Substance Use Disorder Case Management

Magellan Behavioral Health of Pennsylvania (Magellan) Performance Standards

Performance Standards are intended to give guidance for contracted services as part of the HealthChoices program, with a goal to promote the utilization and progress toward providing best practices performances, to increase the quality of services and to improve outcomes for members.

Current Version Information

Substantive changes in most recent update:

Service Description – expanded information related to required training
Expectations of Service Delivery – expanded information related to billable and non-billable services as well as unit definition

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead, added to the foundation provided by current licensing guidelines and regulations. It is Magellan's expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews. Entities providing services as part of the PA HealthChoices Program must first be enrolled in the Pennsylvania Medical Assistance Program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, as well as all associated Medical Assistance (MA) Bulletins, Department of Drug and Alcohol Programs (DDAP) Case Management and Clinical Services Manual, other DDAP licensing requirements, American Society of Addiction Medicine (ASAM) requirements and any contractual agreements made with Magellan in order to be eligible for payment for services. Providers must otherwise be compliant with all components of their approved Program Descriptions (PD) and always ensure that Magellan has a copy of the most current PD on file.

Please routinely visit the link below to stay up to date on compliance email blasts:
https://www.magellanofpa.com/for-providers/

Level of Care Description

The definition of case management varies by setting, but in general terms, it is a coordinated, individualized approach that links members with appropriate services to address their specific needs and help them achieve their stated goals. Case management for members with substance use disorders (SUDs) has been found to be effective because it helps them to stay in treatment and recovery. Also, by concurrently addressing other needs, such as medical struggles, assistance with housing concerns, linkage to community resources, providing education on various topics, it allows members to focus on SUD treatment. Community-Based SUD Case Management Services are an in-lieu-of service in the Pennsylvania HealthChoices continuum. Additionally, other settings and programs may include embedded SUD Case Management including specialty treatment programs, Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers, Drug and Alcohol Clinics, veterans' health programs, and integrated primary care practices.

Scope of Services

Substance Use Disorder Case Management is a coordinated approach to the delivery of health, substance use, mental health, and social services by linking individuals with appropriate services to address specific needs and achieve stated goals. SUD Case Management offers the individual a single point of contact, is individual-driven, community-based, pragmatic, anticipatory, culturally sensitive, flexible, involves advocacy, and requires particular knowledge, skills, and attitudes.

SUD Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

Members with substance abuse disorders may be referred for SUD Case Management Services. SUD Case Management services are intended for adolescents and adults. While all members have unique needs, and discharge decisions are made based on individual circumstances, SUD Case Management services are intended to be time limited with average lengths of stay from 24-36 months. Discharge planning discussions begin at the onset of care and should be documented, at a minimum, with each service plan review. SUD Case Management Services are intended to be delivered in the setting in which the member resides or needs service. Reasonable attempts shall be made to contact the member or the legal guardian, if the member is a minor and a valid release is on file, at least every 2 weeks. The contact or the attempt to contact shall be documented. If contact with the member or a parent cannot be made, attempts to locate another member of the family, a relative or a friend shall be documented when valid releases are on file.

Providers must adhere to maximum caseload size as described in the provider's approved Program Description. However, it may be necessary to have caseloads below the maximum size based on the needs of each member. Services should be offered at times that meet the member's needs, which may include weekend and/or evening hours for those engaged in vocational or educational activities during daytime hours. Members receiving SUD Case Management Services are required to have access to the service 24-hours per day.

Service Description

The term case management includes a multitude of functions and skills and is often difficult to be described in just a few short words. SUD Case Management is a person-centered assistance program that focuses on the individual's unique strengths and needs. Overall, it can be thought of as a coordinated approach to linking members with appropriate services to address their specific individualized goals. Regarding the substance use aspect of healthcare, case management can often keep members engaged for a longer period of time and increase their chances of being successful in treatment. The primary functions of SUD Case Management include evaluation of the client's strengths and needs, monitoring, advocacy, coaching, engagement, and goal setting.

Staff Qualifications

According to the Pennsylvania Department of Drug and Alcohol Programs (DDAP), an individual must meet the minimal education and training (MET) requirements set forward by the by the State Civil Service Commission. The four classifications for case management positions within the scope of drug and alcohol services are: SUD Case Management Specialist, SUD Case Management Specialist Trainee, SUD Treatment Specialist, or SUD Specialist Trainee.

