2020 Provider Compliance Forum

November 2020

Magellan HEALTHCARE SM

Presenters

- Tina Davis, M.Ed., CFE Magellan Claims and Compliance Auditor
- Patty Marth, CFE, Magellan Senior Claims and Compliance Auditor
- Holly McQuiggan, Magellan Compliance Coordinator
- Andrew Searles, Magellan Claims and Compliance Auditor

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If you have any questions throughout the presentation, please submit them to: Tina Davis

TMDavis1@magellanhealth.com

Please look out for an FAQ document in response to your submitted questions.

Agenda

- Positive outcomes
- 2020 audit trends
- Documentation Requirements
- Compliance Interviews
- Self-auditing
- Telehealth-COVID -19
- Resources

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Positive Outcomes

Patty Marth, CFE

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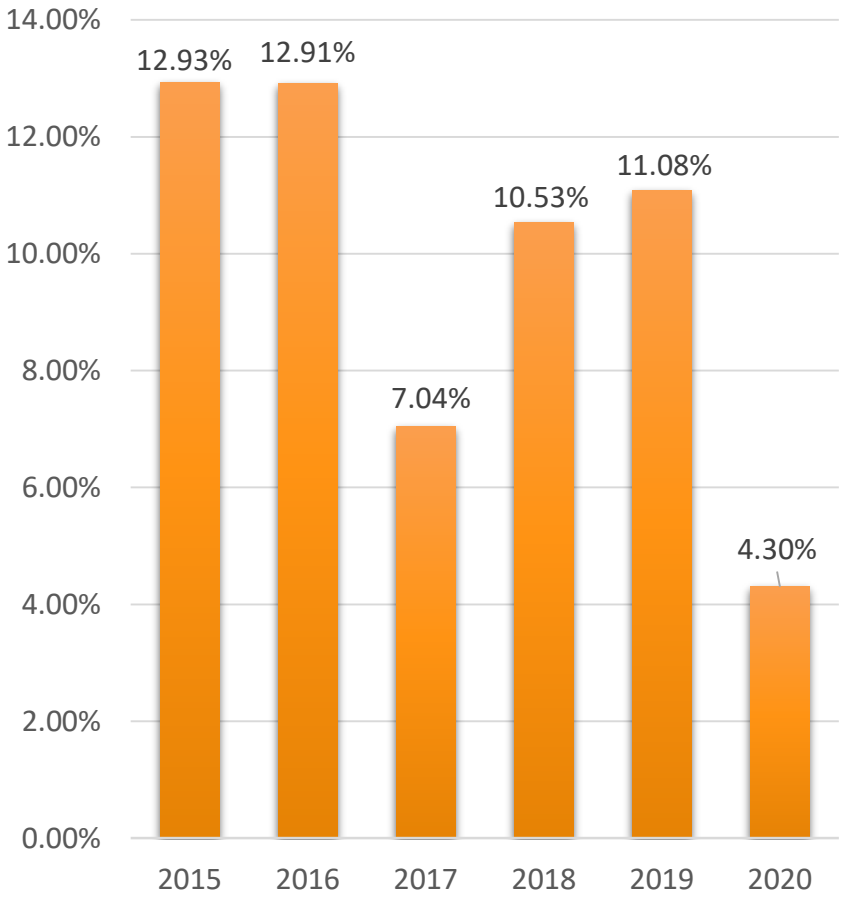
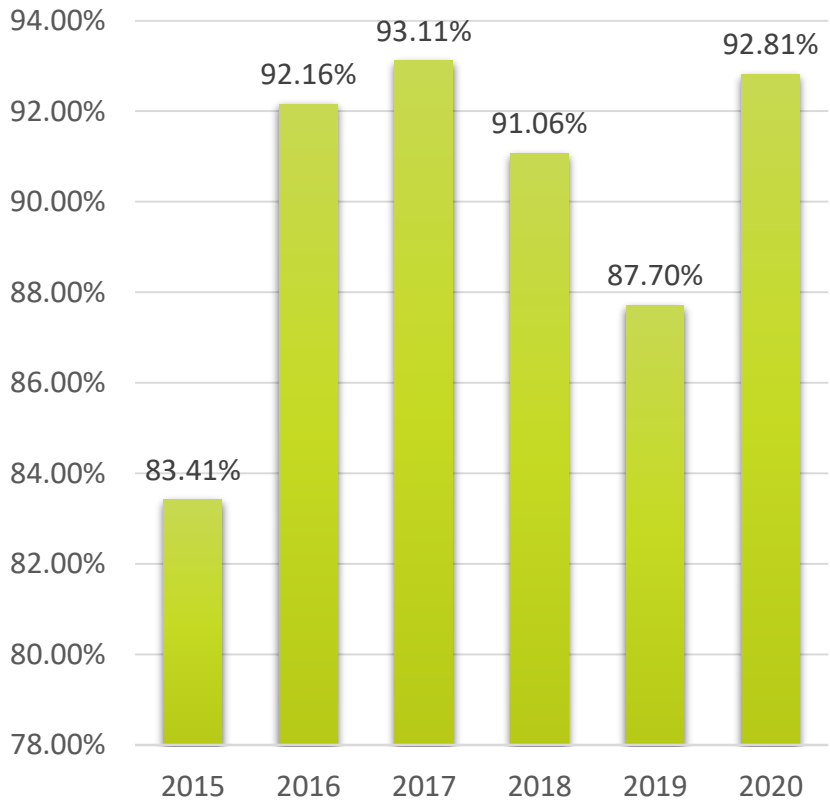
Positive outcomes 2015- Q3 2020

