Section 10.1 PROVIDER REFERRAL PROCESS

10.1.1 Introduction

Magellan Health Services of Arizona is committed to ensuring members are provided with all medically necessary covered services. When those services are not available through the member's assigned provider, the member will be referred to an appropriate provider who can provide the service. Magellan oversees an effective and efficient provider service referral process by facilitating clear communication and coordination between all parties by eliminating barriers to proper coordination of care and by auditing the process to ensure that all requirements are met and process enhancements are implemented as identified. The goal of this section is to provide a uniform process among all providers.

10.1.2 Terms

Primary Provider Service Agency (PPSA) - For this policy the term refers to the adult's or children's service provider who refers the member to another provider for additional services.

10.1.3 Procedures

I. General Requirements

A. This policy applies to the following:

1. Provider network organization providers (PNO);
2. Qualified service providers (QSP);
3. Primary Provider Service Agencies (PPSA);
4. Direct support providers;
5. Out–of-network providers;
6. Child and Family Teams (CFT); and
7. Members, their families and authorized representatives.

B. Providers are expected to comply with all requirements specified in their contracts as well as the requirements in this policy.

C. Providers who refer members for needed services do not relinquish responsibility for the members and their care. Referring providers are expected to follow up with the receiving provider to ensure that all required member records and documentation are received and that member appointments and needed services are coordinated and provided in a timely manner.

D. Receiving providers are expected to notify the referring provider of the documentation received and provide regular progress updates on the member's treatment.

E. Providers will comply with all privacy and confidentiality requirements set forth in the HIPAA privacy and security rules.

F. Referring providers are responsible for identifying those providers who can provide the needed services and who also have availability.

II. Adult Referral Process

A. Prior to initiating a referral, the assigned service provider must determine that the member is eligible for the needed service. If the member is eligible, but services are not available in the provider network, the provider will coordinate with Magellan for a Single Case Agreement. For more information on Single Case Agreements, refer to Section 3.14, Securing Services and Prior Authorization, in the ADHS/DBHS Provider Manual, *Magellan Health Services of Arizona* Edition.

B. If the member is eligible and the service is available in network, the Referring Provider will determine if prior authorization is required.

1. If prior authorization is required, the Referring Provider's clinical team will contact Magellan's Utilization Management (UM) department to obtain authorization.

a. If the prior authorization request is approved, the referring provider will continue to Standard II.C.

b. If the prior authorization request is denied, the referring provider may refer to Section 3.14, Securing Services and Prior Authorization, in the ADHS/DBHS Provider Manual, *Magellan Health Services of Arizona* Edition.

2. If prior authorization is not required, the Referring Provider will continue to Standard II.C.

C. The Referring Provider will obtain a Release of Information (ROI) (Authorization to Use and Disclose Protected Health Information (AUD)), signed by the member/guardian, to allow for the release of the required documents in the Referral Packet to the Receiving Provider.

D. The Referring Provider will prepare the member's records for referral by completing the Provider Referral Packet – Minimum Required Documents form. The Magellan form must be used; however, Referring Providers may include other forms in addition to Magellan's.

1. Receiving Providers should not refuse a referral for missing documents.

2. All mandatory documents will be updated by the Referring Provider as needed, and include the:

a. Assessment *(effective date defined as date initially signed by a staff member; must be completed within last 365 days, and signed by a Behavioral Health Professional (BHP) within 30 days of initial staff member (if not a BHP))*;

b. Individual Service Plan (ISP) *(effective date defined as date signed by member/guardian; must be completed within last 365 days, signed and dated by member/guardian and at least one staff member, based on a current and complete assessment, and the signature date must be on or after date the assessment was documented)*;

- Please note that the Service Plan requirements for Non-Titled XIX/XXI persons determined to have a Serious Mental Illness (SMI) that do not have an assigned Case Manager are unique compared to other populations. For more information, refer to Section 3.9, Assessment and Service Planning, in the ADHS/DBHS Provider Manual, *Magellan Health Services of Arizona* Edition.

c. BHMP Note, including current medications and ICD diagnoses, if available *(if diagnoses are different from the assessment, the note must state the diagnoses have changed moving forward; otherwise the assessment diagnoses should be billed)*;

d. Member face sheet *(should not be used for diagnosis billing purposes)*; and

e. Release of Information (Authorization to Use and Disclose Protected Health Information (AUD) *(signed by member/guardian)*.

3. Additional documents may be included in the referral packet, or requested by the Receiving Provider, and must also be updated and/or current if they are to be forwarded. These may include, but are not limited to:

   a. At Risk Crisis Plan;

   b. Safety Plan;

   c. Member demographics;

   d. Documentation of guardianship;

   e. Court Ordered Treatment documentation;

   f. Advance Directives (if completed);

   g. Special Assistance form (if completed); and

   h. Other Employment and Other Activities.

4. The *Provider Referral Packet – Minimum Required Documents* form is signed and dated by the employee who completes the document preparation process and his/her supervisor.

