \$500 maximum per admission.

Key Advantage - \$200 per admission.

***See Page 18 for biologically based mental illness listing.**

Individual Case Management	Patients who have a serious condition requiring inpatient care may benefit by receiving alternative services that are not normally covered. The patient, family, provider or Magellan Care Manager can request that Individual Case Management be started to receive extra-contractual benefits. All referred treatment alternatives are covered through a trade for unused inpatient benefits. All parties must agree to participate in this program. Acopayment may be applicable in some cases.	
Emergency Care	Authorization is required within 48 hours of the emergency.	
Outpatient Care	Up to 50 medically necessary visits with a licensed professional each benefit period for non-biologically based mental illness. *The 50-visit limit does not apply to biologically based mental illnesses. This total number of visits includes medication management visits.	<p>Cost Alliance - \$35 per visit specialist copay.</p> <p>Key Advantage - \$25 per visit specialist copay.</p>
Out-of-Network Care	<p>Key Advantage All care must be preauthorized and medically necessary. For services rendered by a Provider who does not participate in the Magellan Health mental health/substance abuse managed care program, you pay an additional 25% of the allowable charge plus any applicable deductible, copayment, and/or balance above the allowable charge.</p> <p>Cost Alliance All care must be preauthorized and medically necessary. There is no coverage for services rendered by a provider who does not participate in the Magellan Health mental health/substance abuse managed care program. Only life threatening or urgent care would be covered to an out of network provider.</p>	
EAP Benefits	Up to four free visits per episode per benefit period under the Employee Assistance Program. You and qualified members of your household are eligible for this program. Community resources available at low or no cost may also be recommended..	

***See Page 18 for biologically based mental illness listing.**

Biologically Based Mental Illnesses

The Virginia Mental Health Parity Act (MHP) became law on July 1, 1999, which states that coverage for biologically based mental illnesses will be the same as the coverage for any other physical illness. This means that the day and visit limits described in the Benefits section will not apply to covered individuals receiving treatment for these illnesses. All care must be pre-authorized and medically necessary. Following is a list of biologically based mental illnesses. It may not be all inclusive.

- ADHD
- ADHD NOS
- Alcohol Dependence
- Amphetamine Dependence
- Atypical Autism
- Autistic Disorder
- Bipolar Disorder
- Bipolar Disorder NOS
- Bipolar II Disorder
- Cannabis Dependence
- Catatonic Schizophrenia
- Cocaine Dependence
- Disorganized Schizophrenia
- Hallucinogen Dependence
- Inhalant Dependence
- Major Depressive Disorder
- Nicotine Dependence
- Obsessive Compulsive Disorder
- Opioid Dependence
- Other (or Unknown) Substance-Induced Disorders
- Panic Disorder Without Agoraphobia
- Panic Disorder With Agoraphobia
- Paranoid Schizophrenia
- Phencyclidine Dependence
- Polysubstance Dependence
- Residual Schizophrenia
- Schizoaffective
- Schizophreniform Disorder
- Sedative, Hypnotic, or Anxiolytic Dependence
- Substance Induced Anxiety Disorder
- Substance Induced Mood Disorder
- Substance Induced Psychotic Disorder
- Undifferentiated Schizophrenia

APPEALS

You have the right to request Magellan to review the denial or payment of any claim. There are strict limits on each stage of appeal. You will be notified of these limits in correspondence which denies your claim. Look for and observe these strict time limits. You must initiate an appeal to Magellan within 60 days of Magellan's denial of your initial claim.

Magellan will have previously reviewed your medical records for any claim requiring a medical determination. If Magellan denies a claim for medical reasons, you may request verbally or in writing that Magellan review the claim.

If you are not satisfied with the results of the review, you may file a written appeal to Magellan. The appeal must be written and include your full name, the enrollee's identification number (indicated on your membership card), the date of the service, the name of the provider for whose services payment was denied, and the reason you think the claim should be paid. You are responsible for providing Magellan with all information necessary to review the denial of your claim. Magellan will review your appeal and respond within 60 days of Magellan's receipt of all information necessary to make a decision.

If you are not satisfied with the results of the first appeal, you may request a review by Magellan's appeals committee. The request must be written and include your full name, the enrollee's identification number, the date of the service, the name of the provider for whose services payment was denied, and the reason you think the claim should be paid. You are responsible for providing Magellan with all information necessary to review the denial of your claim. The committee will review your appeal and respond within 60 days of Magellan's receipt of all information necessary to make a decision. If, after review, the claim remains denied, that denial is final, unless you appeal that determination to the Commonwealth of Virginia, Department of Human Resource Management.