Error Rates



Compliance Program Scores



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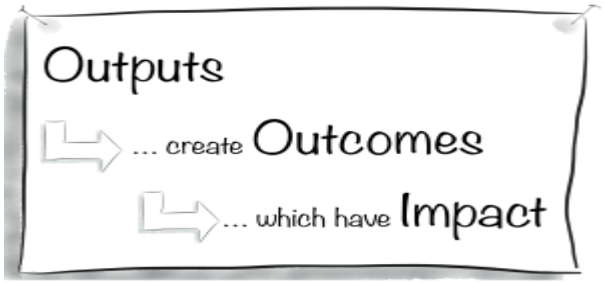
Positive outcomes

- Examples Include:
  - Compliance hotline information hanging on posters throughout a facility.
  - Include an assessment or quiz attached to all required compliance trainings. Set a minimum standard for passing.
  - Establish a “culture of compliance” (i.e. host an Anti-Fraud week)
  - Require board of directors to complete an annual compliance training. Compliance is a standing agenda for all board meetings.
  - Develop and publish an annual corporate compliance report. This practice upholds a provider’s commitment to comply with Medicaid standards/regulations.
  - Utilize a service verification process (random calls or letters to members and/ or guardians to verify that services were delivered as indicated).
  - Utilize GPS technology on company-owned vehicles or Ipads.
  - Some providers that utilize EHR systems deactivate short-cuts such as cutting-and-pasting from a prior note.



2020 Audit Trends

Tina Davis, CFE

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Most Common Overall Audit Trends

- Missing documentation
- Non-compliance with minimum documentation standards (please reference Magellan provider handbook supplement)
- Treatment/ service plan requirements
- Adherence to Magellan rate sheet/ reimbursement schedule
- Duplicate and unbundling of services
- Rounding
- EHR time stamps
- Start and end times
- Documentation does not support the length of the session
- Correct place of service code
- Third party liability billing (when Magellan Medicaid is not the primary payer)
- Billing correct service location in addition to the billing location, as these may not be the same.
  - The NPI listed should reflect the agency's financial/ business/ main location.
  - The address should match the agency's financial/ business/ main location.

Outpatient Audit Trends

- Duplicate progress notes & treatment plans - copying & pasting content or sections from one progress note or treatment plan to another
- 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)
- Outpatient group therapy exceeds maximum number of participants (12 persons; or 15 with an approved waiver)
  - PA Code 55 § 1153.2
  - PA Code 55 § 1223.2
- Providers must implement a sound tracking mechanism for group participation including arrival and departure time as well as structured breaks. This is individualized by each participant's actual attendance and must correlate to the billable units. Only face-to-face time is billable for all outpatient services.
- Per § 5200.31, treatment plans must be reviewed and approved by a psychiatrist.

BHRS/IBHS Audit Trends

- Documentation does not support units billed
  - BSC: excessive time spent completing paperwork; Documentation does not support the length of the session
  - TSS: excessive community time without supporting documentation
- Non-billable function of MT services which requires direct contact with the family or other involved professionals.
- Encounter forms- blank encounter forms should **NOT** be signed by parent/guardian
- Billing proper procedure code/modifier combination for ABA services
- Billing correct unit definition for level of service
- BHRS age requirements

CPS/CRS 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, with the **member present**.
- Documentation does not support the units billed (i.e. 1-2 sentences for 4 hours of services)
- Payment ***will not*** be made 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.
  - Text messages and social media correspondence.

Case Management Services

- Rounding is allowed for Mental Health Case Management but must be the better part of a unit, which is 8 minutes or more.
- Rounding is not allowed for D&A Case Management
- Documentation does not support the units billed (i.e. 1-2 sentences for 4 hours of services)
- Payment ***will not*** be made for the following:
  - Services that have no therapeutic or programmatic content (waiting for member).
  - Administrative costs, such as those resulting from agency staff meetings and record-keeping activities.
  - Time spent **traveling or transporting** members is not directly reimbursable and must be separated out on the documentation.
  - Text messages and social media correspondence.

Center of Excellence

- Lack of encounter data to support monthly APA payment
- Documentation standards
- Documentation at discharge
- Face to face contact needs to be one time a month & within 30 days
- Limited face to face contact
- Limited engagement with members
- Limited linkages to community support
- Limited collaboration

24 Hour Level of Care Audit Trends

- If a member is not engaged in any therapeutic activities for an entire day and/or no therapeutic interventions are documented (i.e., member sleeping all day),
- Billing for date of service when member is not present (i.e., home passes/"therapeutic leave", AWOL/AMA discharge, member goes to the medical hospital or transfers to another LOC or another program, etc.), unclear or undocumented return times or leave times per Magellan Bed Hold policy.
- If a member is not engaged in any therapeutic activities for an entire day and/or no therapeutic interventions are documented (i.e., member sleeping all day), payment for that date would be subject to retraction.
- Progress notes must document interventions used, the individual's response, and tie back to the member's treatment plan goals. Interventions should be individualized and specific; use of vague language such as "Listened and provided positive feedback" or "watched a video on substance abuse" would not be considered sufficient. Group therapy notes must include individualized information for each participant (their behavior during group session, level of participation, response to interventions/information provided or discussed, etc).
- Clear and concise documentation is required for substantiating payments made to the provider, and must meet the required standards as set forth in the Magellan Provider Handbook Provider Handbook Supplement for HealthChoices' Program Providers (pgs. 54-55). If no documentation is found for a date of service that was billed/paid, or none of the progress notes for the day meet the documentation standards, payment for that date is subject to retraction.
- Daily progress note are present for the date of service billed. Progress notes follow documentation standards per Magellan Provider Handbook Provider Handbook Supplement for HealthChoices' Program Providers (pgs. 54-55)