5. The Referring Provider will conduct a final review of the packet to ensure all documents are current and signed;

6. E-mail (preferred) or fax the packet to the receiving provider and verify it was received; and

7. Assist the member with any transportation needs.

E. Upon receipt of the referral packet, the Receiving Provider will:

1. Review the packet and ensure all needed documents are included, current and signed as required:

   a. If the packet is complete, the Receiving Provider will confirm receipt with the Referring Provider.

   b. If the packet is incomplete, the Receiving Provider will proceed to Standard IV, Referral Documentation Resolution Protocol, and contact the Referring Provider to request that he/she provide the missing and/or current documentation in accordance with the Referral Documentation Resolution Protocol.

   c. If unable to coordinate for the required documentation, the Receiving Provider will contact Magellan for assistance at servicereferral@magellanhealth.com.

2. Contact the member, set up an appointment within established timeframes, and notify the Referring Provider of the outcome.

3. Coordinate with the Referring Provider throughout the process ensuring updated records are shared as appropriate as the member continues to receive services.
4. If services are completed or terminated for any reason, coordinate a proper transition or discharge with the Referring Provider.

F. The Referring Provider will follow up with the Receiving Provider within established timeframes to ensure the member is scheduled for an appointment and is, or will be, receiving services.

1. If either the Referring or Receiving Provider identifies unresolved barriers to service, such as records not being received, the appointment not being set or services not being provided, he/she may contact Magellan and request assistance at servicereferral@magellanhealth.com .
2. If the Receiving Provider does not accept the referral, the Referring Provider will reinitiate the referral process with another provider until the service is secured.

G. **The Referring Provider will continue to forward updated documents (service plans, assessments, etc.) to the Receiving Provider to ensure all entities providing care to the member are coordinating their service delivery.**

III. Children Referral Process

A. The Guardian/CFT requests a service that is not available from the current provider. If the member is eligible, but services are not available in the provider network, the provider will coordinate with Magellan and/or the Children's Provider Network Organization (CPNO) for a Single Case Agreement. For more information on Single Case Agreements, refer to Section 3.14, Securing Services and Prior Authorization, in the ADHS/DBHS Provider Manual, *Magellan Health Services of Arizona* Edition.

B. The Case Manager (CM)/CFT Facilitator updates the service plan to reflect the requested service.

C. If the member is eligible and the service is available in network, the Referring Provider (PPSA) determines if prior authorization is required:

1. If prior authorization is required, the Referring Provider's clinical team will contact Magellan's Utilization Management (UM) department to obtain authorization.
   a. If the prior authorization request is approved, the Referring Provider will continue to Standard III.D.
   b. If the prior authorization request is denied, the Referring Provider may refer to Section 3.14, Securing Services and Prior Authorization, in the ADHS/DBHS Provider Manual, *Magellan Health Services of Arizona* Edition.
2. If prior authorization is not required, the Referring Provider will continue to Standard III.D.

D. The Referring Provider will obtain a Release of Information (ROI) (Authorization to Use and Disclose Protected Health Information (AUD)), signed by the member/guardian to allow for the release of the required documents in the Referral Packet to the Receiving Provider.

E. The Referring Provider will prepare the referral packet, including a completed and signed *Provider Referral Packet – Minimum Required Documents* form. The Magellan form must be used; however, Referring Providers may include other forms in addition to Magellan's.

1. Receiving Providers should not refuse a referral for missing documents.
2. All mandatory documents are updated by the Referring Provider as needed, and include:
    a. Assessment *(effective date defined as date initially signed by a staff member; must be completed within last 365 days, and signed by a Behavioral Health Professional (BHP) within 30 days of initial staff member (if not a BHP))*;
    b. Individual Service Plan (ISP) *(effective date defined as date signed by member/guardian; must be completed within last 365 days, signed and dated by member/guardian and at least one staff member, based on a current and complete assessment, and the signature date must be on or after date the assessment was documented)*;
    c. BHMP Note, including current medications and ICD diagnoses, if available *(if diagnoses are different from the assessment, the note must state the diagnoses have changed moving forward; otherwise the assessment diagnoses should be billed)*;
    d. Member face sheet *(should not be used for diagnosis billing purposes)*; and
    e. Release of Information (Authorization to Use and Disclose Protected Health Information (AUD)) *(signed by member/guardian)*.
3. Additional documents may be included in the referral packet, or requested by the Receiving Provider, and must also be updated and/or current if they are to be forwarded. These may include, but are not limited to:
    a. Crisis Plan;
    b. Safety Plan;
    c. Child and Adolescent Service Intensity Instrument (CASII);
    d. Strength, Needs and Culture Discovery (SNCD);
    e. Member demographics;
    f. Documentation of guardianship; and
    g. Advance Directives (if completed).
4. The *Provider Referral Packet – Minimum Required Documents* form is signed and dated by the employee who completed the document preparation process and his/her supervisor.
5. The Referring Provider will conduct a final review of the packet to ensure all documents are current and signed;
6. E-mail (preferred) or fax the packet to all approved/potential providers and verify it was received; and
7. Assist the member with any transportation needs.

