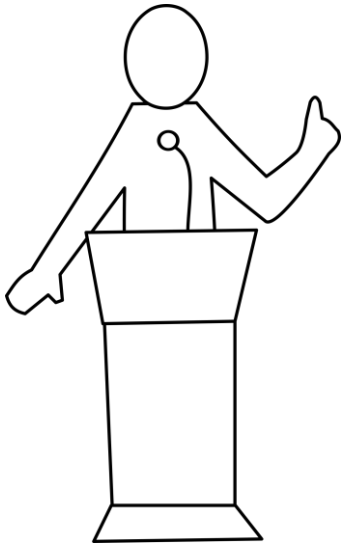
Magellan Behavioral Health of Pennsylvania, Inc.

2017 Compliance Forum

November 3, 2017

Presenters

- Lydia Briggs, Compliance & Claims Auditor
- Tina Davis, Compliance & Claims Auditor
- Patty Marth, Compliance & Claims Auditor
- Jackie Kline, SIU Manager
- Karli Schilling, PA Compliance Manager



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Agenda

- Review of Basic Terminology
- Effective Compliance Programs
- Compliance Plan Trends
- Compliance Best Practices
- PA Medicaid Regulations
- Claims Trends by Program/ Service
- Self-Auditing
- Resources

Basic Terminology and Examples

Fraud *is an intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.*

Examples include:

- Intentionally billing for services that were not provided
- Falsifying signatures
- Rounding up time spent with a member
- Altering claim forms

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Abuse *refers to provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.*

Examples include:

- Services that are billed by mistake
- Misusing codes: code on claim does not comply with contractual guidelines; not billed as rendered
- Billing for a non-covered service
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)

Waste *means over-utilization of services or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.*

Examples include:

- Using excessive services such as outpatient therapy
- Providing services that aren't medically necessary
- BHRS Providers- BSC staff conducting excessive non face-to-face services
- Multiple clinicians or provider staff billing for attending the same meeting or service
- Over-ordering of Assessments/ Evaluations

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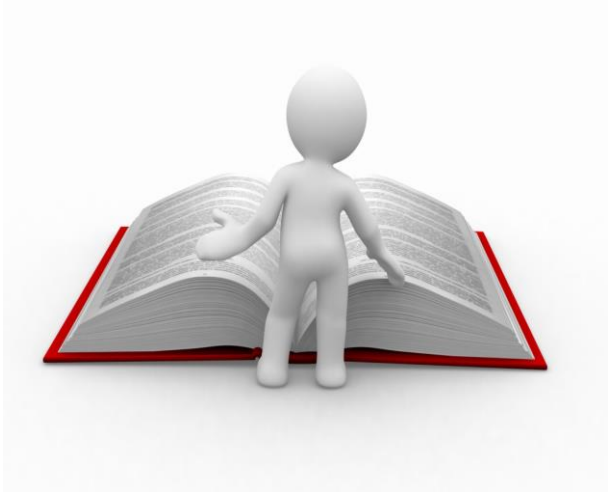
Effective Compliance Programs

Compliance Program Audits

- Compliance program audits evaluate a provider's overall compliance oversight including policies and procedures, self-auditing, staff training, compliance investigations, etc.
- Regulatory and contractual obligation that all providers have a compliance plan/manual.



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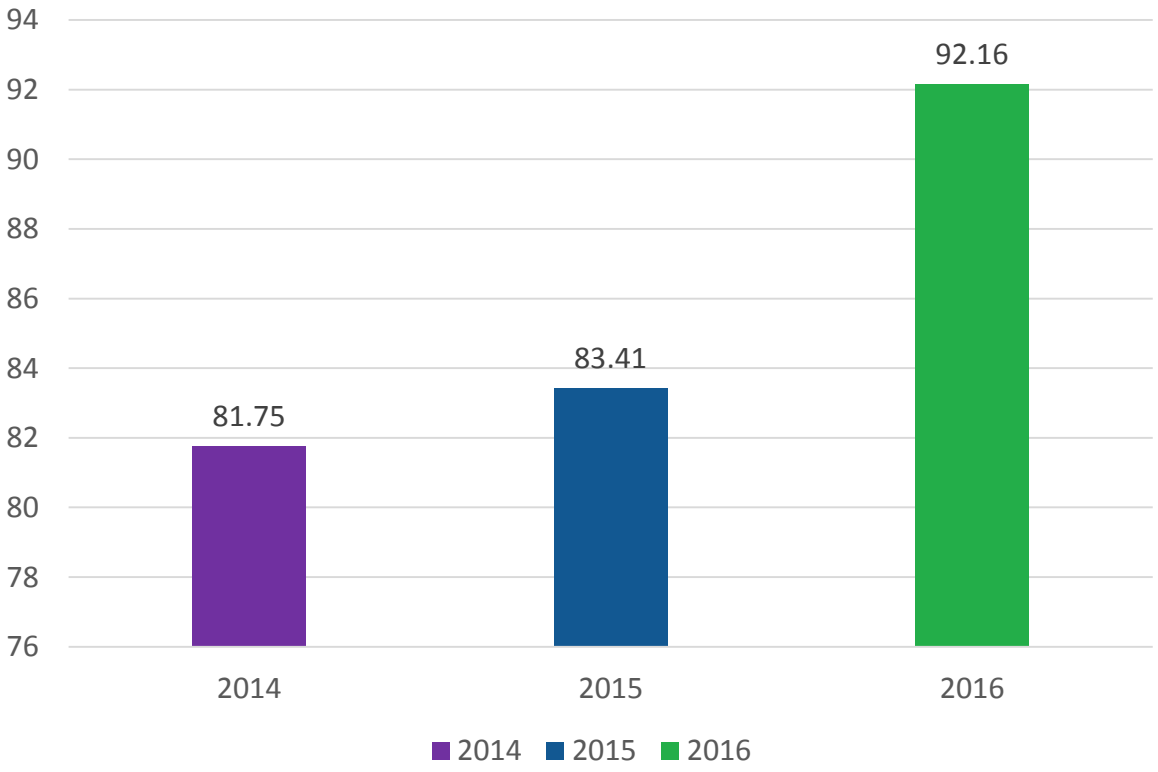
Compliance Program Audits

2014-2016 Audit Results:



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Compliance Program Audit Tool

- Based on CMS Compliance Program Guidance Elements of an Effective Compliance Program
  - Written policies and procedures
  - Compliance committee and compliance officer
  - Training and education
  - Effective lines of communication
  - Auditing and monitoring
  - Reinforcement and discipline
  - Response and prevention
- An effective compliance program must be an ongoing process that includes prevention, detection, collaboration and enforcement.