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
- P&P regarding responding to and reporting of compliance concerns includes:
  - 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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TMDavis1@magellanhealth.com

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Documentation Standards

Andrew Searles

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Documentation Standards

In addition to serving as a legal record of services rendered, the documentation within each member's health record serves many purposes. It allows healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time; facilitates communication and continuity of care among the physicians and other healthcare professionals involved in the patient's care; ensures accurate and timely claims review and payment; promotes appropriate utilization review and quality of care evaluations; can be used for research and education; and finally serves as evidence that the services were provided as billed to a payer. Magellan has established minimum record-keeping requirements which align with Pennsylvania Medical Assistance regulations. Specifically:

- *The record shall be legible throughout.*
- *The record shall identify the patient on each page.*
- *Entries shall be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be counter signed by the responsible licensed provider. Entries should also contain the printed provider name accompanied by their credentials.*
- *Alterations of the record shall be signed and dated.*
- *The record shall contain a preliminary working diagnosis as well as a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based.*
- *Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's records shall have a notation to this effect.*
- *The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment*
- *The record shall contain the results, including interpretations of diagnostic tests and reports of consultations.*
- *The disposition of the case shall be entered in the record.*
- *The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.*

Documentation Standards

The documentation of treatment or progress notes for all services, **at a minimum**, must include:

- *The specific services rendered;*
- *The date that the service was provided;*
- *The name(s) of the individuals(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 visit, any change in diagnosis, changes in treatment and response to treatment; and*
- ***The actual time in clock hours that services were rendered. For example: the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 AM - 11:00 AM.***

Documentation Standards

Some important reminders about documenting start and end times:

- The start and end times should represent the actual billable/ face-to-face time with the member. Some providers utilize an Electronic Health Record system in which the times default to the appointment time. This does not account for late arrival or other variables during the session that may affect timing. The rendering clinician must ensure that they update the start and end times to reflect the actual billable time.
- Documentation time (writing a progress note) is not billable time unless a provider is adhering to the *Collaborative Documentation* requirements
- The session time must be represented by the start and end time in actual clock hours. Documenting the duration of the session (i.e. “30 minutes”) is not sufficient.
- In transitioning from paper records to an Electronic Health Record (EHR), providers should ensure that their EHR vendor can support all of the PA Medicaid HealthChoices documentation requirements.

While not a comprehensive list, for your reference, here are some additional regulatory citations related to documentation:

- MA Bulletin #28-99-02, 29-99-01 (http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_004450.pdf)
- MA Bulletin #99-97-06 (http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005037.pdf)
- MA Bulletin #29-02-03, 33-02-03, 41-02-02 (http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_006952.pdf)
- PA Code, Title 55 (http://www.pacode.com/secure/data/055/055toc.html)

Documentation Standards-Collaborative Documentation

- The Office of Mental Health and Substance Abuse Services (OMHSAS) first published documentation that supports the use and reimbursement of Collaborative Documentation (CD) in 2014. Then in 2015, following the establishment of a workgroup to better define and support the implementation of the growing practice of CD, additional information and guidance was issued. In response, Magellan sent an e-mail blast in July, 2015 to its provider network supporting the OMHSAS guidelines, which at the time centered on Peer Support Services.

- On February 20, 2020, following the expanded use of CD, OMHSAS distributed updated correspondence on CD's use in behavioral health services in Pennsylvania. OMHSAS reported that they do not intend to develop additional standards, training or regulatory requirements. CD continues to be an optional therapeutic activity/ model that should be used at a provider's discretion. Each provider can make the decision based on the services provided if CD is appropriate for the service and the individual receiving care.

- In order to bill for the time spent working collaboratively with a member on documentation (including service plans and progress notes), providers must be compliant with these expectations. Documentation that does not follow these essential elements is not a billable activity and is considered to be part of the administrative cost included in the rate.

- CD also does not replace any of the required documentation elements within the PA regulations, MA bulletins and Magellan's Provider Handbook Supplement.

https://www.magellanofpa.com/media/5830/collaborative-documentation-cover-letter-and-guidelines_12015.pdf

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Documentation Standards-Collaborative Documentation

Magellan fully supports the OMHSAS position and guidance on Collaborative Documentation. We require that the below elements be met in order to bill for the time spent working collaboratively with a member on documentation:

1) Providers must have specific policy/ procedures in place for using CD which includes training for staff and ongoing supervision focused on CD.

2) The session must be face-to-face (there is an allowance for CD provided via Telehealth during the COVID-19 federal emergency).

3) CD is an interactive approach. The individual must be engaged in the process by providing input and perspective.

4) CD can be used in the assessment process, service planning and the writing of progress notes.

5) CD is an *Intentional Therapeutic Technique* to engage the individual to develop their objectives and support their goals.

6) Providers must define CD to the individual so they are FULLY informed of the process and may choose to participate or not. If an individual declines, the practitioner may NOT mandate CD.

