Provider Compliance Forum- 2021

OCTOBER 15, 2021

PRESENTED BY: MAGELLAN BEHAVIORAL HEALTH OF PENNSYLVANIA, INC.

Magellan HEALTHCARE®

Meet Our Team

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CAMBRIA COUNTY

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ALL COUNTIES

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ALL COUNTIES

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COMPLIANCE AND CLAIMS AUDITOR
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SENIOR COMPLIANCE MANAGER/ PRIVACY OFFICER
ALL COUNTIES

Housekeeping

Introduction/ Housekeeping

- Magellan provides a focused Compliance Training for Providers annually
  - Prior trainings are posted on the Magellan of PA Compliance website page: https://www.magellanofpa.com/media/2717/trainings-and-education-compliance.pdf
- Today's training is being recorded
  - The Power Point and recording link will be sent to providers in an upcoming Compliance E-mail Blast and will be posted on our website
- All participants are muted. Please submit questions utilizing the Q&A feature in Zoom. Please do not use the Chat for questions.

Agenda

1. Positive Feedback
2. 2021 Audit Trends
3. Telehealth
4. 2022 Audit Plan
5. Confidentiality & Consent to Treat
6. Other Reminders/ Compliance Toolbox & Resources

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Positive Feedback

Remote Auditing

Thank you for your flexibility and willingness to adapt to remote auditing during COVID!

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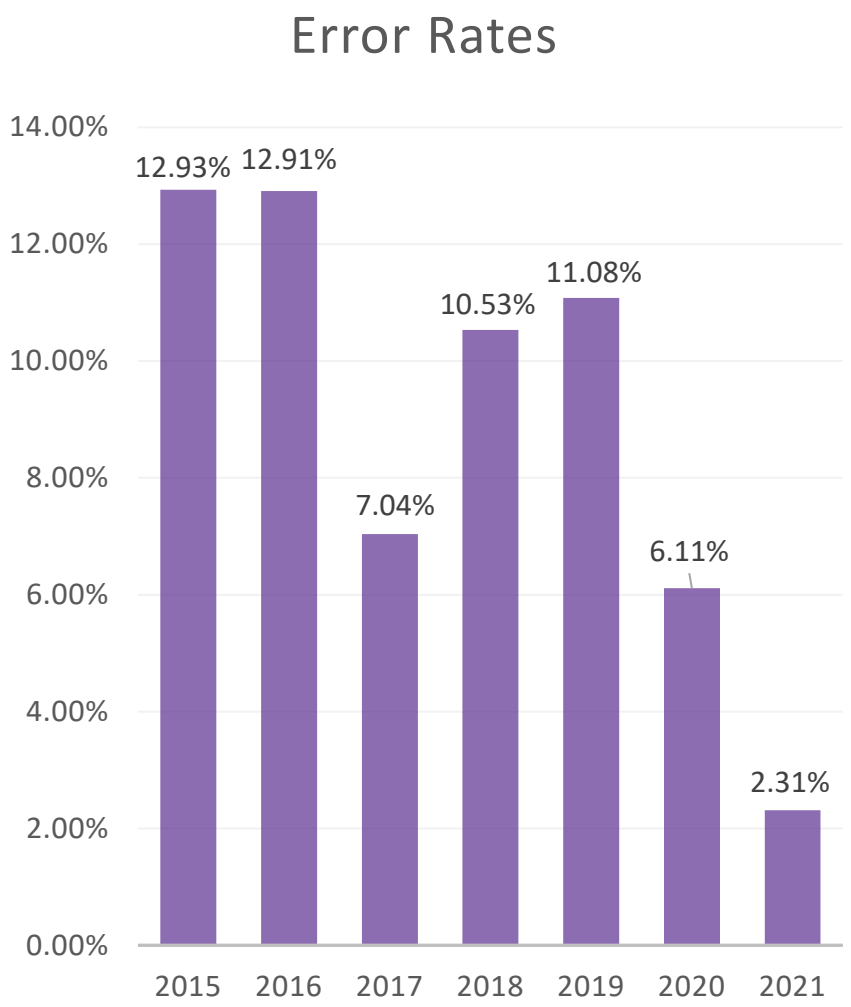
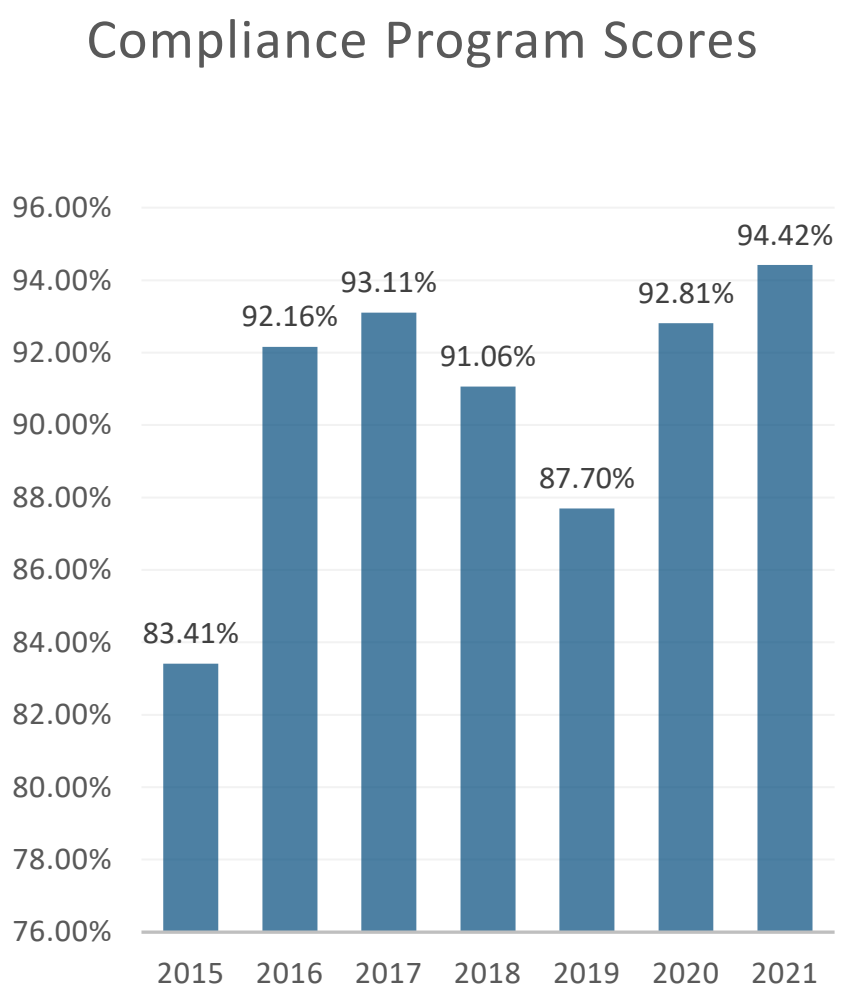
Positive outcomes 2015 - current





