Data system transition for NBHS services

Important Update for Division of Behavioral Health Providers

Effective May 16, 2016, the Division of Behavioral Health will begin use of the new Centralized Data System (CDS) operated through a contract with Orion Healthcare Technology, Inc. Upon this contract transition, Magellan Behavioral Health of Nebraska will no longer provide data management or utilization review services for providers rendering services under the Division of Behavioral Health / Regional Funding Systems (NBHS).

This transition *does not apply to any process or data requirements for Medicaid funded services*. Please continue to follow current practices for Medicaid funded services with Magellan Behavioral Health of Nebraska.

This frequently asked questions (FAQs) document is intended to provide information for providers and other stakeholders regarding the Division of Behavioral Health and NBHS data system and authorization process change. Additional details regarding this transition will be provided to you from Orion Healthcare Technology, Inc. and the Division of Behavioral Health. For CDS questions, please visit: OrionHealthcare.com.

Frequently Asked Questions

What is the last date providers will be able to enter registrations on the Magellan provider website for NBHS services?
Providers will continue to access the Magellan provider / NBHS website to enter registrations and pre-authorizations through 5 p.m. (Central time) on May 13, 2016. After this time, the Magellan provider / NBHS website will be locked down to prepare final reports to support data transfer to the new Division of Behavioral Health CDS. Please plan to print any necessary TADs documentation for review prior to the Magellan system lock down.

What is the last date providers will be able to secure authorizations for services for NBHS services?
Magellan will provide utilization management services and authorization reviews through 5 p.m. (Central time) on May 13, 2016. Providers will continue to be required to enter pre-authorizations through the Magellan provider / NBHS website to support these authorization reviews through May 13. No additional authorization reviews will start after this deadline, even if a pre-authorization was entered. After this date, all authorization requests will be processed by the new vendor; Magellan will no longer conduct authorization reviews for services funded through the Division of Behavioral Health.

What will happen to reviews that are in Magellan's appeal process on May 13, 2016?
Magellan will resolve all authorization requests that are received prior to 5 p.m. (Central time) on May 13, 2016. Appeal requests that are received before this time will also be processed. DBH will be notified of all authorization and non-authorization decisions for requests in appeal review during this timeframe to facilitate appropriate data entry into the CDS system.

Authorization for service requests after May 13, 2016, will be conducted through the Division of Behavioral Health CDS online authorization request process. Please visit http://www.orionhealthcare.com/contact/cds/ or email support@orionhealthcare.com to request more information on the new Division of Behavioral Health authorization of service process.

Will Magellan continue to process the Behavioral Health Authorization Modification Requests for providers?
Magellan will continue to process all Behavioral Health Authorization Request forms received through May 6, 2016 to ensure all data is corrected and prepared for transfer to DBH. Providers requiring data corrections after this date will be directed to use the process available through the new vendor.

Currently, providers are able to contact Magellan and have authorizations for services transferred to the appropriate funding source (Division of Behavioral Health or Magellan) when a member's Medicaid eligibility changes; will this continue?
As Magellan no longer will be providing utilization management review services or have access to the authorization status of services funded by the Division of Behavioral Health, the existing authorization transfer process will no longer be utilized after May 13, 2016. Providers will be expected to track member eligibility status and secure necessary authorization through the appropriate funding source, even when a member's eligibility changes during the course of a treatment episode. For example, if a member enters into care on May 1, 2016, and is eligible for DBH-funded services, but becomes Medicaid Managed Care eligible effective July 1, 2016, the provider is responsible for timely contacting Magellan to secure authorization under Medicaid Managed Care funding and discharge the member from the NBHS data system. Providers will be held accountable for accurately identifying, seeking prior authorization when required and billing the appropriate payor source depending on ongoing current member eligibility.

Since providers will need to contact Magellan for a new authorization when a member becomes Medicaid eligible, will providers still be allowed 30 days to notify Magellan and conduct the utilization review?
For Medicaid managed care members, providers will be required to follow standard authorization timelines for all services requested, including prior authorization and retro-eligibility authorization timelines. Failure to do so may lead to denial of authorization. Information on these expectations can be found in the Nebraska provider handbook supplement located in the *For Providers* section of the Magellan of Nebraska website at www.MagellanofNebraska.com.

Providers should review the Nebraska provider handbook supplement and be familiar with the authorization requirements for specific levels of care. Failure to request prior authorization may lead to denial of authorization and claims payment denials.

Will a new authorization / utilization review be conducted by Magellan for members who become Medicaid eligible, but have already been approved through Division of Behavioral Health funding?
Magellan will no longer have access to the clinical documentation for members authorized for services under the Division of Behavioral Health funding system, and therefore will need to conduct an authorization review to ensure that all Medicaid Managed Care eligible members meet Medicaid Medical Necessity Criteria for requested services. Providers are required to complete the authorization review process according to each payor source with any change in member eligibility. Member eligibility determines the payor source and which authorization requirements are applicable.

What will happen in the case that a member is authorized for service under Division of Behavioral Health funding but becomes Medicaid eligible and, upon review by Magellan, is non-authorized for services?

Magellan is required to ensure that members authorized for Medicaid funded services meet established Medical Necessity Criteria. An approved service authorization rendered by a third party does not necessarily demonstrate that the service is medically necessary, as defined by Magellan and relevant Medicaid regulations. Providers will have full access to Magellan's clinical appeal process in any case that a service authorization request is not authorized at the initial review level. Magellan and the Division of Behavioral Health will continue to work closely to ensure that level of care determinations are consistent whenever possible.