Those persons responsible for supervision of staff delivering case management services must meet the MET requirements established by the State Civil Service Commission for the Case Management Supervisor or Treatment Specialist Supervisor. If case management services are being performed by a contracted or licensed drug and alcohol treatment provider, individuals delivering the services must meet either the MET requirements for the classifications referenced in this paragraph or the DDAP licensing staffing regulations for either a Counselor or Counselor Assistant. An individual who meets the qualifications of a counselor or counselor assistant but is providing case management services, must deliver the services separately from treatment or therapy services. Supervisors of these staff must meet either the MET requirements for the supervisory classifications referenced in this paragraph or the DDAP licensing staffing requirements for Clinical Supervisor or Lead Counselor.

Core Training

The following are core training components according to DDAP:

- Case Management staff and their supervisors are required to complete the following DDAP courses:
    1. Addictions 101
    2. Confidentiality
    3. Practical Application of Confidentiality Laws and Regulations
        a. The confidentiality Course is a pre-requisite for the Practical Application of Confidentiality Laws and Regulation Course. The Practical Application of Confidentiality Laws and Regulations Course Certificate is note valid if it predates the Confidentiality Course Certificate.
    4. Case Management Overview
    5. Screening and Assessment (required only for case managers who perform screening and assessments.)
    6. Motivational Interviewing, Advancing the Practice (Required for all staff hired on or after July 1, 2021; however, it is recommended that all case managers complete training in Motivational Interviewing).
    7. The ASAM Criteria, 2013.
- All case management services, and their supervisors must complete all case management core trainings within 365 days of hire.
- The providers must maintain certificates of completed trainings.
- Provider staff who have already conducted screening and assessment and have completed the DDAP-required core trainings are not required to take Addictions 101, and Screening and Assessment trainings.
- Provider staff may also be otherwise exempted to complete the Case Management Overview, Addictions 101, and Screening and Assessment if they have already had comparable education

and training. The exemption must be made by the Single County Authority (SCA) Administrator and there must be written documentation to justify it.

Service Exclusions

While there may be times when additional services are clinically indicated, it is considered a duplication of services for a member to receive SUD Case Management and some other services concurrently including Mental Health Targeted Case Management, and Substance Use Residential programs that already include embedded case management services. Any exceptions to this would require prior approval.

Referral Process

Initial referrals may come from many different entities within the community. Some examples may include Emergency Departments (ED), the criminal or juvenile justice system, schools, clergy, primary health care providers, individual practitioners, mental health agencies, child welfare system, family, employers, self-referrals, treatment facilities, and other social service agencies. The first step in identifying the presence of a substance abuse problem is screening. During the screening process, general information is obtained to best understand an individual's immediate care needs which may result in a referral to detoxification or other medical facility.

According to DDAP, screenings can be completed in three different ways:

- Individuals conducting screening are skilled medical or human service professionals (e.g. ED triage nurse, crisis intervention caseworker, SCA Case Manager, counselor) proficient in identifying the need for a referral for emergent care services through a combination of education, training, and experience; or
- Support staff conduct screening in conjunction with skilled medical or human service professionals. And if needed, transfer the individual to a skilled professional to determine emergent care services; or
- Support staff conduct screening if the provider is able to demonstrate, through documentation provided during the onsite monitoring visit or upon DDAP request, that the individual determining the need for a referral for emergent care services has a combination of education, training, and experience in the following areas:
    a) Psychiatric (identification of suicide and homicide risk factors);
    b) Prenatal (identification of alcohol and other substance use effects on the fetus); and
    c) Withdrawal Management (pharmacology, basic addiction, identification of drug interactions).