Provider Compliance Best Practices

- 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.
  - EHR systems that deactivate short-cuts such as cutting-and-pasting from a prior note.
  - Internal claims audit prior to claims being billed.

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2021 Audit Trends

Most Common Overall Audit Trends

- Missing documentation
- Charging out-of-pocket costs to members (i.e. for missed appointments)
- Non-compliance with documentation standards (please reference Magellan provider handbook supplement). Specifically:
  - Start and end times
  - Using credentials
  - Legibility
  - Error correction
- Treatment/ service plan requirements
- Adherence to Magellan rate sheet/ reimbursement schedule
- EHR time stamps
- Billing for non-billable or non-covered services
- 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.

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Mental Health 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 reflecting true time
  - MA Bulletin 99-97-06 and Magellan Provider Handbook (https://www.magellanprovider.com/media/1661/pa_healthchoices_supp.pdf)
- Per § 5200.31, treatment plan effective dates & required signatures
  - Within 30 consecutive calendar days following intake for individuals who continue to participate in the treatment process, a mental health professional or mental health worker under the supervision of a mental health professional, shall complete an assessment and initial treatment plan
  - The treatment plan shall be reviewed and updated at least every 180 days
  - The treatment plan shall be reviewed on an annual basis by the psychiatrist or advanced practice professional

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Drug & Alcohol Outpatient Audit Trends

- Outpatient group therapy exceeds maximum number of participants (10 persons; or 12 with an approved waiver)
  - 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.
- Group progress notes need to be individualized

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Peer Support/ Certified Recovery Services Audit Trends

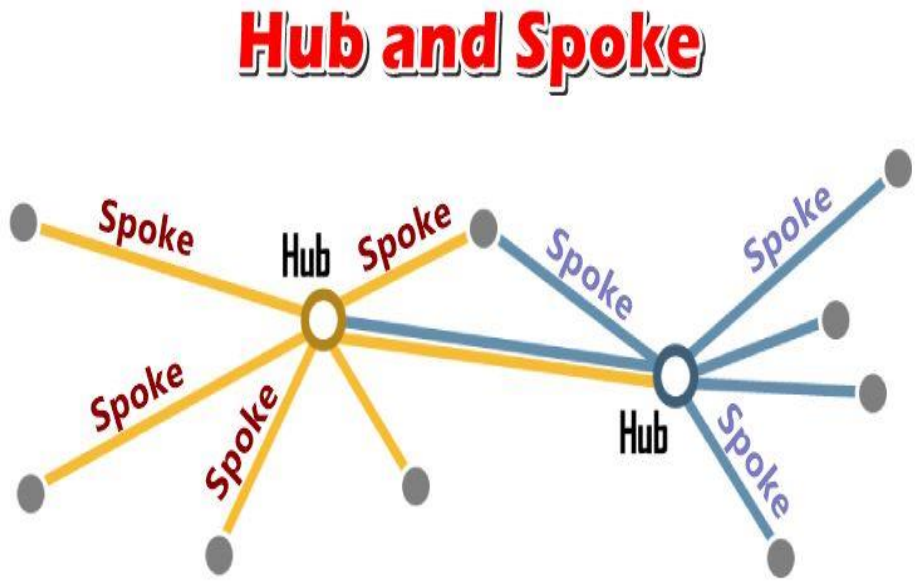
- Collateral Contact: services may be billed for the time that the CPS has face-to-face interaction (or telehealth/ telephone) with the individual's family, friends, service providers or other essential persons, with the **member present**.
- Duplication/ overlap of services
- Payment will not be made 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 up to the billable unit definition is allowed for Mental Health Case Management but must be the better part of a unit, which is 8 minutes or more.
- Rounding up to the billable unit definition is **not** allowed for D&A Case Management services.
- Matrix/Service plan updates
- Payment will not be made for the following:
  - Services that have no therapeutic or programmatic content (waiting for a member or leaving a voicemail)
  - 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

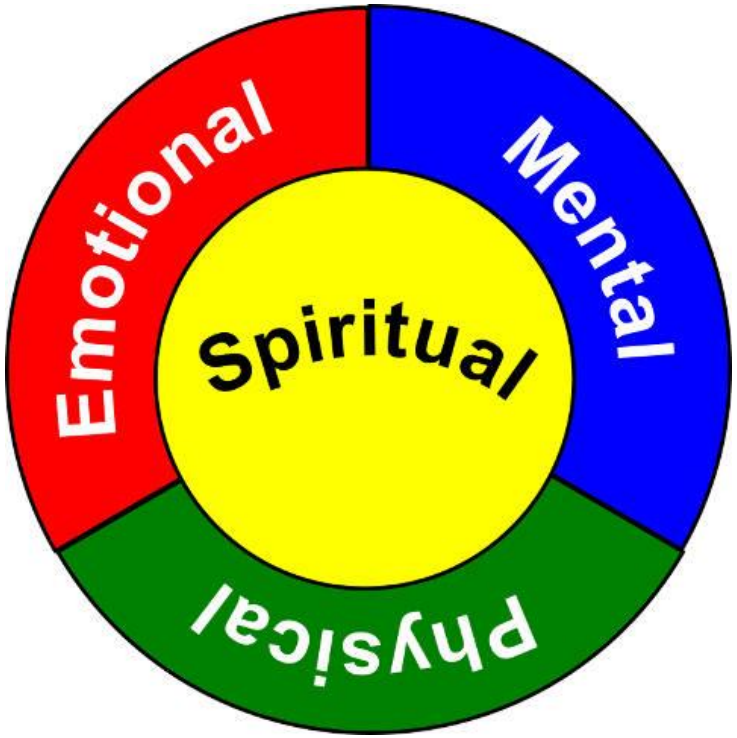
Center of Excellence (COE) Audit Trends

- Non-compliance with documentation standards (please reference Magellan provider handbook supplement- https://www.magellanprovider.com/media/1661/pa_healthchoices_supp.pdf)
- Documentation of discharge
- Limited engagement with members
  - Face-to-face contact is required at least once monthly & within 30 days of intake
- Limited linkages to community support
- Limited collaboration
  - Central hub for care coordination and referrals