Compliance Program Standards

1. Written Policies and Procedures

- Standards of Conduct
  - Includes guidelines for business decision-making
  - Behavior and ethics
- Policies and Procedures
  - Includes: Employee Training, Whistleblower Protections, Exclusionary Sanction Monitoring, Billing Practices, Documentation Requirements and Record Retention Policies
  - Realistic, specific and measurable
  - Focus on areas of risk

The only thing worse than not having a policy is having a policy and not following it. Do what you say and say what you do.

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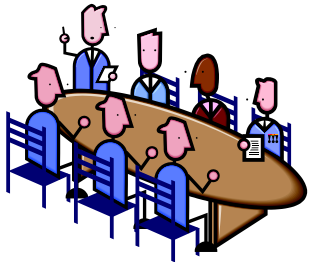
Compliance Program Standards

2. Designation of a Compliance Officer and Compliance Committee

- Compliance Officer
  - Primary responsibility is to oversee and monitor the implementation and effectiveness of the Compliance Plan
  - Authority, Independence
  - Advise and provide recommendations to management, board of directors and employees
  - A policy identifying who the Compliance Officer is and what their job functions include should be present
- Compliance Committee
  - Assist in implementation of the Compliance Plan
  - Advise Compliance Officer
  - Diverse membership



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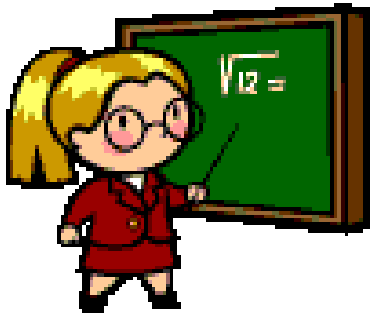
Compliance Program Standards

3. Effective Training and Communication

- Formal Training Plan
  - Requirement for all staff
  - At hire and annually at a minimum
  - Content should include requirements/ expectations of the Compliance Program (policies, Code of Conduct, hotline, regulatory requirements)
  - Attestations must be present in HR records
  - Additional training for high-risk staff (i.e. billing and claims personnel)
- Informal Training
  - Posters
  - E-mail communications
  - Newsletters
  - Compliance Awareness Week



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Compliance Program Standards

4. Effective Lines of Communication

- Access to Compliance Officer
  - Open door policy
  - Confidentiality and non-retaliation policies
  - Comfortable environment

- Reporting Mechanisms
  - Hotline (multiple options including anonymity)
  - Policy/ Procedure regarding tracking and investigating reports

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Compliance Program Standards

5. Auditing and Monitoring

An effective and successful compliance program has a process of constant evaluation- a process for continually improving compliance activities

- Auditing
  - Comprehensive Internal Audit System
  - Assessing overall Compliance Program

- Monitoring
  - Regular, ongoing review of effectiveness
  - Ensure that recommendations and action plan items from oversight agencies continue to be implemented
- Risk Areas

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Compliance Program Standards

6. Reinforcement and Discipline

- Consistent and fair
- A written policy should outline the degrees of disciplinary actions
  - Sanctions for non-compliance as well as failure to report
  - Outline of disciplinary procedures and options to impose
- Conduct background and sanction list checks on new hires and ongoing regular reviews of current employees against the federal healthcare sanctions lists (MA Bulletin 99-11-05):
  - LEIE
  - SAM
  - Pennsylvania Medicheck

Compliance Program Standards

7. Response and Prevention

- Once misconduct has been reported or detected, an organization must respond swiftly and appropriately.
- Once report has been made, a policy should describe in detail how the investigation will ensue.
- A thorough investigation should include a clear process, timeframe and documentation.
- An outside audit or consulting firm should be available as needed
- Disclosing/ Reporting to Oversight Agencies including the MCO and BPI

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Compliance Program Audit Trends

Most Common Compliance Program Audit Trends

- Policy & Procedure (P&P) on internal claims audits (i.e. comparison of clinical documentation vs. accuracy of billing)
- Conducting periodic reviews, at least annually, of the Code of Conduct & Compliance P&P
- Refresher training for all staff at least annually with employee sign off
- P&P regarding responding to and reporting of compliance concerns include:
  - Plan that addresses how internal investigations should be conducted
  - Time limit for closing a compliance investigation
  - When to have an investigation performed by an outside, independent investigator
  - Reporting to State and BH-MCO

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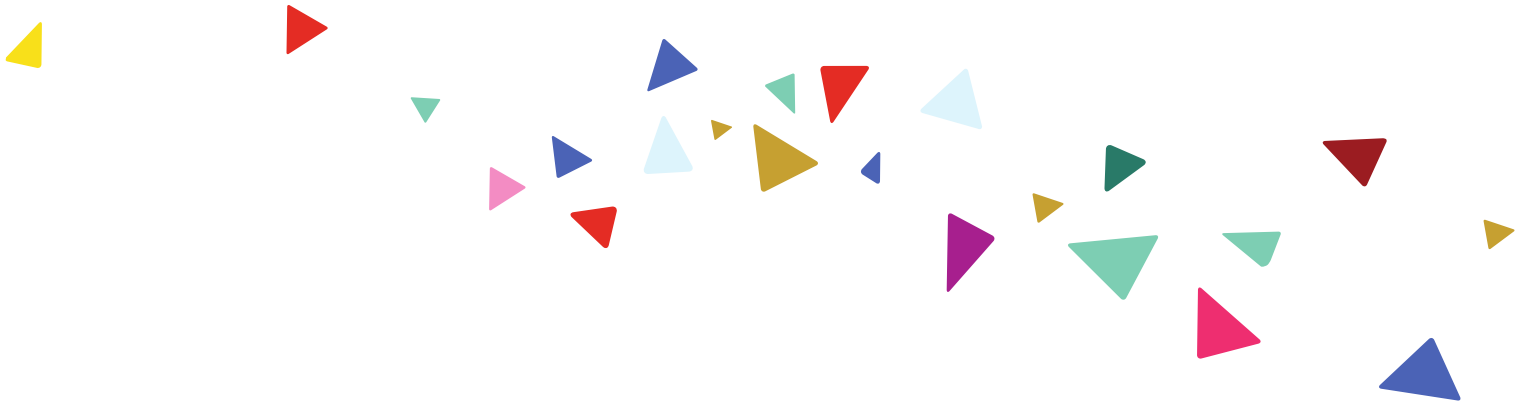