A level of care assessment (LOCA) is normally scheduled in the case that there are no immediate care needs identified for an individual. During a LOCA, an individual meets with a qualified assessor to determine what level of services, if any, are needed to best treat the members possible drug and

alcohol issues. The member is encouraged to discuss what they feel their needs and concerns are, as well as how their substance use may be impacting their daily lives. In order to determine the appropriate level of care, the assessor completing the LOCA must utilize ASAM criteria to complete the ASAM Summary and Risk Rating Scale. The ASAM Summary is a multidimensional assessment of the strengths and needs of the individual and the Risk Rating addresses the individual's severity and level of function. Risk Rating is not meant to indicate the level of services required for an individual. According to DDAP, the following components are addressed in an assessment:

- **Education**: literacy, degree to which substance use has interfered with education.
- **Employment**: degree to which substance use interferes with employment; current employment, length and placement of employment, employment history.
- **Military**: eligibility for VA benefits, combat experience/potential trauma issues, injuries related to military service.
- **Physical health**: chronic and current acute medical conditions; past and present medications, are medications taken as prescribed, pregnancy, and TB questions.
- **Substance use history**: type and frequency, date of first and last use, amount, and route of administration, length, patterns and progression of use, impact on behavior and relationships with others; treatment history.
- **Abstinence and recovery periods**: recovery support systems, periods of abstinence; periods of active recovery; 7) behavioral health: cognitive functioning; mental health symptoms, current and past treatment; hospitalizations, suicidal/homicidal ideations or attempts; psychotropic medications.
- **Family/social/sexual**: child custody/visitation, childcare arrangements, risky behaviors; relationship status; family supports.
- **Spiritual**: spiritual identity; Part V - Case Management CMCS Manual July 2020 V.4
- **Living arrangements**: current living arrangements, supportive recovery environment.
- **Abuse**: history of abuse, issues that might impact placement.
- **Legal**: probation/parole status, conviction record to include disposition, current and pending charges.
- **Gambling**: lack of control in frequency of betting, lack of control over amount bet, lying about how much is bet.
- **Potential barriers to treatment**: other areas that may impact treatment (i.e. transportation, cultural/language, childcare needs).
- **Assessment summary**: clinical impressions, strengths, needs, special considerations.

If treatment is appropriate and funding eligibility has been determined, the individual completing the assessment, or another support staff from that agency will make a referral to an appropriate treatment facility. The actual formal referral process for case management can vary from agency to agency. Most facilities have their own referral forms and request a copy of the individual's assessment or a psychiatric evaluation if they have one completed within the past year.

Admission Process

The admission process to begin SUD Case Management Services often varies depending on the provider's internal procedure. After an individual completes the referral process, they must be referred and admitted to the SUD Case Management provider within 14 days. If these timeframes cannot be met, a reason needs to be documented in the individual's file. Once the agency to which the individual is being referred, receives the completed request, the individual and/or referral source is contacted and are informed of an admission decision, which is based on referral material and completed ASAM. An individual is admitted to services at the first attended appointment with a provider after the referral process has been completed. SUD Case Management providers should ensure that their referral process is described in their Program Description.

Treatment or Service Plan

All members receiving SUD Case Management Services should have a written service/ recovery plan which identifies the person's needs and goals. Service plans are recommended to incorporate all available resources and services that are appropriate for the member and be strength-based in nature. The member receiving the case management services should work with the service provider to develop the recovery plan in efforts to ensure that there is agreement in what the focus of treatment will be, as well as, letting all parties know what their roles and expectations are. The service plan shall also include referral to any services not specifically for SUD clients, for example legal services and dental services, for which the client may be eligible.

In order for a service plan to be most effective, it is recommended that the member's identified goals be broken into objectives, which can then be then made into smaller tasks that are behaviorally specific, measurable, and tangible. Individuals are often more successful with achieving a goal when steps are clear and achievable within reasonable timeframes. Setting up a service plan in this manner often reduces the likelihood of an individual feeling overwhelmed and giving up. Collaboration when developing a service plan allows the individual and service provider to work together to effectively understand one another and work together in a positive context.

According to DDAP, the Case Management Service Plan, which is referred to as a recovery plan in PA WITS, must be addressed at the time of LOCA and updated no less than every 60 days throughout an individual's time in treatment. Documentation should be kept regarding the member's progress or lack thereof, regarding their recovery plan. If a member does not complete or make progress on a goal in the service plan, new interventions should be added to the plan in efforts to assist the individual with having a successful outcome.

The service plan should be signed by the member, the case manager, and others as appropriate. If a signature cannot be obtained from the member, the reason why and attempts to obtain it should be documented.