Federally Qualified Healthcare Clinic (FQHC) Audit Trends

- Documentation standards
  - https://www.magellanprovider.com/media/1661/pa_healthchoices_supp.pdf
- Documentation at discharge
- Limited collaboration
- Treatment planning
  - Treatments as well as the treatment plan shall be entered in the record.
- Limited linkages to community support



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24-Hour Level of Care Audit Trends

- Billing for dates of service when the 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): unclear or undocumented return/ leave times per PA MA regulations and Magellan's 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.
- 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' 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 notes must be present for each date of service billed. Progress Notes/ Daily Entries must document the interventions used, the individual's response, and relate to the 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.
- For additional information, please reference Magellan's March 2020 compliance e-mail blast

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Compliance Program Audit Trends

- Policy or 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&Ps
- Collaborative Documentation Policy
- Compliance is an element of the employee's evaluation
- 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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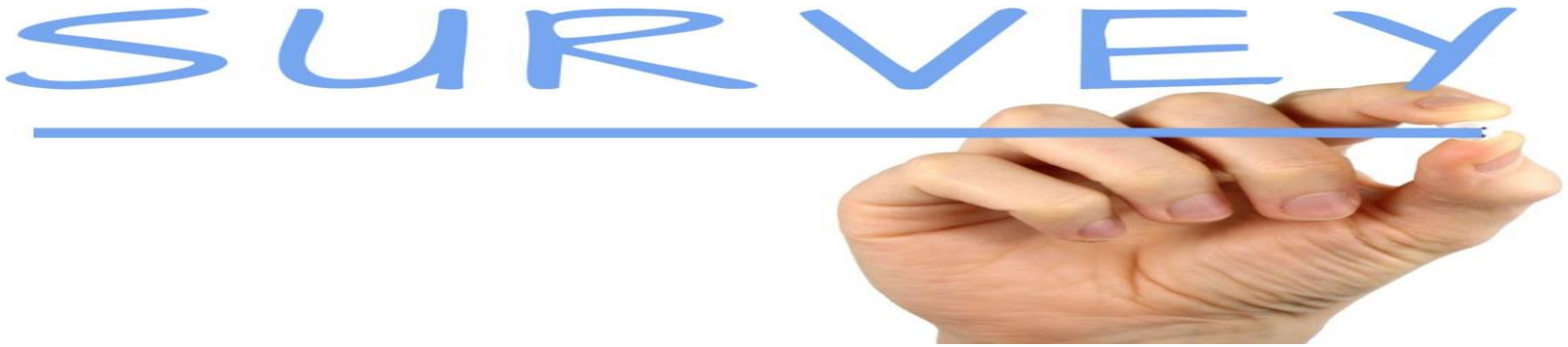
Compliance Survey Audit Trends

- Knowledge of external resources to report FWA
  - MCO
  - County
  - State
- Legal consequences for FWA
- Agencies compliance officer
- Not completing the entire survey
- Understanding what is collaborative documentation



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Telehealth Audit Trends

- Adherence to all other regulations and requirements still apply to the service being delivered as they would when delivered face-to-face. That includes but is not limited to the following Magellan's Minimum Documentation Guidelines starting on page 54 of our Provider 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 never permitted.
- Services must be provided in accordance with the member's Treatment/ Service/ Recovery Plan.
- Additional documentation requirements when utilizing Telehealth includes the following:
  - The documentation must indicate the mechanism for how services were delivered (i.e. telehealth, phone).
  - The documentation must indicate the telehealth platform that was used if applicable (i.e. zoom).
  - 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

Telehealth

On August 26, 2021, The Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS) announced that Bulletin OMHSAS-21-09, titled "Guidelines for the Delivery of Behavioral Health Services Through Telehealth" was issued and posted on the Department's website.

The purpose of the bulletin was to update the guidelines for payment of behavioral health services delivered using telehealth technology previously issued in *OMHSAS-20-02 Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services.* The updated guidelines include the following key changes from OMHSAS-20-02:

1. Permits the delivery of services through audio-only without video, in limited circumstances, if consistent with Pennsylvania regulations and federal requirements, including guidance by the Centers for Medicare & Medicaid Services with respect to Medicaid payment and the US Department of Health and Human Services Office of Civil Rights with respect to the Health Insurance Portability and Accountability Act (HIPAA) compliance.

2. Expands the use of telehealth service delivery to include drug and alcohol providers licensed by the Pennsylvania Department of Drug and Alcohol Programs for services paid for by the Medicaid (MA) program.

3. Expands the use of telehealth to include services provided by unlicensed mental health staff working through a licensed provider agency including unlicensed master's level therapists, mental health targeted case managers, mental health certified peer support specialists, certified recovery specialists, and drug and alcohol counselors (as defined in 28 Pa. Code §704.7(b)) as allowable for in-person services delivery in the MA Program.

4. Permits the delivery of services through telehealth in community settings.

5. Removes the requirement for providers to submit attestations prior to initiating the delivery of services through telehealth.

House Bill 1861

House Bill 1861 amends The Administrative Code of 1929 to provide for temporary regulatory flexibility authority. The bill temporarily **extends certain suspensions** of regulations and statutes that were issued by agencies under the COVID-19 disaster declaration through **March 31, 2022**.

The continued suspension of these regulations and statutes allows the commonwealth to use all necessary resources to fight COVID-19 and help Pennsylvania get back on track from the pandemic.