In situations requiring immediate medical care, Magellan provides a separate expedited emergency appeals process. You or your provider may request an expedited review. Magellan will provide resolution within one business day of receipt of all information.

To appeal a claim decision made by Magellan, you must submit to the director of the department in writing, within 60 days of Magellan's denial, your full name, the enrollee's identification number, the date of the service, the name of the provider for whose services payment was denied, and the reason you think the claim should be paid. You are responsible for providing the department with all information necessary to review the denial of your claim. The department will ask you to submit any additional information you wish to have considered in its review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied due to such things as contractual or eligibility issues will be reviewed by the director. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization. If, after review, the claim remains denied, that denial is final, unless you appeal that determination within 30 days, as provided under the Administrative Process Act. You may obtain a "State Health Benefits Program Appeal Form" of the Web at www.dhrm.state.va.us.

EXCLUSIONS

The following is a list of excluded services.

We do not cover services and supplies:

- not shown in your member handbook as a covered service.
- that are not preauthorized and medically necessary
- not prescribed, performed or guided by eligible practitioners.
- for inpatient treatment (or for an inpatient stay) for conditions which require only observation, diagnostic examinations, or diagnostic laboratory testing.
- for inpatient treatment which might be safely and adequately rendered in a home, provider's office, or at any lesser level of institutional care.
- which we determine are experimental or investigative in nature or for services related to them. Experimental/ investigative describes any service or supply which is judged to be experimental or investigative by Magellan Behavioral Health in its sole discretion. Magellan will apply the following criteria to decide this: any supply or drug used must have received final approval to market by the U.S. Food & Drug Administration; there must be enough information in the peer-reviewed medical and scientific literature to let Magellan Behavioral Health judge the safety and its efficacy; the available scientific evidence must show a good effect on health outcomes outside of a research setting; the service or supply must be safe and effective outside a research setting as current diagnostic or therapeutic options.
- for lab tests and prescription drugs.
- when you are not legally obligated to pay for the charge, or where the charge is made only to insured persons. This exclusion does not apply to Medicaid.
- for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services.
- charged through separate billings by a provider's employee normally included in such provider's charges and billed for by them.
- provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner.
- for rest cures, residential, convalescent, custodial care in group home, halfway house or residential setting
- for travel whether or not it is prescribed by a practitioner.
- for court ordered examinations or care (unless medically necessary).
- for guest meals, telephones, televisions, and other convenience items.
- for routine examinations or testing.
- for the treatment of any injury, illness, or medical condition that is not medically necessary.

- for illnesses resulting from an act of war or relating to a felony.
- for treatment of organic brain syndrome.
- for treatment of the following conditions: anti-social personality, inadequate personality, sexual deviation or sexual dysfunction; social maladjustment without apparent psychiatric disorder; group delinquent reaction of childhood; mental retardation; Tourette's disorder; learning disabilities; and conduct and oppositional disorders.
- for acupuncture.
- for examinations of an inpatient which are not related to the diagnosis.
- for educational or teachers' services, or separate charges by interns, residents, house physicians, or other health care professionals employed by the covered facility.
- for marital counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy.
- for weight loss and weight management programs.
- for psychoanalysis to complete degree or residency requirements.
- for experimental treatment or treatment performed for the purpose of research.
- for pastoral counseling.
- for psychological testing for educational purposes.
- for hypnosis for non-DSM classified disorders.
- for treatment of conditions without recognizable DSM diagnostic classification (such as adult child of alcoholic families, "ACOA," "co-dependency"); conditions classified as "V-codes" in the DSM classification; conditions arising from the following developmental disorders: mental retardation, academic skills disorders, motor skills disorders, and organic brain disorders in which demonstrable and significant improvement from psychiatric treatment is unlikely.

DEFINITIONS OF KEY TERMS

Acute Care: Care provided in a psychiatric hospital setting or a detoxification unit. It is the most intensive level of care.

Appeal: The process by which a utilization management decision may be challenged by any patient, provider or facility involved with a particular case.

Appropriateness: The term used to describe treatment setting best suited for the care of a diagnosis/clinical problem in which an individual patient best responds.

Assessment: The process by which a mental health care provider determines the patient's current biological, psychological and social functioning.

Authorization: The result of a utilization management review conducted by a Magellan Behavioral Health Care Manager recommending that care be approved or continued.

Benefit Period: The period from July 1 of one year to June 30 of the next. It can also mean a part of this period if your effective date is other than July 1 or if your enrollment ends other than on June 30.