7) CD is a highly engaged conversation through shared narrative between the individual and the provider to assure that both are of the same understanding with regard to what was accomplished during the session and what the next steps are that supports the individual's treatment/ recovery plan.

8) Documentation must clearly indicate that it was written collaboratively with the individual (one recommendation is to add a check-box to progress note templates).

9) CD must occur within the scheduled time of the session. For example, if the scheduled session is 3:00 - 4:00 PM, the rendering provider can't ask the individual to stay an additional 15 minutes to work on the documentation. It must be completed by 4:00 PM.

10) CD may not be used every session even if a member agrees with the process during previous sessions. For example, if a provider is meeting with an individual in the community, it might not be appropriate to utilize CD due to confidentiality. Or if an individual is agitated or in crisis during a particular session, it may not be appropriate or beneficial at that time. CD should be utilized on a case-by-case and session-by-session basis.

Compliance Interviews

Andrew Searles

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Compliance Interviews

- As another part of the Compliance and Claims audit process, in order to gain knowledge on the agency's compliance culture, the claims/compliance auditor may have staff answer compliance related questions to the best of their ability.
- Responses are for educational purposes only and names are not included on the survey.
- Ensure all sections of the survey are completed.
  - General Compliance
  - Electronic Health Record
  - Telehealth
  - Community- Based

- If any are non-applicable put N/A. Do not leave sections blank.
- Surveys will be sent out to providers along with the audit confirmation letters.
- Completed surveys are due one week prior to the audit and are to be emailed to the appropriate Claims/Compliance Auditor.

Self-Auditing and Self-Reports Workflow Review

Tina Davis, CFE

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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. A strong self-auditing policy includes the following components:
  - Comparison of claims or potential claims to medical records
  - Regulatory and contractual requirements
  - Frequency of claims audits
  - Number or percentage of claims or records to be reviewed
  - How records are selected
  - Procedure when errors are identified as well as procedure to ensure errors do not continue

Self-auditing requirement

- Self-auditing is a good tool to measure internal compliance and ensures compliance with MA regulations.

- 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

Self-auditing requirement

- 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/

Self-auditing requirement

The three types of provider self-audits include:

- *Option 1 - 100 Percent Claim Review*
- *Option 2 - Provider-Developed Audit Work Plan*
- *Option 3- Statistically Valid Random Sample (SVRS)*

For options #2 and 3, the audit work plan must be submitted to Magellan for pre-approval prior to conducting the audit*

Self-audits- Magellan workflow

- Submit materials to: PAHCSelfreport@magellanhealth.com
- Please include:
  - Provider self-disclosure spreadsheet (as an excel attachment)
  - 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)

Self-audits Identified Trends

- Missing investigative summary
- Lack of claims detail (i.e. missing claims numbers)
- Lack of claims detail (i.e. missing member ID)
- Claims report should be submitted in an excel spreadsheet, not as a PDF or hard copy
- **New column added to excel tracking sheet is member DOB**

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Telehealth-COVID-19

Patty Marth, CFE

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Telehealth Guidelines Related to COVID-19

- On March 15, 2020, the Office of Mental Health and Substance Abuse Services (OMHSAS) issued a Memorandum to offer clarification regarding the ability of providers to render telehealth behavioral health services to Medical Assistance (MA) beneficiaries as a result of the emergency disaster declaration for COVID-19.
- This is an unprecedented challenge and Magellan is committed to working with providers on ensuring some flexibility in the highly regulated Medicaid space.
- Magellan fully supports the OMHSAS position for the preference for use of telehealth as a delivery method for medically necessary behavioral health services as ordered, referred, or prescribed by a provider or practitioner, that can be delivered effectively when the patient is quarantined, self-quarantined, or self-isolated due to exposure or possible risk of exposure to the COVID-19 virus.

Telehealth-COVID-19

Providers utilizing Telehealth in accordance with MA Bulletin OMHSAS-20-02 may do so during this state of emergency and waive the following requirements:

- Telephone only services may be utilized in situations where video technology is not available.
- Telehealth will allow the use of telephonic video technology commonly available on smart phones and other electronic devices.
- Staff trained in the use of the telehealth equipment and protocols to provide operating support are not required to be present while services are being rendered.
- Staff trained to provide in-person clinical intervention will not be required to be present with the individual while they are receiving services.
- There is no restriction on the type of Practitioner that may provide services through Telehealth. If the individual meets the criteria to render the services in accordance with the level of care specific regulations and bulletins, they may continue to do so during this state of emergency utilizing Telehealth.

Telehealth-COVID-19

Adherence to all other requirements still apply to the service being delivered as they would when delivered face-to-face. That includes but not limited to the following:

- Providers must continue to follow Magellan's Minimum Documentation Guidelines starting on page 54 of our Pennsylvania HealthChoices Handbook Supplement.
- For programs reimbursed fee-for-service, providers must continue to adhere to the Unit Definition/ Description on their Magellan Reimbursement Schedule in order to bill a unit of service (i.e. 15 minutes, 30 minutes). Rounding up is still never permitted.
- For all programs funded as a per diem (per day), the member must continue to be physically present in the facility in order to bill (outside of temporary therapeutic leave).
- Services must be provided in accordance with the member's Treatment/ Service/ Recovery Plan.