Here is a link to the full bill:
https://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2021&sessInd=0&billBody=H&billTyp=B&billNbr=1861&pn=2200

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1861 Session of

2021

INTRODUCED BY LEWIS, LEWIS DELROSSO, ROWE AND GROVE,
SEPTEMBER 14, 2021

SENATOR BROOKS, HEALTH AND HUMAN SERVICES, IN SENATE, REREPORTED AS AMENDED, SEPTEMBER 28, 2021

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House Bill 1861

- Included in the extensions were: “all regulatory statutes, rules, or regulations **enforced by The Department of Human Services**.”
- Master List of Suspended Regulations updated September 30, 2021 as a result of HB 1861: https://www.pa.gov/wp-content/uploads/2021/09/Final-Master-List-Suspended-Regulations-updated-9.30.21-w-HB-1861-extensions.pdf
- OMHSAS also issued an announcement on September 30, 2021. Specifically: *“Pursuant to Act 73 of 2021, the suspension of various regulatory provisions under the state disaster emergency declaration that are currently in effect and which were set to expire on September 30, 2021, are now extended until further notice.”*
- **Act 73 supersedes the requirement for providers to submit requests for waivers of the following suspended regulations**: 55 Pa. Code § 5221.33 for Mental Health Intensive Case Management services; 55 Pa. Code § 1153.14 for Outpatient Psychiatric Services (psychiatric outpatient clinics, partial hospitalization outpatient facilities and mobile mental health treatment services); and 55 Pa. Code § 1223.14 for Outpatient Drug and Alcohol Clinic Services.
- The suspension of these regulations will remain in effect until further notice. OMHSAS-21-09 has been updated to reflect these temporary changes. Additional guidance will be forthcoming for providers that have already submitted requests for waivers of these regulations.
- If you have questions or concerns regarding Bulletin OMHSAS-21-09, please e-mail the OMHSAS Bureau of Policy, Planning and Program Development’s Tele-Behavioral Health Services resource account at RA-PWTBHS@pa.gov.

Telehealth Bulletin

OMHSAS-21-09, titled "Guidelines for the Delivery of Behavioral Health Services Through Telehealth" re-issued 9/30/21

pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

ISSUE DATE:	EFFECTIVE DATE:	NUMBER:
September 30, 2021	September 30, 2021	OMHSAS-21-09

SUBJECT:	BY:
Guidelines for the Delivery of Behavioral Health Services Through Telehealth	Kristen Houser Kristen Houser, Deputy Secretary Office of Mental Health and Substance Abuse Services

SCOPE:

The bulletin applies to: (1) providers enrolled in the Medical Assistance (MA) Program who render behavioral health services in the fee-for-service (FFS) or managed care delivery system and (2) Primary Contractors and Behavioral Health Managed Care Organizations (BH-MCOs) in the HealthChoices (HC) Program.

PURPOSE:

The purpose of this bulletin is to update the guidelines for payment of behavioral health services delivered using telehealth technology previously issued in *OMHSAS-20-02 Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services.* Telehealth generally refers to the delivery of compensable behavioral health services using real-time, two-way interactive audio-video transmission. Telehealth does not include text messaging, electronic mail messaging or facsimile (fax) transmissions. These updated guidelines include the following key changes from OMHSAS-20-02:

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Telehealth Bulletin- Updates

Documentation

The medical record for the individual served must indicate each time a service is provided using telehealth including the receipt of informed consent prior to the start of the session, start time of service and end time of service. Additionally, if the individual served or their legal guardian, as applicable, consents to the recording of a telehealth service, documentation of consent must be included in the medical record.

Signatures for consent to treatment, service verification, and acknowledgement of receipt of treatment or service plan(s) may include hand-written or electronic signatures. Consistent with Act 69 of 1999 Electronic Transactions Act, an electronic signature is an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

In situations where signatures cannot be obtained from the individual served or their legal guardian, as applicable, documentation of verbal consent in the medical record meets the requirement for a signature except where inconsistent with Pennsylvania regulations unless the regulations are suspended by Act 73. ~~Verbal consent/verification is not allowable for Mental Health Intensive Case Management services. See 55 Pa. Code § 5221.33. Providers may consider submitting a request for waiver of this regulatory standard.~~

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Telehealth Bulletin- Updates

Technology

Technology used for telehealth, whether fixed or mobile, should be capable of presenting sound and image in real-time and without delay. Telehealth equipment should clearly display the practitioners' and participants' faces to facilitate clinical interactions. The telehealth equipment must meet all state and federal requirements for the transmission or security of health information and comply with the Health Insurance Portability and Accountability Act (HIPAA).

Audio-only refers to the delivery of behavioral health services at a distance using real-time, two-way interactive audio only transmission. Audio-only does not include text messaging, electronic mail messaging or facsimile (fax) transmissions. Providers may utilize audio-only when the individual served does not have access to video capability or for an urgent medical situation, provided that the use of audio-only is consistent with Pennsylvania regulations and federal requirements, including guidance by the Centers for Medicare & Medicaid Services with respect to Medicaid payment and the US Department of Health and Human Services Office of Civil Rights enforcement of HIPAA compliance. ~~Audio-only service delivery is not allowed for Outpatient Psychiatric Services (55 Pa. Code § 1153.14) or Outpatient Drug and Alcohol Clinic Services (55 Pa. Code § 1223.14). OMHSAS intends to revise these regulations to allow audio-only delivery of services. Providers may consider submitting a request for waiver of these regulatory standards.~~

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Telehealth- Distance Requirements

In the managed care delivery system, the HealthChoices Primary Contractor and BH-MCO must ensure that provider agencies and licensed practitioners who deliver services through telehealth within their service area can arrange for services to be delivered in-person as clinically appropriate or requested by the individual served. HealthChoices Primary Contractors must ensure that each contracted provider agency and licensed practitioner meets one of the two following criteria:

The provider agency or licensed practitioner maintains a physical location in Pennsylvania within 60 minutes or 45 miles (whichever is greater) of the area served with appropriate licensure for all services provided through telehealth;

or

The provider agency or licensed practitioner maintains a physical location in a state bordering Pennsylvania, located within 60 minutes or 45 miles (whichever is greater) of the area served in Pennsylvania, maintains licensure in the state where they are physically located for all services provided through telehealth and is enrolled with the Pennsylvania MA program.