Compliance Program Best Practices

Compliance Program Best Practices

- Many providers require staff to review and attest to the agency's Compliance Program Manual and/or Code of Conduct on an annual basis. It is recommended that all staff also receive a **formal** training (either in person or online) on Compliance at hire and at least annually thereafter.
- Include a section of Definitions and Examples (such as for Fraud, Waste, Abuse, etc.) within the Compliance Program Manual. Ensure that employees/ staff review these definitions/ examples on at least an annual basis by incorporating them into a training and attestation process.
- Include an assessment or quiz attached to all required Compliance Trainings. Set a minimum standard for passing.
- Reference Federal, State and Local laws related to Fraud, Waste & Abuse within a Provider's Code of Conduct and/or Compliance Plan.

Compliance Program Best Practices

- EMR systems/electronic progress notes offer a lot of benefits, most notably legibility; however, they can also lead to “cutting and pasting” from session to session. Disable this feature in your EHR systems.
- For services that allow some non-direct billable contact (i.e. BHRS, Family-Based Mental Health Services): the researched material could be printed out and included in the record as evidence (attached to the applicable progress note). Implement agency standards or limits regarding non-direct contact.
- Providers with community-based services should utilize a service verification process (random calls or letters to members and/ or guardians to verify that services were delivered as indicated).

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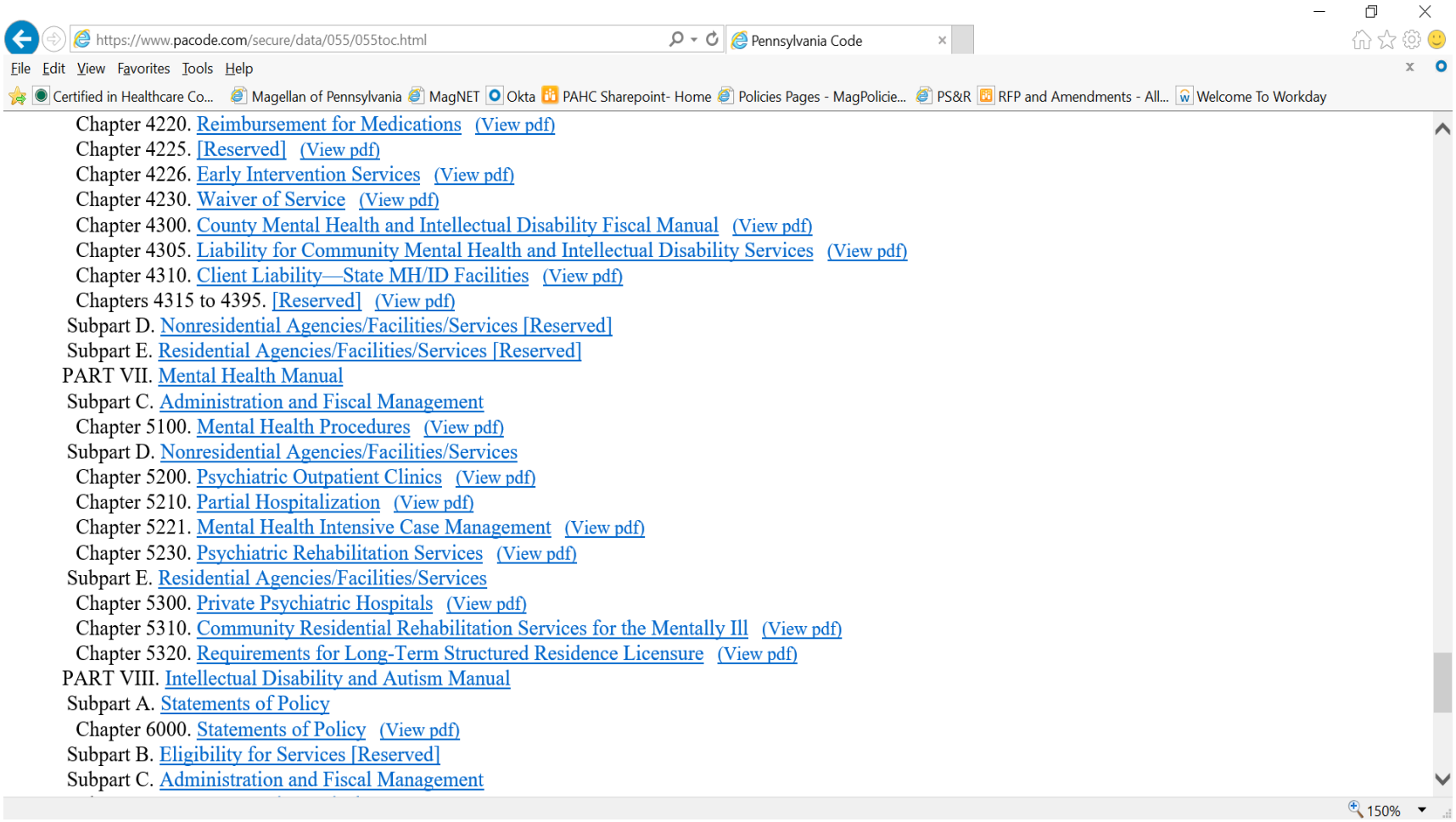
Compliance Program Best Practices

- One progress note template should be used consistently throughout an agency or practice. This helps to reduce errors and ensure compliance with MA documentation requirements.
- Encounter Verification Forms: incorporate the clinical documentation and encounter signature on the same form/ template (or attach them and file together).
- Utilize peer reviews when conducting self-auditing activities that demonstrate Interrater Reliability