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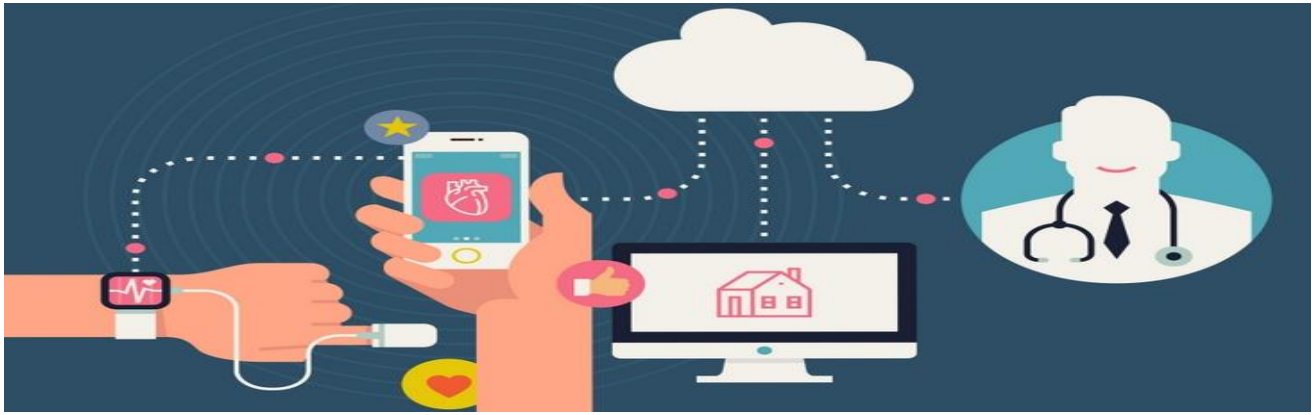
Telehealth-COVID-19

Additional documentation requirements when utilizing Telehealth in accordance with these guidelines includes the following:

- The documentation must indicate the mechanism for how services were delivered (i.e. Telehealth, phone, FaceTime, Skype, etc).
- The documentation must include the member's verbal consent to deliver services in this manner.
- The documentation must include the member's phone number that was utilized if applicable.

Telehealth-COVID-19

- Program requirements for the number or percentage of face-to-face contacts for various behavioral health services may be met with the use of telehealth.
- Any limits on the amount of service that can be provided through telehealth or telephone contact are temporarily suspended (i.e. the 25% annual limit on phone units in Peer Support will not apply during this state of emergency).
- Encounter Forms are only required for face-to-face contact. Thus, any sessions or services provided via Telehealth or telephone are signature exempt.
- Any requirements for face-to-face “Supervision” may be temporarily completed via phone or video. The Supervision note must reflect how the session was conducted.



Public Health Emergency Suspended Regulations List

- OMHSAS Memo regarding the Pennsylvania Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) announced the temporary suspension of certain regulatory provisions, effective August 14, 2020.

- The temporary suspension of the specified regulatory provisions is intended to support the health and safety efforts of the agencies and facilities by affording them the flexibility needed to focus on patient care in the most effective way possible.

- The suspension supports the continued and uninterrupted delivery of behavioral health services in the face of the challenges created by the COVID-19 pandemic.

- The regulatory suspensions announced will remain in place while the Governor's Disaster Proclamation remains in effect or such other time as DHS/OMHSAS directs.

- Specific details about service delivery should be documented in a member's record.

Public Health Emergency Suspended Regulations List

The temporary suspension of the specified regulatory provisions is intended to support the health and safety efforts of the agencies and facilities in protecting the individuals and families they serve and their workforce by affording providers the flexibility needed to focus on patient care in the most effective ways possible. The suspension supports the continued and uninterrupted delivery of behavioral health services in the face of the challenges created by the COVID-19 pandemic. The regulatory provisions that have been suspended address the following requirements for certain services:

- Timeframes for the completion of training and certification requirements for staff that provide certain services.
- Requirements for fire inspections and fire drills.
- Timeframes for assessments and treatment or service plan development and revisions.
- Timelines until which MA payments will be made to certain unlicensed providers.
- Requirements regarding living areas and other spaces in residential settings.
- Requirements regarding the right of individuals to receive visitors in a facility.
- Requirements pertaining to beneficiary signatures.
- Requirements regarding staff supervision.
- Requirements for staff-to-patient ratios.
- Requirements regarding the minimum hours of operation.
- Requirements regarding face-to-face interventions and services (thus allowing the use of telehealth).
- Requirements that only physicians can provide certain services (thus allowing other licensed practitioners to provide those services within their scope of practice).

pennsylvania DEPARTMENT OF HEALTH

Public Health Emergency Suspended Regulations List

- *The PHE Suspended Regulations Memorandum and Chart have been updated effective 10/22/20.*
- OMHSAS originally issued this memorandum on August 14, 2020, to inform BH-MCOs, County Mental Health/Intellectual Disability Offices and behavioral health providers that specified regulatory provisions in 55 Pa. Code Chapters 1151, 1153, 1155, 1223, 5100, 5200, 5210, 5221, 5230, 5310, 5320 and 5240 have been temporarily suspended during the COVID-19 disaster emergency declaration period.
- This memorandum has been re-issued to update signature requirements for treatment and service plans. The original memorandum issued on August 14, 2020, required that signatures of individuals be obtained for treatment and service plans that were created or updated during the disaster emergency declaration period within 60 days after the end of the disaster emergency declaration period. *This updated memorandum removes the requirement to obtain signatures within 60 days after the end of the disaster emergency declaration period.*
- ***Requirements for obtaining verbal consent and documentation of the verbal consent remain and must be included in the medical record for every occurrence of a new and updated treatment plan. Providers are strongly encouraged to obtain signatures electronically when possible.***