Providers may apply for an exception to allow licensed practitioners and/or provider agencies beyond the 60 minute/ 45 mile restriction to deliver services through telehealth in their service area when supporting additional access to services or in circumstances when the licensed practitioner and/or provider agency is needed to meet the cultural, racial/ethnic, sexual/affectional or linguistic needs of individual(s) served. Exception requests forms (Attachment B) can be submitted to OMHSAS.

Telehealth- Magellan FAQ

September 30: https://www.magellanofpa.com/media/6518/20210929_th_faq-final.pdf

- Is telehealth still an option for all PA HealthChoices services?

  Yes, in accordance with Bulletin OMHSAS-21-09.

- Can you tell me the process for providing telehealth permanently? Do we need a contract modification?

  In accordance with Bulletin OMHSAS-21-09, telehealth can be provided permanently. Magellan will not be making any contractual changes. Providers should continue to bill Place of Service (POS) Code 02 for all services provided via telehealth. More information will be forthcoming regarding the billing of audio-only services.

- Are providers permitted to use telehealth platforms such as Skype or Facetime for all services including evaluations?

  Telehealth equipment must meet all state and federal requirements for the transmission or security of health information and comply with the Health Insurance Portability and Accountability Act (HIPAA). Providers should consult their legal counsel or compliance officer for guidance on HIPAA-compliant platforms. Health Resources & Services Administration (HRSA) has published resources related to HIPAA compliant telehealth platforms. Please note that public-facing sites such as Facebook Live and Twitch should NEVER be used for telehealth.

Telehealth- Magellan FAQ

September 30: https://www.magellanofpa.com/media/6518/20210929_th_faq-final.pdf

- Do providers need a letter of support from the Primary Contractor and/or BH-MCO to continue providing telehealth?

  No, a letter of support is not required to continue providing telehealth after 9/30/21 in accordance with OMHSAS-21-09. A letter of support is only required if requesting a waiver of certain requirements or exclusions.

- Can mental health workers (bachelor level therapists) and student interns under the supervision of a mental health professional provide telehealth services?

  Providers will be required to maintain compliance with the existing minimum qualifications for staff per level of care specific regulations. Per the telehealth bulletin, provider agencies using behavioral health staff who are unlicensed may provide services using telehealth if they are otherwise qualified to render the service. Provider agencies should establish and enforce policies for assessing when it is clinically appropriate to deliver services through telehealth. Services delivered using telehealth must comply with all service specific and payment requirements for the service.

- Can telehealth or hybrid (a combination of in-person and telehealth) services be used for psych rehab, Partial Hospital (PHP), Intensive Outpatient (IOP), and group therapy, and how should providers proceed with providing these services via phone or telehealth?

  As group therapy generally relies on social cueing and fluency and the privacy of each member may be challenging to maintain, providers must strongly evaluate the clinical appropriateness of utilizing telehealth for these services.

Telehealth FAQ- Encounter Forms

- Providers should follow all applicable Pennsylvania Medicaid Regulations/ Bulletins and Magellan guidelines which outline the levels of care requiring encounter forms.
- Per OMHSAS-21-09, signatures for service verification may include hand-written or electronic signatures. Consistent with Act 69 of 1999 Electronic Transactions Act, an electronic signature is an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.
- In situations where signatures cannot be obtained from the individual served or their legal guardian, as applicable, documentation of verbal consent in the medical record meets the requirement for a signature except where inconsistent with Pennsylvania regulations.
- More guidance regarding encounter forms will be forthcoming. Over time, Magellan expects this to be a firm requirement, but for the time being, will support verbal consent on encounters forms following telehealth sessions (signed encounters are still required for face-to-face services in community-based levels of care). Providers who don't have the capabilities for electronic signatures should begin the process of exploring options related to putting the proper technology/platform in place. Intent to obtain signatures is the critical factor behind the requirement. Providers must also implement additional checks-and-balances and monitoring to provide oversight of service delivery.

Telehealth FAQ- Billing

- Will Magellan issue separate billing codes for services provided via telehealth or phone?

  There are no changes to procedure code or modifier combinations from your current contract. Documentation should reflect telehealth in accordance with Magellan's guidelines to match the billing submissions. POS 02 should be used on claims for all rendered services through telehealth for dates of service April 1, 2020 and forward. More information is forthcoming regarding billing for audio-only services.

- What code(s) should be used for place of service (POS) when billing for telehealth services?

  Magellan is requiring that all rendered services through telehealth be represented with POS 02 on your claim form for date of service April 1, 2020 and forward. When a non-telehealth service is rendered, please use the appropriate POS as previously submitted to Magellan.

- Will Magellan issue separate billing codes for services provided via telehealth or phone?

  There are no changes to procedure code or modifier combinations from your current contract. Documentation should reflect telehealth in accordance with Magellan's guidelines to match the billing submissions. POS 02 should be used on claims for all rendered services through telehealth for dates of service April 1, 2020 and forward. More information is forthcoming regarding billing for audio-only services. Providers who were previously contracted with Magellan for telehealth with a GT modifier prior to COVID-19 will be receiving an updated fee schedule. The GT modifier will no longer be allowable.

Telehealth FAQ- Billing

- What should providers list for the originating site address when billing for services provided telephonically from various locations including offices and homes?

  Providers should use a site location for which they are contracted and that would have been used if the services were provided in person.

- If a member's primary insurance plan does not cover telehealth, will Magellan cover it as the secondary payor?

  Providers should submit to Magellan as they normally would in a situation where a member's primary insurance is not covering a service.

- How should providers get authorizations for members whose primary insurance will not pay for telehealth services?

  If a member's primary insurance plan states telehealth is not a covered service, providers should seek pre-authorization of services as they normally would.

- If the member has a commercial insurance plan covering their telehealth services, will Magellan continue to cover copays?

  Yes, this process will remain the same.

Telehealth FAQ- Documentation

How should providers document a telehealth session in the record?

In accordance with Magellan's Telehealth Guidelines that were issued during the COVID-19 disaster declaration, providers must clearly document a telehealth session. In addition to following the minimum documentation requirements in our Pennsylvania HealthChoices Handbook Supplement, the following information must be included in the record for each rendered service:

- The documentation must indicate the mechanism for how services were delivered (i.e., telehealth, phone).
- The documentation must include the telehealth platform that was utilized, if applicable (i.e., zoom)
- The documentation must include the member's verbal consent to receive services in this manner.
- The documentation must include the member's phone number that was utilized, if applicable.