PA Medicaid Regulations

Pennsylvania Code

https://www.pacode.com/secure/data/055/055toc.html



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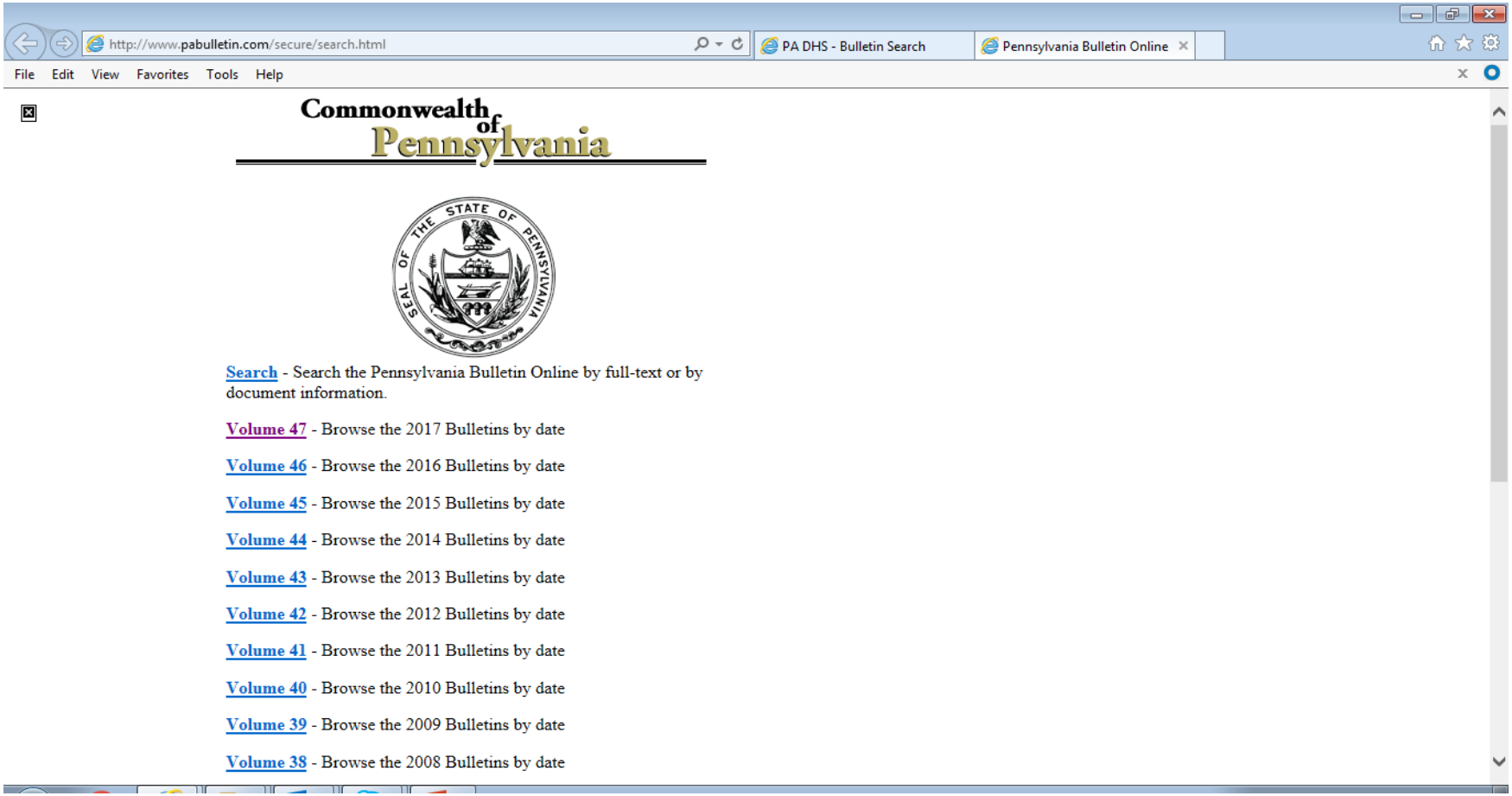
Pennsylvania Bulletin

http://www.pabulletin.com/secure/search.html



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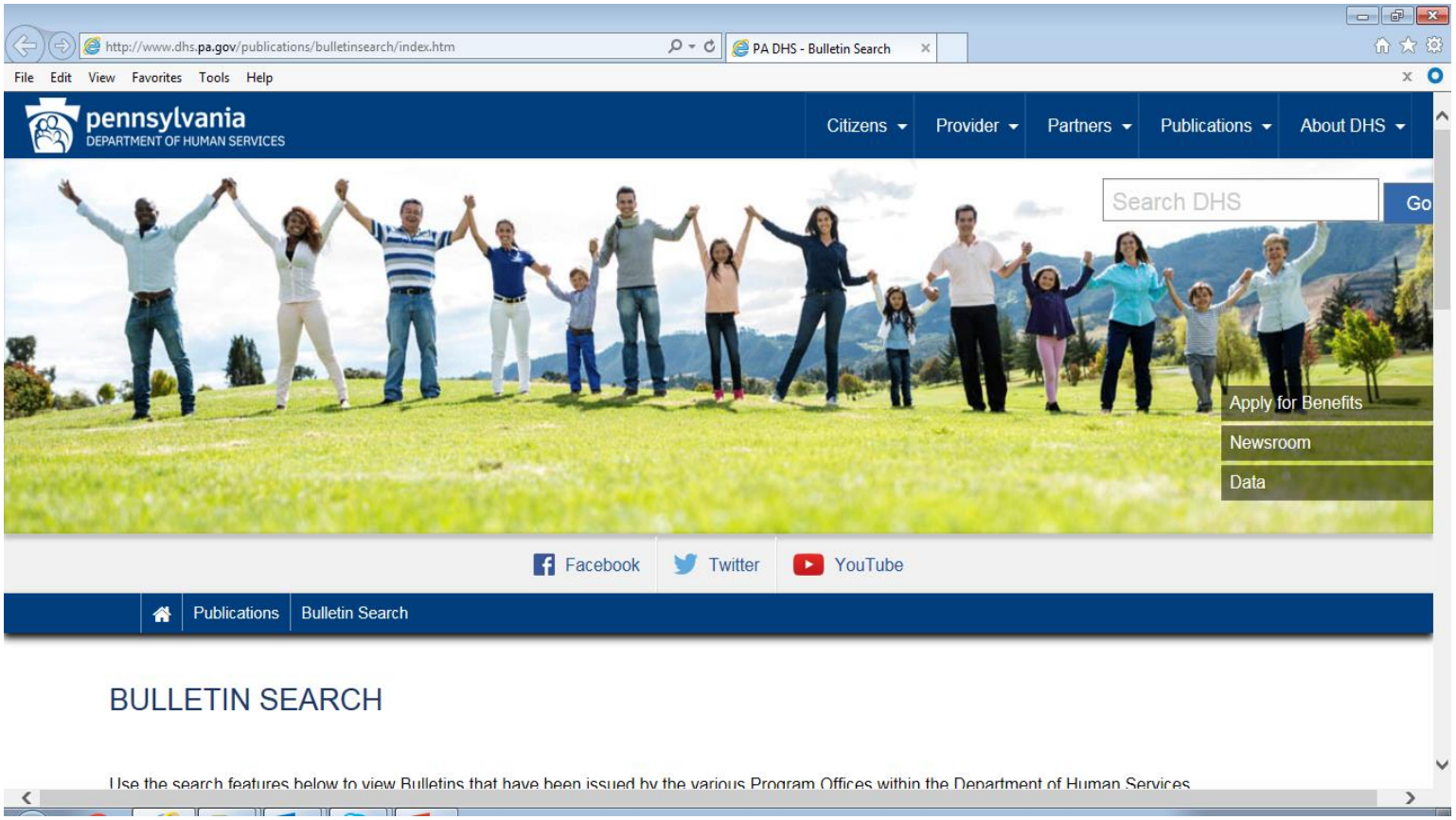
DHS Bulletin Search