Resource Guide

Holly McQuiggan

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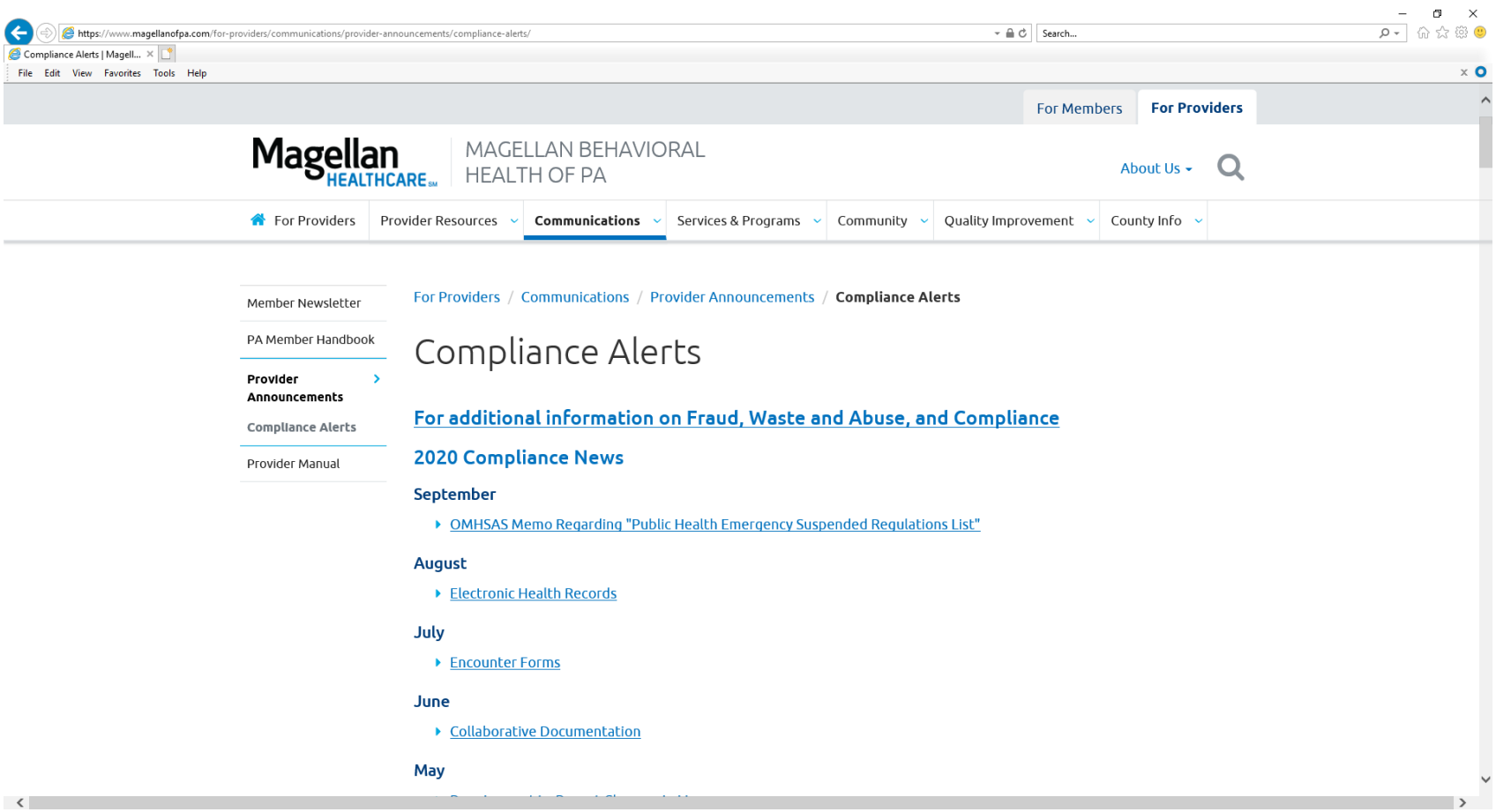
Compliance Alerts

https://www.magellanofpa.com/for-providers/communications/provider-announcements/compliance-alerts/