F. Upon receipt of the referral packet, the Receiving Provider will:
    1. Review the packet and ensure all needed documents are included, current and signed as required:
        a. If the packet is complete, the Receiving Provider will confirm receipt with the Referring Provider.

b. If the packet is incomplete, the Receiving Provider will proceed to Standard IV, Referral Documentation Resolution Protocol, and contact the Referring Provider to request that he/she provide the missing and/or current documentation in accordance with the Referral Documentation Resolution Protocol.

c. If unable to coordinate for the required documentation, the Receiving Provider will contact Magellan for assistance at childservicereferral@magellanhealth.com.

2. Contact the member, set up an appointment within established timeframes, and notify the Referring Provider of the outcome.

3. Coordinate with the Referring Provider throughout the process ensuring updated records are shared as appropriate as the member continues to receive services.

4. If services are completed or terminated for any reason, coordinate a proper transition or discharge with the Referring Provider.

G. The Referring Provider will follow up with the Receiving Provider within established timeframes to ensure the documentation was received, the member is scheduled for an appointment and is, or will be, receiving services.

1. If either the Referring or Receiving Provider identifies unresolved barriers to service, such as records not being received, the appointment not being set or services not being provided, he/she may contact Magellan and request assistance at childservicereferral@magellanhealth.com.

2. If the Receiving Provider does not accept the referral, the Referring Provider will reinitiate the referral process with another provider until the service is secured.

H. The Receiving Provider sends monthly reports to the Referring Provider to document the member's progress.

I. **The Referring Provider will continue to forward updated documents (service plans, assessments, etc.) to the Receiving Provider to ensure all entities providing care to the member are coordinating their service delivery.**

IV. Referral Documentation Resolution Protocol

A. When there are barriers to receiving referral packet documentation in a timely manner, the Receiving Provider should proceed according to the following steps with the goal being to resolve issues at the lowest step and earliest opportunity.

B. Routine Referral

1. Adult SMI System of Care -If complete and up-to-date referral information is not received upon referral:

a. **Step 1** – The Receiving Provider contacts the Referring Provider's Clinical Coordinator (supervisor who signed the referral packet form) via telephone and e-mail with a copy to the Clinical Director and Site Administrator.

b. **Step 2** – If there is no resolution within one (1) business day, the Receiving Provider contacts the Referring Provider's Clinical Director (or the Site Administrator if the Clinical Director is unavailable) via telephone and e-mail with a copy to the Referring Provider's Regional Director.

c. **Step 3** – If there is no resolution within one (1) business day, the Receiving Provider contacts the RBHA via e-mail at

servicereferral@magellanhealth.com with a copy to the Referring Provider's Regional Director.

2. Adult GMH/SA System of Care - If complete and up-to-date referral information is not received upon referral:
    a. **Step 1** – The Receiving Provider contacts the Referring Provider's Specified Point of Contact (available at http://magellanofaz.com/for-providers/providing-care.aspx) via telephone and e-mail.
    b. **Step 2** – If there is no resolution within two (2) business days, the Receiving Provider contacts the Referring Provider's Clinical Director via telephone and e-mail with a copy to the Referring Provider's Specified Point of Contact.
    c. **Step 3** – If there is no resolution within one (1) business day, the Receiving Provider contacts the RBHA via e-mail at servicereferral@magellanhealth.com with a copy to the Referring Provider's Clinical Director.
3. Children System - If complete and up-to-date referral information is not received upon referral:
    a. **Step 1** – Receiving Provider contacts the program supervisor of the Referring Provider agency (supervisor who signed the referral packet form) via telephone and e-mail with a copy to the Children PNO's Clinical Director.
    b. **Step 2** – If no resolution within one (1) business day, Receiving Provider contacts the Children's PNO designated point of contact via telephone and e-mail.
    c. **Step 3** – If no resolution within one (1) business day, Receiving Provider contacts the RBHA via e-mail at childservicereferral@magellanhealth.com.

C. High Priority

In circumstances in which clinical judgment determines that referral documentation is essential to appropriate treatment planning and initiation of service delivery by the Receiving Provider, the timeframes identified in Standard IV.B. above for elevating the request may be expedited as indicated by the member's behavioral health condition.

D. Magellan Service Referral E-mail - When contacting Magellan for assistance via email at servicereferral@magellanhealth.com (Adults) or childservicereferral@magellanhealth.com (Children), the Provider should include, at a minimum, the following information:

1. Referring Case Manager Name;
2. Referring Site;
3. Referring PNO or Provider;
4. Recipient Name;
5. Recipient Date of Birth;
6. Receiving Provider;
7. Date referral initially sent;
8. Receiving Provider Contact person;
9. Service requesting;

10. Dates of attempted contact;
11. Who was spoken to/attempted to contact; and
12. A description of the situation requesting assistance.

V. Oversight and Monitoring

A. Response to Performance Standards and Improvement Measurements

1. Providers who fail to comply with this policy will be subject to the following steps, including, but not limited to:
    a. Letter of Concern;
    b. Performance Improvement Plan;
    c. Corrective Action Plan;
    d. Notice to Cure;
    e. Sanction;
    f. Contract Termination; and
    g. Other remedies as available under the Provider Participation Agreement.