Telehealth- Provider Policies

Prior to delivering services through telehealth, providers or practitioners should provide information to the individual receiving services that supports the delivery of quality services. At a minimum, information should address the importance of the individual being in a private location, preventing interruptions and distractions such as from children or other family members, visitors in the household and from other communication or band-width reducing devices. When services are being provided to a child, youth or young adult consideration should also be given to how much caregiver involvement will be needed during the appointment. Providers using telehealth must maintain written policies including but not limited to:

- Policy on the operation and use of telehealth equipment.
- Policy around staff training to ensure telehealth is provided in accordance with the guidance in MA Bulletin OMHSAS-21-09, any MCO specific requirements as well as the provider's established patient care standards.
- Policy around contingency plans for transmission failure or other technical difficulties that render the behavioral health service undeliverable, delayed or interrupted. Contingency plans should describe how the plan will be communicated to individuals receiving services.
- Policy that addresses how to handle emergency situations, such as a risk of harm to self or others when services are being provided via telehealth.
- Policy for how appropriateness for telehealth will be determined
- Policy that describes how interpretation services, including sign language interpretation, will be delivered for individuals being served through telehealth.

Telehealth- Clinical Appropriateness

- Licensed practitioners and provider agencies delivering services through telehealth must have policies that ensure services are delivered using telehealth only when it is clinically appropriate to do so and that licensed practitioners are complying with standards of practice set by their licensing board for telehealth where applicable. Factors to consider include but are not limited to:
  - The preference of the member served and/or the preference of parents/guardians
  - Whether there is an established relationship with the service provider and the length of time the member has been in treatment
  - Level of acuity needed for care
  - Risk of harm to self or others
  - Age of a minor child
  - Ability of the individual served to communicate, either independently or with accommodation such as an interpreter or electronic communication device
  - Any barriers to in-person service delivery for the member
  - Access to technology of the individual served
  - Whether privacy for the member served could be maintained if services are delivered using telehealth
  - Whether the service relies on social cueing and fluency

Telehealth- Clinical Appropriateness

- Providers and practitioners should carefully consider the clinical appropriateness of telehealth delivery for such services, including, but not limited to: Partial Hospitalization, Intensive Behavioral Health Services (IBHS), Family Based Mental Health, Assertive Community Treatment (ACT), or if the beneficiary is in a residential facility or inpatient setting.
- Please reference OMHSAS-21-09 Attachment A for Best Practice Guidelines for Telehealth Service Delivery for Children and Youth.
- Additional suggestions for Best Practices when assessing the appropriateness of telehealth include the following (CASSP, April 2020):
  - ✓ Do caregivers have access to necessary technology and internet connection?
  - ✓ Will a caregiver be available to facilitate?
  - ✓ Are there specific protocols that must be implemented in person?
  - ✓ Have risks versus benefits of telehealth been identified?
  - ✓ Will telehealth be utilized as the main method of implementation, as needed or for a temporary time?

Audit Process Review & 2022 Audit Plan

Audit Process:
How Providers are Selected for an Audit

- Routine Integrated Audit
  - Statistically valid random sample selected annually from pool of all providers regardless of size and type (individual, group or organization)
  - Includes any combination of Quality, Compliance/ SIU and Network Departments
- Targeted Audit
  - Magellan follow-up to an identified concern, complaint, whistleblower, etc.
  - Typically involves Quality Department but depending on the allegation may also include SIU, Clinical and/or Network
- Implementation Oversight Integrated Audit
  - Conducted on new providers who have recently joined the Network
  - Includes Quality, Compliance/ SIU and Network Departments
- Follow-up Audit
  - Follow-up to assess implementation of a prior action plan
- Data Mining/ Compliance Audit
  - On a quarterly basis, a minimum of three (3) providers in the top tier for a specific service or code will be selected for a claims audit by SIU.
  - Annually, SIU will also conduct compliance-focused audits on a specific subset of providers (typically includes review of agency's compliance plan, staff interviews and a claims audit)

Audit Process:
Preparing for an Integrated Audit

- Notification from Magellan - Magellan will contact you to determine a mutually agreeable date (certain extenuating circumstances may require us to come out immediately or with little notice).
- Confirmation letter and tools will be sent electronically.
- For routine audits, member names will be sent approximately 1 week prior to the audit date via secured e-mail.
  - If there are questions about any of the names that are sent, please contact us in advance.
  - We may look at both open and closed records.
- The entire member record should be available for review.
- Magellan always invites its county partners to attend. We will make a conscious effort to determine the number of participants prior to the audit; but, at times, this is subject to change, due to scheduling conflicts.

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Audit Process:
Expectations for the day of the audit

- BE READY!
  - ✓ Policy & Procedure Manual
  - ✓ Compliance Plan
  - ✓ Encounter Forms (if applicable)
  - ✓ Clinical Records
  - ✓ HR files (including Supervision)

- Start time will be indicated in the confirmation letter. Please read the letter carefully.
- Someone should be available throughout the day to answer questions.
- Otherwise, the auditors will work independently in a designated space that is comfortable and quiet (multiple outlets will be needed). If using an EHR, multiple workstations will be needed.
- Compliance auditors may request to interview staff. This will also be indicated in the confirmation letter.
- Magellan will do a brief and informal wrap-up at the conclusion of the audit.

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Audit Process:
After the audit expectations

❖ Expect to receive findings electronically within 30 days following the audit:

- ✓ Initial claims finding letter
- ✓ Final claims finding letter
- ✓ Overall findings

❖ The feedback will be organized in the following manner:

- ✓ Strengths
- ✓ Recommendations
- ✓ Recommendations requiring internal provider action
- ✓ Compliance interviews (if applicable)
- ✓ Items that require follow up (if applicable)

❖ Action Plans

- ✓ Indicate who is responsible for monitoring and the expected implementation date (no more than 60 days)
- ✓ Enter responses in the template provided and submit as a word document
- ✓ Responses are due electronically, within 15 calendar days.
- ✓ Any questions, please call us!
- ✓ A follow-up audit may be required to assess implementation of your action plan response.

