Provider Notice

Thank you for being part of the Magellan Complete Care of Virginia (MCC of VA) provider network and helping our members live healthier lives. Please review the below updates and reminders about working with our Utilization Management department for authorization requests.

1. All registration notifications **must** be submitted to MCC of VA within 7 days from service start date. Registrations received outside of this window will have a start date of the date we receive the notice for claims payment.

2. Crisis Stabilization - H2019, Crisis Intervention - H0036, and Mental Health Peer Support, H0023, H0024 and H0025 - individual or group concurrent reviews will be defined as: a concurrent review for services that has no gap in treatment **or** a gap in treatment for same service less than 7 days will be considered a concurrent review and require a service authorization request for medical necessity review.

3. All intensive in home services will be authorized initially for 6-8 weeks with concurrent reviews every 4 weeks thereafter to ensure medical necessity and to ensure they are in the right level of care for the member's needs.

4. All Therapeutic Day Treatment and Mental Health Skill-building Services will be authorized no longer than 3 months at any time depending on member's medical necessity.

5. For accurate and appropriate transition of care from the inpatient setting we are asking that all facilities send in the member discharge orders with discharge medication list upon discharge or day after.

6. All service authorization requests require timely submittal of supporting clinical documents. MCC of VA will attempt two requests to obtain the clinical documents; if clinical documents are not received within the standard turnaround time as dictated by the Department of Medical Assistance Services and the National Committee for Quality Assurance, the case will then be administratively denied for lack of supporting clinical documentation. To have a case reviewed for medical necessity if it was administratively denied, but the member received services without an authorization, the provider must send in a claim, which will be denied due to no authorization, and appeal rights will be provided to you for medical necessity review. Administering services without prior authorization does not guarantee payment. We highly encourage you ensure clinical documents are received in a timely manner to avoid a delay in claim payments.

7. MCC of VA requires all clinical documentation for concurrent review cases for physical and behavioral health inpatient to be submitted before the last covered day of current authorization, and/or up to 48 hours after the last covered day. If additional clinical

information is not received within 48 hours of last covered day for inpatient concurrent review authorizations, MCC of VA will put the discharge date in as the last covered date and will only authorize to the last covered day. If additional days are requested for authorization after this time frame you will have to submit the request with supporting documentation to the appeals department for review of medical necessity.