Care Management: An integrated and coordinated care delivery approach to managed mental health care services, providing network management and a full continuum of care.

Care Managers: Trained Magellan clinicians who assess your clinical needs, make provider referrals, and preauthorize and coordinate care for mental health and substance abuse benefits.

Confidentiality: It is Magellan Behavioral Health's policy to strictly limit access to patient information and to comply with State and Federal regulations pertaining to confidentiality.

Concurrent Review: The process by which requests for additional days of care or outpatient visits are reviewed simultaneous with care delivery.

Copayment: The amount of the providers' charges that you must pay.

Covered Facility: A network institution where you receive covered services.

Covered Service: A service or supply for which benefits will be provided.

Credentialing: The thorough process by which Magellan screens and accepts providers into the local and state provider networks.

Crisis Intervention: The process by which emergencies are recognized and treated in an urgent manner.

Custodial Care: Care provided mainly for the comfort and convenience of the patient.

Days Of Inpatient Care: The number of days of care up to which you are covered as an inpatient if medically necessary.

Deductible: A specified dollar amount which you must pay for covered services before we will pay any additional amount for these services.

Detoxification: A medical procedure which frees a person from an intoxicating or an addictive substance in the body, minimizing withdrawal symptoms.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard diagnostic nomenclature of emotional illness used by health care practitioners.

Discharge Planning: The plan of action developed by providers which patients and providers must undertake following a patient's hospital discharge.

Effective Date: The date on which your coverage begins.

Employee Assistance Program (EAP): A confidential program available to all qualified members of your household to help in crisis situations, as well as with other problems that occur in daily life such as work, family, legal, financial, and child care problems.

Employee Assistance Program (EAP) Specialist: Trained Magellan clinicians who assess your needs, make referrals, and preauthorize and coordinate care as part of the Employee Assistance Program.

Help Line: Magellan Behavioral Health's account-dedicated, toll free phone number which is available to members 24 hours a day, 7 days a week.

Initial Assessment: The therapeutic session or result thereof in which the provider interviews the patient, allowing the provider to evaluate the patient's condition.

Inpatient Care: Referred to as acute care, the patient is physically in care at a facility 24 hours/day under the care and direction of an attending physician.

Intensive Outpatient: A treatment program offering a coordinated plan of clinical services and modalities delivered in an outpatient ambulatory setting.

Level of Care: Refers to the different types of treatment settings available to patients, such as: inpatient, partial, intensive outpatient, outpatient, etc.

Medically Necessary: The term used to refer to care which is consistent with the efficient diagnosis and treatment of a condition; required for other than convenience; the most appropriate level of service; unable to be provided in a more cost-effective, efficient manner; and unable to be provided at a facility providing a less intensive level of care.

Network Services: Services provided by a facility/program or practitioner who is under contract with Magellan Behavioral Health for the Commonwealth of Virginia account who has met Magellan credentialing requirements. A network provider must be listed as such at the time you receive the service for which coverage is sought.

Non-Network Services: Services provided by a facility/program or practitioner who is not under contract with Magellan Behavioral Health for the Commonwealth of Virginia account.

Out-Of-Pocket: The amount that you must pay in copayments and deductibles before we will begin reimbursing for services at 100%.

Outpatient Treatment: Care provided on an individual, group, or family basis in an office setting. The frequency of visits may range from once per month to three sessions per week.

Partial Hospitalization: Intensive treatment in a medically supervised setting with the opportunity for the patient to return home or to another residential setting at night. Services are usually offered three to five times per week for more than several hours per day.

Physician Advisors: Board-certified psychiatrists engaged by Magellan to assist Care Managers in making and reviewing preauthorization and appeals decisions.

Preauthorization: The process by which care is approved prior to the beginning of treatment. The process also includes referring you to an appropriate provider for your condition.

Referral: The process in which a patient is introduced to a health provider for treatment (i.e., through another health care or mental health care provider, or a supervisor).

Self-Referral: The process in which a patient directly contacts a mental health organization or participating provider for treatment.

Referred Provider: A facility/program or practitioner to whom our Care Manager referred you.

Self-Referred Provider: A facility/program or practitioner that you chose to use without a referral from a Care Manager.

Treatment Plan: The individualized therapeutic course of action proposed by a provider in order to resolve the subscriber's difficulties.

Utilization Management: The process of evaluating the medical necessity and appropriateness of the use of psychiatric and substance abuse services, procedures and facilities on a prospective, concurrent or retrospective basis.

YOUR 24 HOUR HELP LINE
1-800-775-5138
(TDD Service 1-800-828-1120 VA Relay Center)



7/1/00