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2022 Audit Plan

- Regular provider oversight will continue
- Our goal is to have on-site audits in 2022
- FFS Reimbursement= normal recovery process
  - Providers have 10 business days to submit appeal documentation before recovery process is initiated
- Repayment flexibilities continue as needed

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2022 Areas of Focus

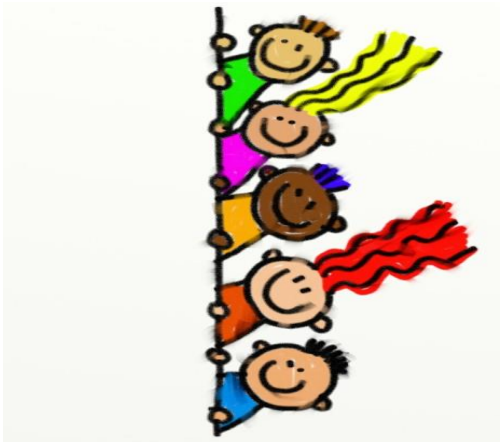
IBHS

Telehealth

ASAM Alignment

Intensive Behavioral Health Services (IBHS)

- Effective January 17, 2020, Intensive Behavioral Health Services (IBHS) replaced Behavioral Health Rehabilitation Services (BHRS).
- Magellan has worked closely with the Department of Human Services (DHS), our county partners, providers and other stakeholders during this implementation.
- IBHS support children, youth, and young adults with mental, emotional, and behavioral health needs. IBHS offers a wide array of services that meet the needs of these individuals in their homes, schools, and communities. IBHS has three categories of service: 1) Individual services which provide services to one child; 2) Applied Behavior Analysis (ABA) which is a specific behavioral approach to services; and 3) Group services which are most often provided to multiple children at a specific place. Evidence-based treatment (EBT) can be delivered through individual services, ABA services, and group services.
- Magellan allowed providers a year to adapt to the new regulations before auditing
- IBHS Billing Guide is in process of being developed
- IBHS Provider Collaborative Meetings continue
- Updated contracts/ codes have all been executed
- Resources:
  - DHS IBHS Resource Page
  - Magellan IBHS Resource Page



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Telehealth

- Place of Service (POS) Codes
- Telehealth Documentation Standards
- Telehealth Policies/Procedures
- Oversight and Monitoring Process
  - No physical Encounter Forms
- Clinical Appropriateness/ Member Engagement

ASAM Alignment

- ASAM implementation is not just criteria for Medical Necessity or Level of Care assessments but also using the criteria for the provision of services.
- Effective July 1, 2021, providers are expected to be compliant with specific provisions within *The ASAM Criteria, 2013*, related to Setting, Support Systems, Staffing, Therapies, Assessment/ Treatment Plan Review and Documentation. Magellan sent an e-mail blast in June, 2021 outlining the changes and understands that compliance will be an ongoing process.
- On June 29, 2021, DDAP issued an important Memorandum outlining the procedure for drug and alcohol treatment providers to request an extension beyond July 1, 2021 in reaching "substantial alignment with the service delivery conditions under *The ASAM Criteria, 2013.*
- DDAP will approve satisfactory requests for an extension to December 31, 2021 in substantially aligning with service delivery conditions for ASAM criteria related to 1) training, 2) credentialing, and 3) daily clinical services in LOC 3.5 and 3.7 (i.e. 6 to 8 hours of clinical services). All other requests for extension will be reviewed on a case-by-case basis.
- DDAP/ Mercer will be issuing ASAM monitoring tools and will be providing training for providers

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Confidentiality & Consent to Treat

Confidentiality

- ✓ Confidentiality of **all** information about a member receiving mental health and/or substance abuse treatment service is of paramount importance.

- ✓ Confidentiality is an ethical obligation of all treatment professionals, and a legal right for every member, regardless of the source or the format of the information. As a Magellan network provider, you are responsible for maintaining the confidentiality of all member information.

- ✓ HIPAA (Health Insurance Portability and Accountability Act of 1996) guides what information can be shared and with whom. State Confidentiality Laws as well as State/ Federal Substance Abuse Laws may be more stringent than HIPAA. You must follow the most stringent law.

- ✓ Any requirements under applicable federal and state laws regarding confidentiality must be followed regarding release of information for purposes other than payment, treatment or health care operations without valid authorization from the Member, unless permitted or required to do so by law.

- ✓ Providers are responsible for knowing, understanding and following all applicable laws regarding confidential patient information including any applicable reporting requirements for child or elder abuse, and the common law or statutory duty-to-warn. In providing information regarding confidentiality, Magellan is not furnishing legal advice.

Confidentiality- other reminders

- Providers are covered entities under HIPAA and therefore must follow all applicable regulations concerning reporting requirements (providers do not need to report HIPAA violations to Magellan).
- Members may file complaints related to their treatment providers protecting their privacy and confidentiality.
  - Policies and Procedures;
  - Member Rights
  - Completed release forms
  - Progress notes, if applicable

- Authorization to Use and Disclose (AUD) forms, Magellan's consent form to share information with a third party, should be completed in full by the member (or member's HIPAA representative).
- Providers requesting written information from Magellan related to an individual's past treatment history or other information must have the member (or member's HIPAA representative) complete an AUD.
- HIPAA releases still require a member's (or member's HIPAA representative) **written** consent. Verbal consent is not allowable under HIPAA.

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Records and Privacy

- Under the Pennsylvania HealthChoices' program, DHS, the Primary Contractors and Magellan have access to all Medical Assistance Member records.
- You must maintain each Member's record in a separate file/ EHR record. Follow state level of care specific regulations for record retention requirements.
- For paper records, Member charts must be kept in a locked file when not in use. The office that stores medical records should also be locked when you are not on the premises (one lock is required; however two locks is best practice). Only authorized staff are to have access to Member medical records (this includes EHR systems).
- All provider staff must be informed of the protocol for confidentiality and be made aware of their responsibility to maintain the confidentiality of Members.
- Appointment books are to be treated as confidential and kept in a locked file when not in use.
- Separate entrances and exits, while not required, may help the effort to maintain confidentiality.
- When mailing confidential information, label the document as confidential.