Expectations of Service Delivery

The unit definition for Substance Use Disorder Case Management Services is a full 15-minutes in which the SUD Case Manager is in face-to-face or telephone/ telehealth contact with the individual, the individual's family, service providers, support systems or other essential persons for the purpose of assisting the individual in meeting his/ her needs. Rounding up is not permitted.

Progress notes must verify the necessity for the contact and reflect the goals and objectives of the case management service plan. Provider staff meetings, trainings, recordkeeping activities and other non-direct services are not Medicaid reimbursable. Activities including leaving a voicemail message or just waiting for a member are not Medicaid reimbursable.

Transporting or escorting members to appointments or other places is not identified under 42 CFR §440.169 as a component of case management services. If your agency policy allows for the transporting of members, the time spent in travel or transportation is not directly reimbursable. Travel Training refers to a case manager working with an individual who requires development in relation to learning a specific skill such as riding the bus. Travel transportation may be billable time – if, and only if the service/ recovery plan contains a goal related to the individual needing to gain this skill, and that the progress notes show work related to this goal. The goal must be time limited. Documentation should clearly demonstrate that time spent in travel and transportation is not included in the billable time.

Documentation

The documentation in the member's behavioral health record allows mental health professionals to evaluate and plan for treatment, monitor health care over time, and facilitate communication and continuity of care among healthcare professionals involved in the individual's care. It ensures accurate and timely claims review and payment, promotes appropriate utilization review and quality of care evaluations, and can be used for research and education.

Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations. Specifically:

- The record must be legible throughout.
- The record must identify the youth on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be counter-signed by responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, as well as final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as the treatment plan, must be entered in the record. Drugs prescribed as part of treatment, including quantities and dosages, must be entered in the record. If a prescription is telephoned to pharmacist, the prescriber's records require a notation to this effect.

- The record must indicate the progress at each session, change in diagnosis, change in treatment and response to treatment.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The disposition of the case must be entered in the record.
- The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.
- The documentation of treatment or progress notes for all services, at a minimum, must include:
    - The specific services rendered.
    - The date the service was provided.
    - The name(s) of the individual(s) who rendered the services.
    - The place where the services were rendered.
    - The relationship of the services to the treatment plan – specifically, any goals, objectives and interventions.
    - Progress at each session, any change in diagnosis, changes in treatment and response to treatment;
    - The actual clock hours that services were rendered.

As a result of Magellan's ongoing auditing practices and the continued expansion of fraud, waste, and abuse oversight responsibilities, we identified the need for consistent and comprehensive requirements in the attainment of signature verification for service encounters (i.e. Encounter Forms). Encounter Forms offer an extra check and balance for an agency to ensure that services delivered in the community are done so as documented. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services.

Magellan requires providers of community-based services to obtain a signed Encounter Form for each face-to-face contact that results in a claim being submitted to Magellan. Providers may determine how they comply with and monitor this requirement; however at a minimum, the following information must be recorded on the Encounter: certification statement (reference MA Bulletin 99-85-05), provider name and MA ID, member name and MA ID, date of service, start and end time of the session (the actual time in clock hours, not the duration; i.e. '2:00 PM-4:00 PM', not '2 hours'), the rendering provider's signature and the member or guardian's (if under 14) signature. If the billable face-to-face contact is collateral (the member is not present), then the identified individual who the meets with the provider would need to sign the encounter verification form (i.e. school personnel/ teacher). The signed Encounter Forms should be part of the medical record at the time of a Magellan audit or review. If a provider is unable to obtain a signature on the Encounter Form (including refusal), the reason must be documented, and attempts should be made to obtain a signature the following session.

Care Coordination

Coordination of services is a function of SUD Case Management through which the provider establishes an organized approach to coordinating service delivery to ensure the most comprehensive process for

meeting an individual's treatment and treatment-related needs throughout the recovery process. Through coordination of services, the provider ensures that individuals with complex, multiple problems receive the individualized services they need in a timely and appropriate manner. The process of coordination of services is intended to promote self-sufficiency and empower the individual to assume responsibility for his or her recovery.