http://www.dhs.pa.gov/publications/bulletinsearch/index.htm



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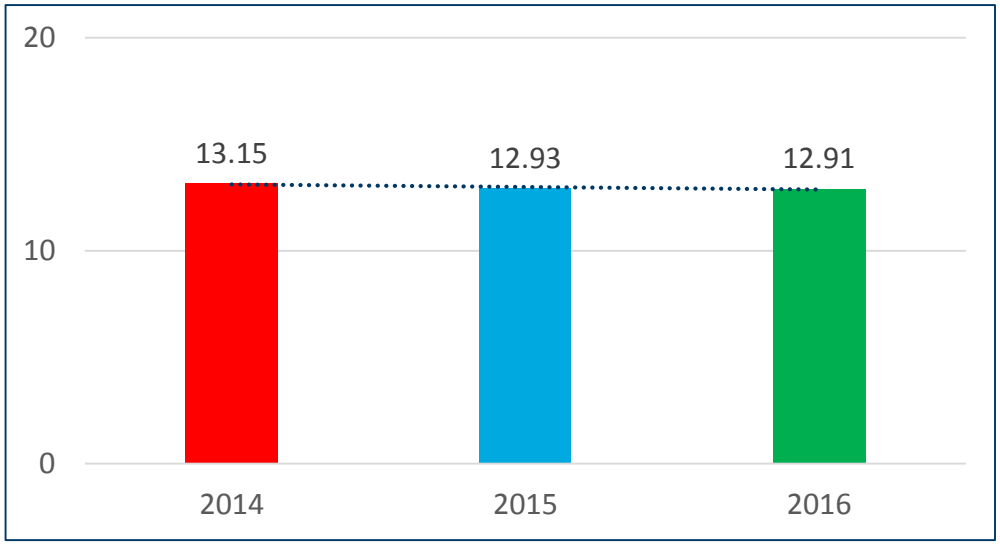
Claims Audits- Current Trends

Claims Audit Results: 2014-2016

- Claims Error Rates have remained steady:



- Highest Rates:
  - D&A Outpatient= 20.41%
  - Case Management= 13.82%
  - MH Outpatient= 11.18%
  - BHRS= 6.44%

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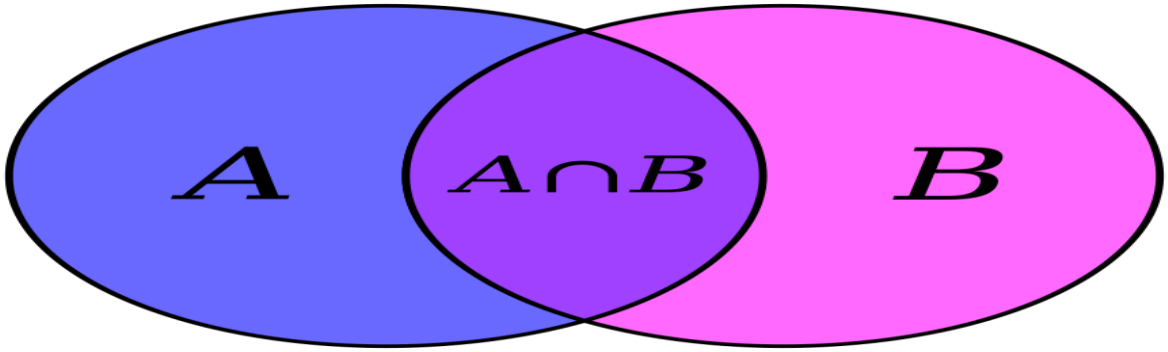
Most Common Overall Audit Trends

- Missing Documentation
- Upcoding
- Treatment/ Service Plan Requirements
- Adherence to Magellan's Contracted Rate Sheet
- Duplicate Progress Notes
- Overlapping Services
- Rounding
- EHR Time Stamp
- Documentation does not support the length of the session

Outpatient MH & D&A Audit Trends

- Overlapping sessions- Individual therapy & Medication Management occurring at the same time on the same date



- Duplicate Progress Notes & Treatment Plans - Copying & pasting content or sections from one progress note or treatment plan to another

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Outpatient MH & D&A Audit Trends

- Outpatient Group Therapy exceeds maximum number of participants (10 persons; or 12 with an approved waiver)
  - PA Code 55 § 1153.2
  - PA Code 55 § 1223.2
- Upcoding: Medication Visits by CRNP
- CRNP Certification
  - (http://www.magellanofpa.com/media/1511850/compliance_alert_april_2016.pdf)
- Start and end times of the session not documented
  - MA Bulletin 99-97-06 and Magellan Provider Handbook (https://www.magellanprovider.com/media/1661/pa_healthchoices_supp.pdf)
- Diagnostic Assessments & Psychiatric Evaluations
  - OMHSAS Policy Clarification #03-08

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BHRS Audit Trends

- Services Not Rendered and Falsifying Claims
- Non-billable function of MT services which requires direct contact with the family or other involved professionals.
- BSC excessive time spent completing paperwork; Documentation does not support the length of the session
- TSS excessive community time