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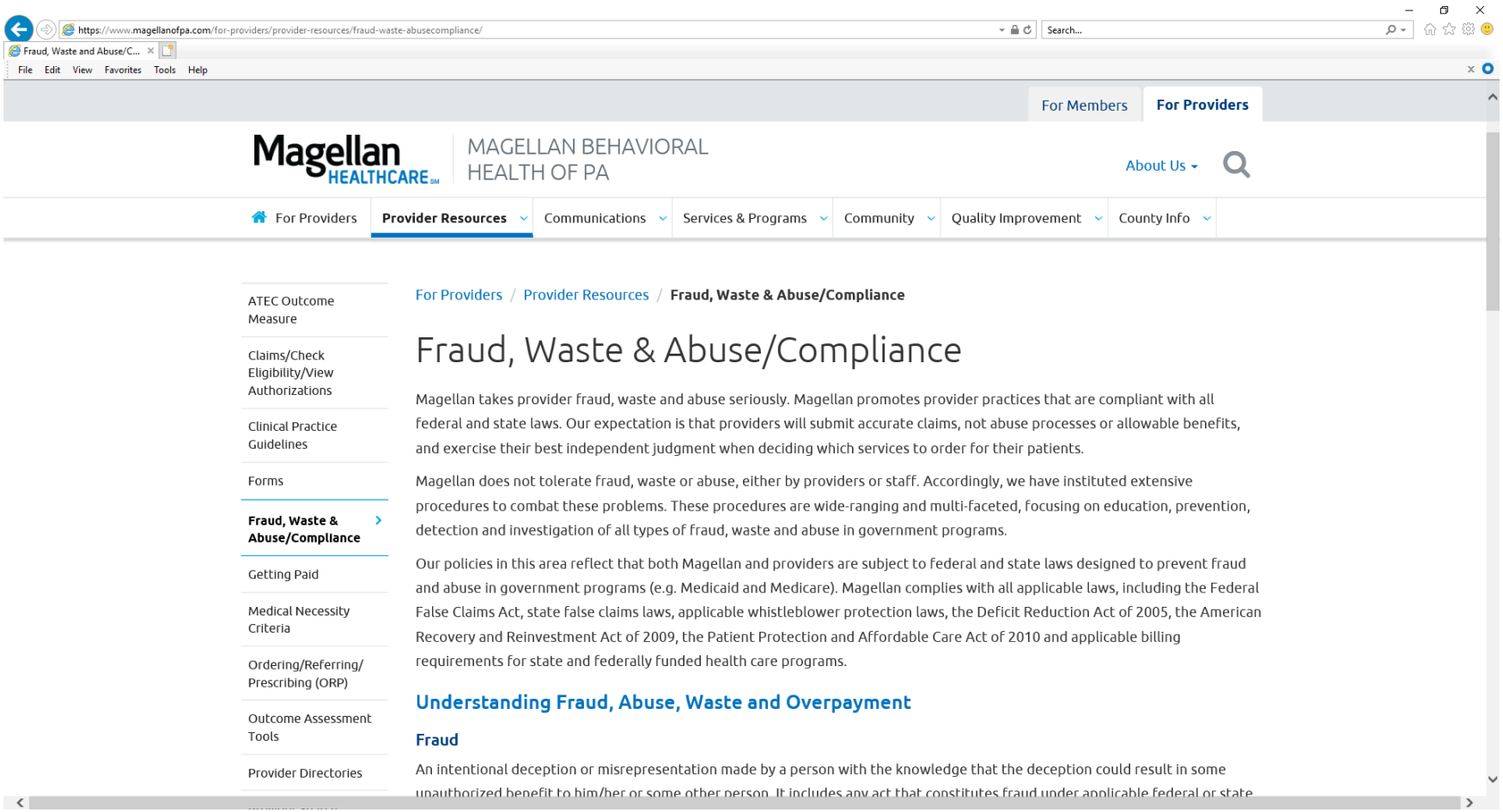
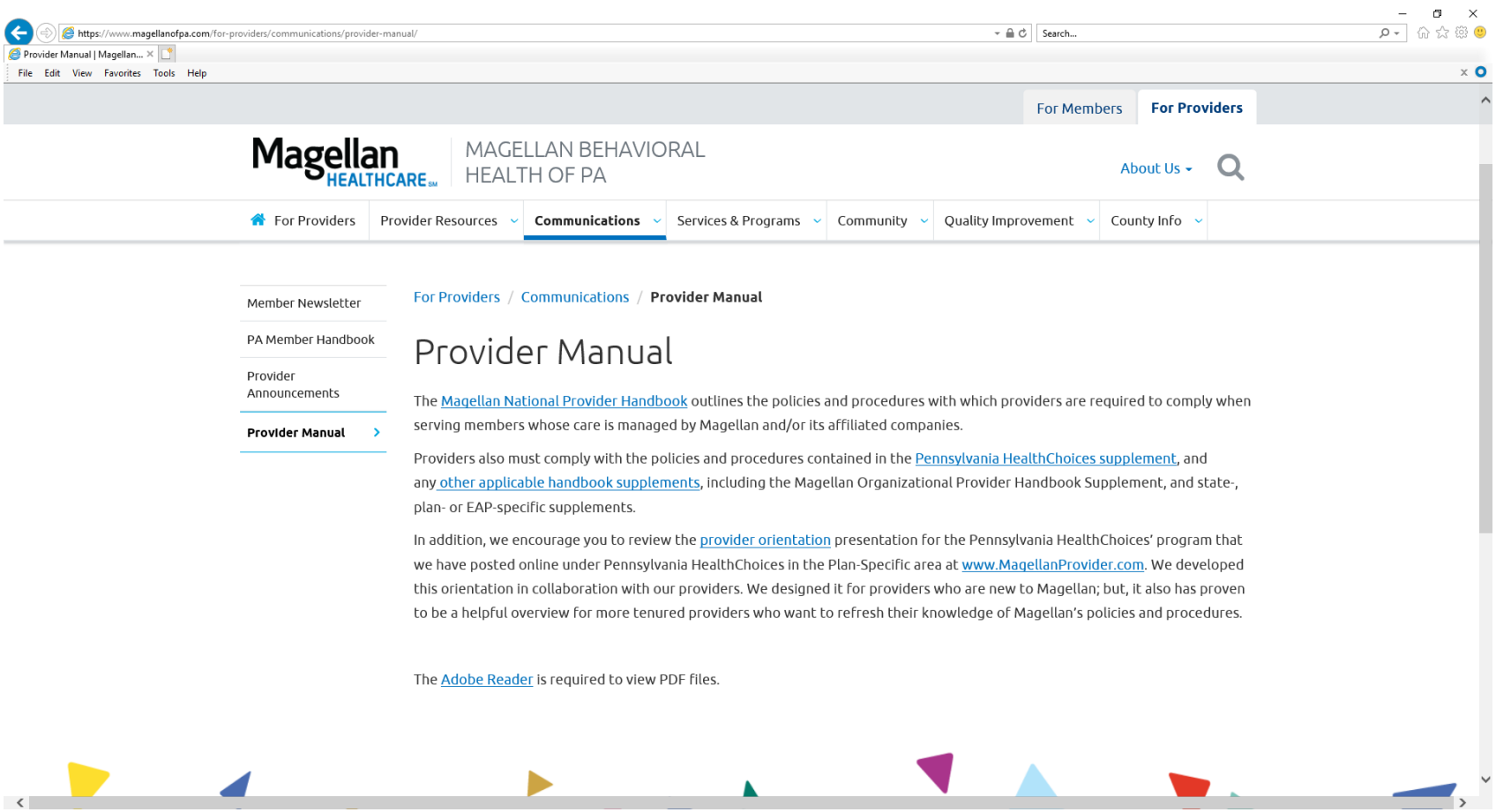
Fraud Waste Abuse