Coordination of services is a collaborative process that includes engagement, evaluation of needs, establishing linkages, arranging access to services, ensuring enrollment in the appropriate healthcare coverage, advocacy, monitoring, and other activities to address the individual's treatment-related needs throughout their course of treatment. Coordination of services includes communication, information sharing, and collaboration, and occurs regularly between the case manager, contracted provider and individual receiving services.

Discharge Planning and Transition

The disengagement of SUD Case Management Services should not be viewed as an event, but instead a process. As the member receiving services begins to function more independently and seems more self-confident of themselves, it should be considered if SUD Case Management Services are still needed. This decision should consider the progress the member has made towards achieving the goals outlined in their treatment/recovery plan. Allowing the member to have a planned and well-organized disengagement gives them the opportunity to reflect on their overall progress and achievements they have been able to achieve. However, if a member continually seems to struggle with making progress or lacks interest in being involved in SUD Case Management assistance, it should also be re-considered if they are appropriate for services.

Outcomes

All providers of SUD Case Management should have policies and procedures in place to evaluate outcomes for the program. Some of the indicators that could be considered include:

- Decreased higher level of care admission rates
- Increased involvement with service providers
- High levels of participant's satisfaction
- Decreased involvement of legal forces
- Increased community tenure
- Increased ability to manage own care
- Increased participant's ability to communicate openly with service providers
- Increased community linkages
- Frequency of contact with members

Complaint Process

Magellan provides a formal mechanism for all members to express a complaint related to care or service, to have any complaints investigated and resolved, and to receive a timely and professional response to their complaint in compliance with the HealthChoices Program Standards and Requirements Appendix H. This Complaint process is managed by Magellan's Quality Improvement Team. Complaint information is integrated as a key indicator for informing patient safety, credentialing, quality improvement activities, and analyzed for trending and opportunities throughout the network.

When a member files a complaint directly with Magellan, Magellan partners with the provider to address the concern. A member's decision to file a complaint with Magellan should not compromise their care or services. Providers are expected to adhere to their Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures (Section 2.2.1; or Section 2.5 in the Network Provider Agreement). The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

The information that is collected through Magellan's investigation is presented to a first level complaint review committee, which makes the first level complaint decision. HealthChoices standards and regulations, contractual standards, and generally accepted standards of care apply those standards to the issue at hand. Magellan is required to make a decision and send a letter to the member explaining the findings and the reasons for the decision within 30 calendar days of receipt of the Complaint.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. Magellan may request corrective action of a provider in response to supported complaints and identified trends in complaints. If Magellan identifies a supported (substantiated) complaint involving an agency, Magellan staff will collaborate with providers to develop a Complaint Resolution Plan to address the concern. Please review the Provider Communication shared with network providers here about this important and collaborative process.

Viewing complaints from the member's perspective is critical. If the member feels the concern sufficiently to raise it, the matter should be taken seriously and treated accordingly. If the member is still active with provider's services, attempts to resolve the member's issue or concerns and an internal review of the concerns should occur. As opportunities for improvement are identified, corrective action(s) should be implemented in accordance with provider's internal policies, procedures, and protocols.

Service providers should also have internal written policies and procedures for filing and resolving complaints within their organization. These policies and procedures must comply with state and

federal regulations, as well as applicable accreditation standards. Staff should be trained to listen effectively and manage a member's expectations and employ a proactive approach to customer service. Organizations should always try to resolve the member's concerns immediately and informally whenever possible. Complaints/concerns involving minor issues might not require a formal written response. However, even if the matter is addressed quickly and informally, documentation of the member's complaint/concern and actions taken to resolve it should be documented and recorded.

If the member (or their family members or representatives) feel that their concerns have not been addressed, the matter might require a more formal review involving designated staff within provider's organization. Because these reports might be received by a variety of staff, clear definitions, and clearly defined procedures for submission of verbal or written complaints/grievances are essential. The information must be forwarded promptly to the designated staff or department for investigation and follow up.

Persons receiving services should be provided with information explaining the agency's complaint/grievance policies and procedures. Programs often provide this information upon admission to the service; however, it should also be readily accessible throughout the duration of services. Physicians and staff should have adequate training on helping individuals as needed to report, address, and resolve a complaint or grievance.

Grievance Process

Magellan and the Pennsylvania HealthChoices Program Standards and Requirements defines a grievance as a request by a member, the member's representative or health care provider (with written consent of the member), to have Magellan or a utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

Magellan reviews requests from providers for behavioral health services to ensure that approved services are medically necessary and appropriate.