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Case Management Audit Trends

- Documentation does not support the length of the session
- All or most non-direct contacts are exactly 8 minutes in duration
- Services do not correspond to Treatment/ Service Plan goals
  - OMHSAS-09-02
- Billing for Travel and/ or Transportation
  - OMSAS-13-01
- Billing for time spent “Waiting”
  - Time spent on activities that do not constitute actual contacts are not Medicaid Reimbursable

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Family-Based Services Audit Trends

- Utilization of Family Support Service Funds
  - http://www.magellanofpa.com/media/1511859/compliance_alert_august_2016.pdf
- Billing for No-Shows
- Billing the incorrect modifier combination per the Magellan contract
- Provider staff meetings, supervision, recordkeeping activities and other non-direct services, may not be billed as a Family-Based Mental Health. Service Unit. Costs for these activities are included in the rate.
  - Chapter 5260: FAMILY BASED MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS
- Non-direct contact
  - Chapter 5260

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Peer Support Services Audit Trends

- Services may be billed for the time that the CPS has face-to-face interaction with the individual's family, friends, service providers or other essential persons if the individual is present.

- Payment ***will not*** be made to a Peer Support Services agency for the following:
  - Services that are purely recreational, social or leisure in nature, or have no therapeutic or programmatic content.
  - Administrative costs, such as those resulting from agency staff meetings, record-keeping activities and other non-direct services.
  - Time spent traveling or transporting members is not directly reimbursable and must be separated out on the documentation.

EHR Time Stamp

- Signatures Stamps precede end time of the session
- Signature Stamps conflict with another session or activity

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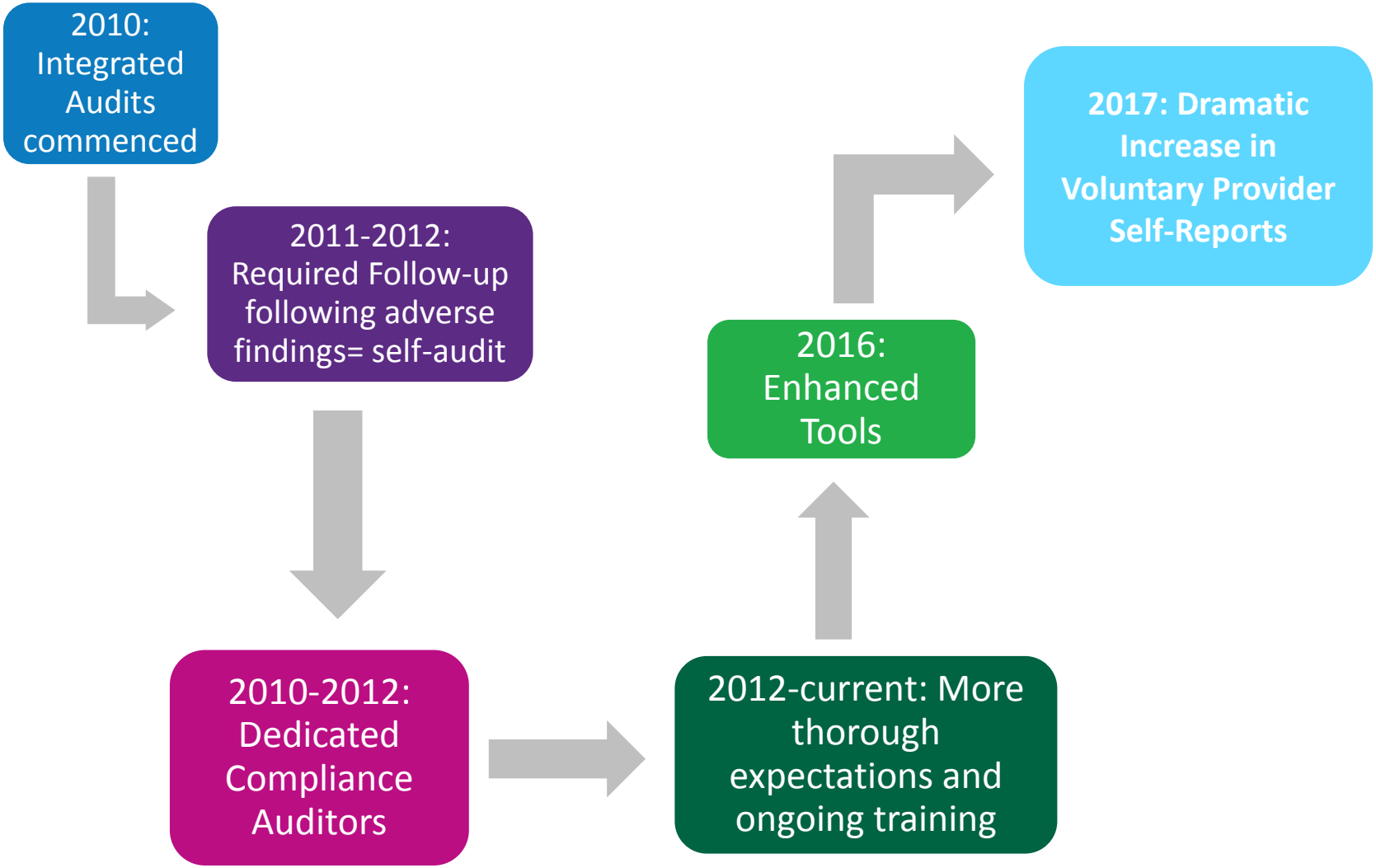
Self-Auditing