https://www.magellanofpa.com/for-providers/provider-resources/fraud-waste-abusecompliance/



Magellan Handbooks

https://www.magellanofpa.com/for-providers/communications/provider-manual/



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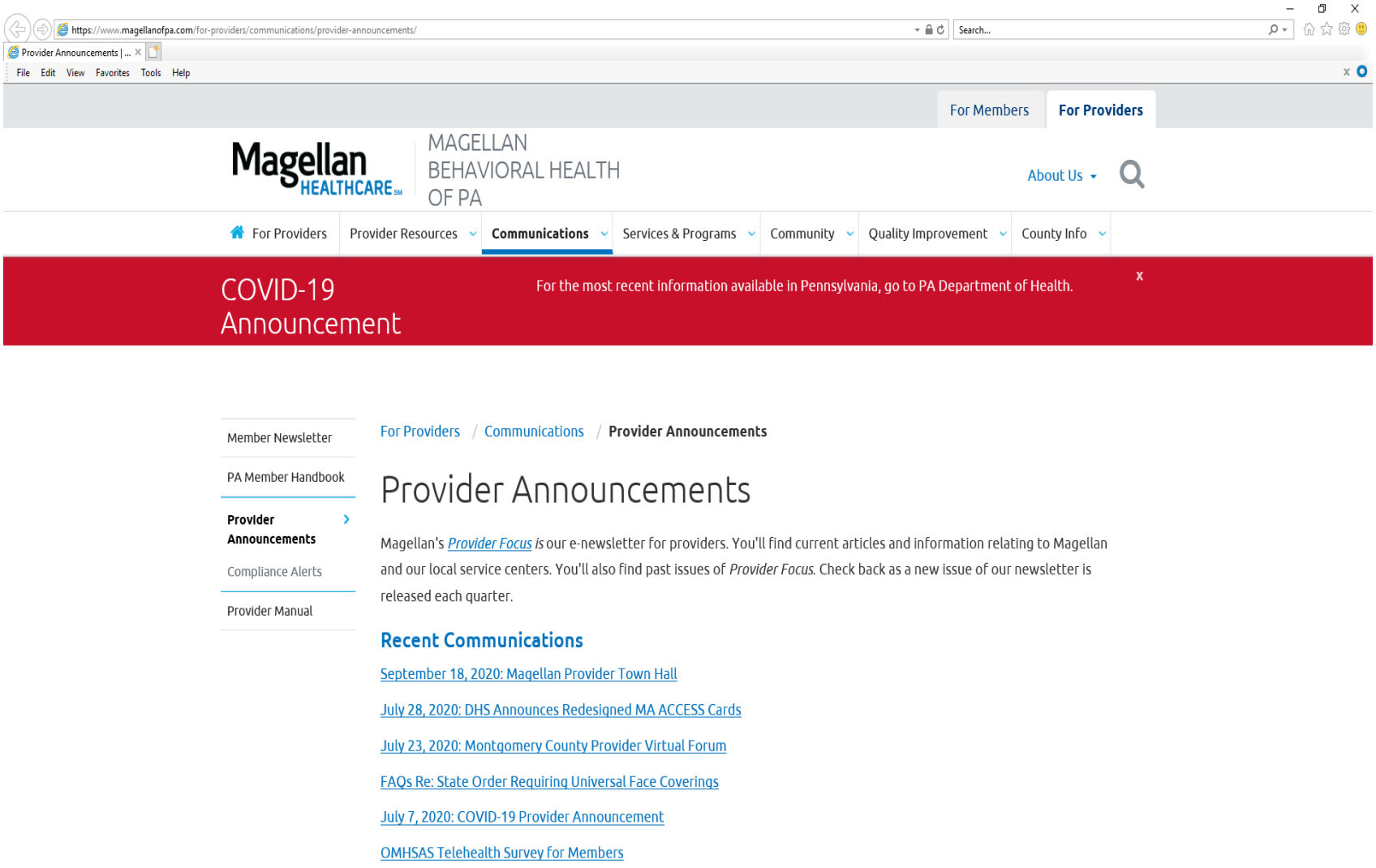
COVID-19 Announcements

https://www.magellanofpa.com/for-providers/communications/provider-announcements/



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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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We can not accomplish all that we need to do without working together!

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Confidentiality statement

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