If a level-of-care request is not authorized at the level, frequency, or duration as requested, Magellan members are entitled to grieve a medical necessity denial. At the time of a denial, Magellan informs members of this right and how to proceed. Each medical necessity grievance is handled in a timely manner consistent with the clinical urgency of the situation and in compliance with the HealthChoices Program Standards and Requirements Appendix H.

If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member, and the member's family if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other

options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Please see the Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information including provider-initiated grievances and filing a provider complaint.

Quality Management

Quality care for members and their families is important. Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and services. Magellan has collaborated with Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

Magellan's Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA) and URAC. Assessment of compliance with these requirements is integrated into our quality improvement activities.

NCQA's accreditation standards for managed behavioral health care organizations (MBHOs) emphasize quality standards and activities in a number of areas. NCQA reviews the quality of care and service we deliver, as well as the direct care provided, particularly in the areas of access and availability to care, utilization management, and continuity of care across behavioral health programs. Magellan has developed a number of performance measurement and quality oversight activities to support these NCQA standards and HealthChoices' requirements.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures and activities. Providers shall permit access to any and all portions of the medical record that resulted from member'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.

In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members in order to provide, safe, effective, patient-centered, timely, and equitable care in a culturally sensitive manner. Please refer to the Magellan National Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information and guidelines.

In addition to adhering to state and federal regulations, providers are responsible to:

- Follow policies and procedures outlined in Magellan's Provider Handbook and Provider Handbook Supplement.

- Meet treatment record standards as outlined in the Treatment Record Review Tool found under Audit Tools in the Appendix of Magellan's Provider Handbook.
- Provide treatment records as requested for quality of care issues and adhere to clinical practice guidelines and HEDIS®-related measures.
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities.
- Use evidence-based practices.
- Adhere to principles of member safety.
- Attend or log on to provider training and orientation sessions.
- Participate in the completion of a remediation plan if quality of care concern arises.
- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together.
- Incorporate the use of secure technology into their practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, electronic referrals to other practitioners or programs, and online access to personal health record information.
- Assist in the investigation and timely response of member complaints.
- Assist in the investigation and timely response of adverse incidents.

Magellan supports a wide range of evidence-based and best practices. Magellan requests that contracted providers and practitioners keep inventory and fidelity of evidence-based or best practices that they offer and incorporate into treatment.

Magellan commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective treatment in a manner that is respectful of individual member preferences, needs and values and sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices that are deeply rooted in cultural competence as well, focusing on continual training and education to support staff. Cultural Competency and the LGBTQIA+ Tools are available on www.Magellanofpa.com to help with development of provider cultural competency programs.

There are instances where Members may benefit from oral interpretation, translation services, non-English languages, or alternative formats of materials or communication approaches. Providers are encouraged to maintain a process of accessibility and training for staff so that when opportunities present to support Members that may have language assistance needs, the team is prepared to fully respond to ensure the best possible treatment outcomes. Magellan offers language assistance service educational resources for network providers. These are located on Magellan's website.

Please note: Reporting requirements for Magellan remain consistent and in line with the PA DHS Bulletin, OMHSAS-15-01. A copy of all reportable incidents must be submitted to Magellan's Quality Management Department within 24 hours of an incident or upon notification of an incident. The types of incidents that are reported to Magellan include: Death, Attempted Suicide, Significant Medication

Error, Need for Emergency Services, Abuse/Childline Report, Neglect, Injury/Illness, Missing Person, Seclusion, Restraint, Other (https://www.magellanprovider.com/media/29919/adverseincidentreporting.pdf).

Appendix A to the Pennsylvania HealthChoices Supplement to the Magellan National Provider Handbook offers an updated Incident Reporting Form, Provider Instructions and Definitions. Magellan also provides an electronic format for incident reporting for submission to ease provider paper burden.

Addendum

DDAP Case Management and Clinical Services Manual can be found at: https://www.ddap.pa.gov/Professionals/Documents/SCA%20Manuals%20and%20incorporated%20documents/2020-25%20Case_Mgt_and_Clinical_Srvcs_FINAL.pdf