Evolution of the Self-Report



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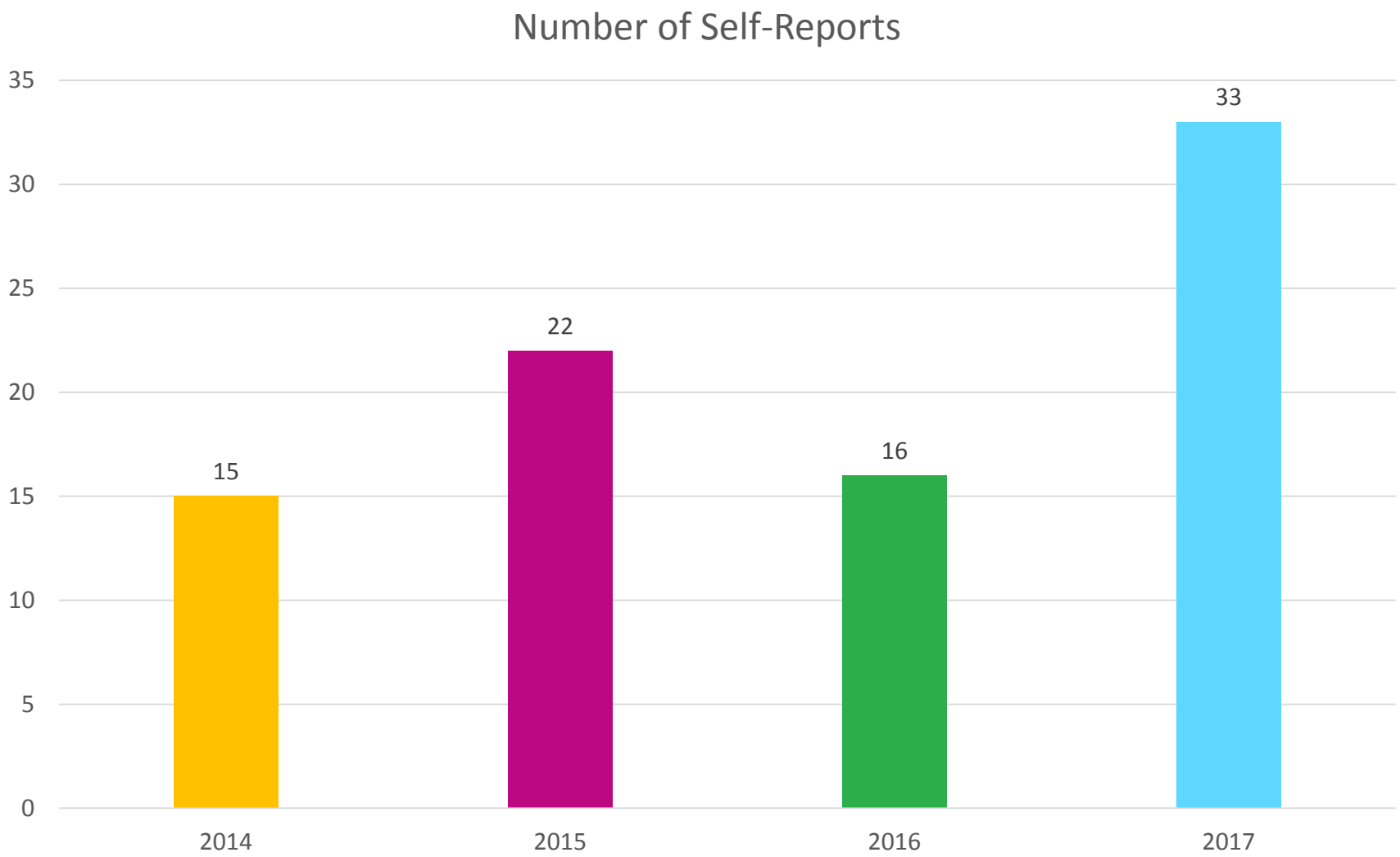
Self-Report Trends



Self-Auditing Requirement

- Magellan supports the Centers for Medicare & Medicaid Services (CMS) Compliance Program Guidelines which includes a component on provider self-auditing.
- All providers should develop a Claims Auditing Policy which includes a procedure and mechanism for oversight in this area.
- Self-auditing is a good tool to measure internal compliance and ensures compliance with MA regulations.

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Guidelines for Self-Audits

- ✓ Magellan's Compliance Program Audit Tool includes a requirement for providers to develop and maintain a Claims Auditing Policy.

- ✓ A strong self-auditing policy includes the following components:

  a) Comparison of claims or potential claims to medical records
  b) Regulatory and contractual requirements
  c) Frequency of claims audits
  d) Number or percentage of claims or records to be reviewed
  e) How records are selected
  f) Procedure when errors are identified
  g) Prospective, Retrospective, or both

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Self-Audits

- The CMS Comprehensive Program Integrity Review of Pennsylvania in 2014 identified "Expanded Use of Provider Self-Audits" as one of four *Effective Practices*. There are two types of self-audits:
  - Provider-initiated Self-Audits
  - Targeted provider Self-Audits

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DHS Self-Audit Protocol

- Due to lack of uniformity of provider audits submitted for purposes of self-disclosure, DHS established a protocol for self-audits in 2001.
- This protocol is for MA providers that participate in both the fee-for-service and managed care environments. The protocol provides guidance to providers on the preferred methodology to identify and return inappropriate payments.
- The DHS "Pennsylvania Medical Assistance Provider Self-Audit Protocol" is posted on their website: http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/

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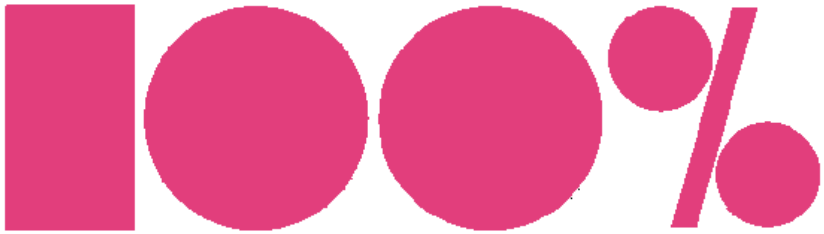
DHS Self-Protocol Types

The three types of provider self-audits include:

Option 1 - 100 Percent Claim Review

A provider may identify actual inappropriate payments by performing a 100 percent review of claims. This option is recommended in instances where a case-by-case review of claims is administratively feasible and cost-effective.



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DHS Self-Protocol Types

Option 2 - Provider-Developed Audit Work Plan

➢ **AUDIT WORK PLAN MUST BE SUBMITTED TO MAGELLAN FOR PRE-APPROVAL PRIOR TO CONDUCTING THE AUDIT**

- When it is not administratively feasible or cost effective for the provider to conduct a 100 percent claim review, a provider may identify and project inappropriate payments pursuant to a detailed work plan submitted to the MCO for approval.
- The proposed work plan should also include an overview of the issues identified, the proposed time period of the review, including the reason for the time period selected, and the corrective action taken to ensure that the errors do not reoccur in the future.

DHS Self-Protocol Types

Option 3- Statistically Valid Random Sample (SVRS)

➢ **AUDIT WORK PLAN MUST BE SUBMITTED TO MAGELLAN FOR PRE-APPROVAL PRIOR TO CONDUCTING THE AUDIT**

- Extrapolation allows auditors the ability to statistically infer that overpayments found in a subset of data (a statistically representative random sample) is representative of the overpayments found in the larger population of claims.
- Extrapolation may only be applied to a SVRS. Magellan uses RAT-STATS, a CMS and HHS-OIG recognized software application, to determine SVRS. This application will be used to evaluate the provider's data when extrapolation is used.

Self audit completed ✓ What's next?

- Contact the assigned Claims and Compliance Auditor in your county to make them aware that your audit is complete. They will send you the Provider Self-Disclosure Spread Sheet and the link to DHS.
- Please include:
  - Provider Self-Disclosure Spread Sheet (as an Excel document)
  - Investigation Summary – Be sure to include:
    - How the issue was initially identified
    - Who conducted the audit
    - Type of audit (Option 1, 2, or 3)
    - Who investigated the incident and the name of the staff person involved (if applicable)
    - The time frame audited
    - Describe the process of the audit
    - The results of the audit and investigation (if applicable)
    - Actions taken to prevent reoccurrence (i.e. staff education, corrective action plan, termination, etc. If there is a termination, please include the date of termination.)

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Resources

Magellan's Dedicated Compliance Website

http://magellanofpa.com/for-providers-pa/fraud,-waste-abusecompliance.aspx

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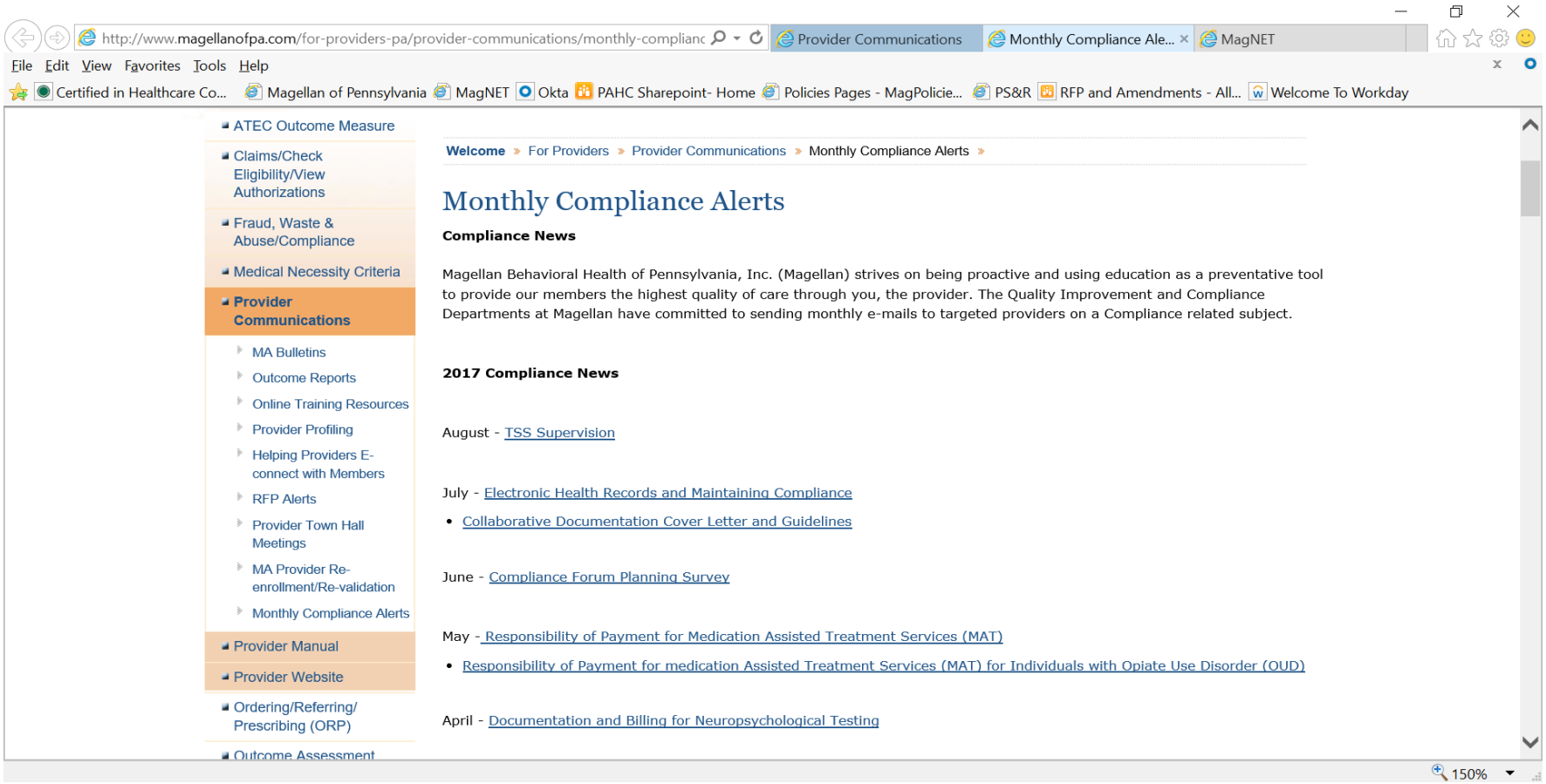
Magellan E-mail Blasts

http://www.magellanofpa.com/for-providers-pa/provider-communications/monthly-compliance-alerts.aspx



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Other Resources

- *Centers for Medicare and Medicaid Services (CMS) Program Integrity Behavioral Health Toolkit:* www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/behavioral-health.html?utm_source=Behavioral+Health+-+March+2016&utm_campaign=Behavioral+Health-+Mar+2016&utm_medium=email
- *The Centers for Medicare and Medicaid Services (CMS)* developed guidelines in 2005 to assist providers in developing and implementing effective compliance programs: www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/compliance.pdf
- *Verification of Licensure*. Professional licensing protects the health, safety and welfare of the public from fraudulent and unethical practitioners. Verification of licensure should be performed for any health care professional. Licensure status and disciplinary history can be viewed online at: www.licensepa.state.pa.us/

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Questions?

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