Consent to Treat

- Children under 14 years of age must have their parent's or legal guardian's permission to get mental health care. Children 14 years or older generally do not need their parent's or legal guardian's permission to get mental health care. All children can get help for alcohol or drug challenges without their parent's or legal guardian's permission.
- Minors between 14 and 17 can consent to mental health care and thus have the right to decide who can see their records if they consented to the mental health care. In addition, a parent or legal guardian can consent to mental health care for a child who is 14 years old or older, but under 18 years of age.
- As a general rule, where a minor has the authority to agree to his/her own treatment and the consent of the minor's parent/guardian is not needed, the minor controls the release of his/her records regarding that treatment.
- A consent to treat must be signed* and tailored to each service that an individual is receiving.

Other Compliance Reminders

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.
- 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.
- Magellan most recently sent an e-mail blast in June 2020 to its provider network supporting the OMHSAS guidelines.
- 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.

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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 staff names are not included on the survey.

Ensure all sections of the survey are completed- General Compliance, EHR, Telehealth, Community-Based Levels of Care.

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-Reports of FWA- Magellan Workflow

Submit materials to: PAHCSelfreport@magellanhealth.com

Please Include:

- Provider self-disclosure spreadsheet (as an excel attachment)
- Investigation summary – Be sure to include (at a minimum):
  - ✓ How the issue was initially identified
  - ✓ Type of audit (100% review, provider-developed audit plan, statistically valid random sample)
  - ✓ Who investigated the incident
  - ✓ Parameters used in determining the audit sample
  - ✓ The time frame audited
  - ✓ Services audited
  - ✓ Verification methods used
  - ✓ 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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Maintaining Active MA Enrollment & Licensure

- **Providers are required to maintain both active licensure with The Office of Mental Health and Substance Abuse Services (OMHSAS) and/or The Department of Drug and Alcohol Program (DDAP); and active Pennsylvania Medicaid Enrollment at the rendering and contracted site location for all contracted levels of care.**
- Some levels of care do not require licensure but must otherwise be approved through the state, Primary Contractors and Magellan. Please check with your Magellan Network representative to verify licensure requirements.
- Providers must also inform Magellan when there is a change in licensure status; and for other major changes such as moving to a new site location (see complete list of changes requiring notification below). Failure to notify Magellan within the identified timelines may affect your network status or lead to recovery action against claims.
- Reference Magellan's April 2021 Compliance E-mail Blast for more information.

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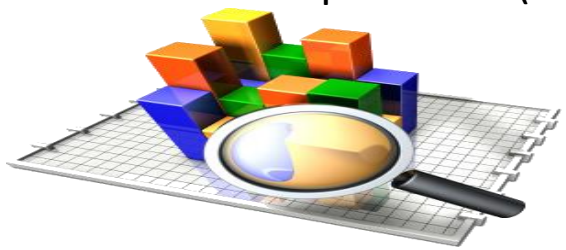
Data Mining Audits

- On a quarterly basis, a select number of providers will receive a desk audit of an identified level of care or service code.

- Process:
  - Selected providers will receive an email requesting medical records
  - Medical records or access to the provider's EHR will be shared with the auditor(s)
  - Audits are conducted
  - Initial claims letters are emailed to the providers detailing the results of the audit
  - Providers have 10 business days to review and provide supporting documentation, if warranted
  - Final claims letters are sent to the provider and the county (if there are no discrepancies/overpayments, this will be the only letter that is received)
  - If discrepancies are identified, the auditor submits information to our Cost Containment Department (CCD) and retractions are initiated
  - An Action Plan (AP) may also be issued to the provider, if applicable



Magellan's Member Service Verification Process

❖ Per the HealthChoices requirement, members are surveyed across all Magellan counties.

❖ Process:

- On a quarterly basis, 1,818 members will receive a survey in the mail
- Members are asked to attest to receiving up to five services based on paid claims data from the prior month
- Magellan will analyze all returned surveys and follow-up with providers related to any "No" response
- Members may be contacted if needed
- Providers may be required to submit documentation to Magellan to verify that services took place as billed
- If discrepancies are identified, the auditor submits information to our Cost Containment Department (CCD) and retractions are initiated
- An Action Plan (AP) may also be issued to the provider, if applicable

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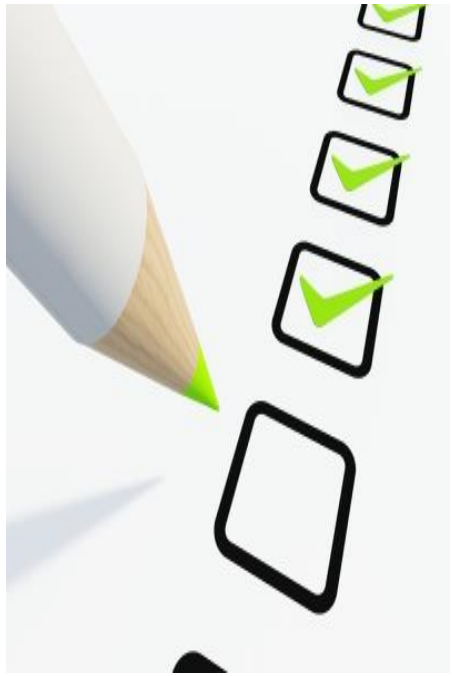
Provider Service Verification Process

- ✓ All Providers should have their own service verification process in place
- ✓ Implement both random and routine checks via phone, mail, text or other electronic mechanism
- ✓ Community-Based Levels of Care should have weighted distribution
- ✓ Increase surveys around telehealth/ phone contacts
- ✓ Compare survey responses to progress notes, encounter forms, and claims
- ✓ Outline investigation process when discrepancies are identified
- ✓ Quality indicators can also be included



Compliance Toolbox & Resources

Provider Trainings

- Ongoing training opportunities are available for both new and existing providers
- All new PAHC providers are required to complete the PA HealthChoices New Provider Training prior to contract execution. Providers will be sent a link to complete the pre-recorded webinar when they receive their contract. ALL provider staff must complete the training.
- The Provider Training supplements the information provided in the PA HealthChoices' Program Provider Handbook Supplement and the Magellan Health National Provider Handbook
- Providers can request additional live trainings as needed
- Pre-recorded webinars are available for existing providers

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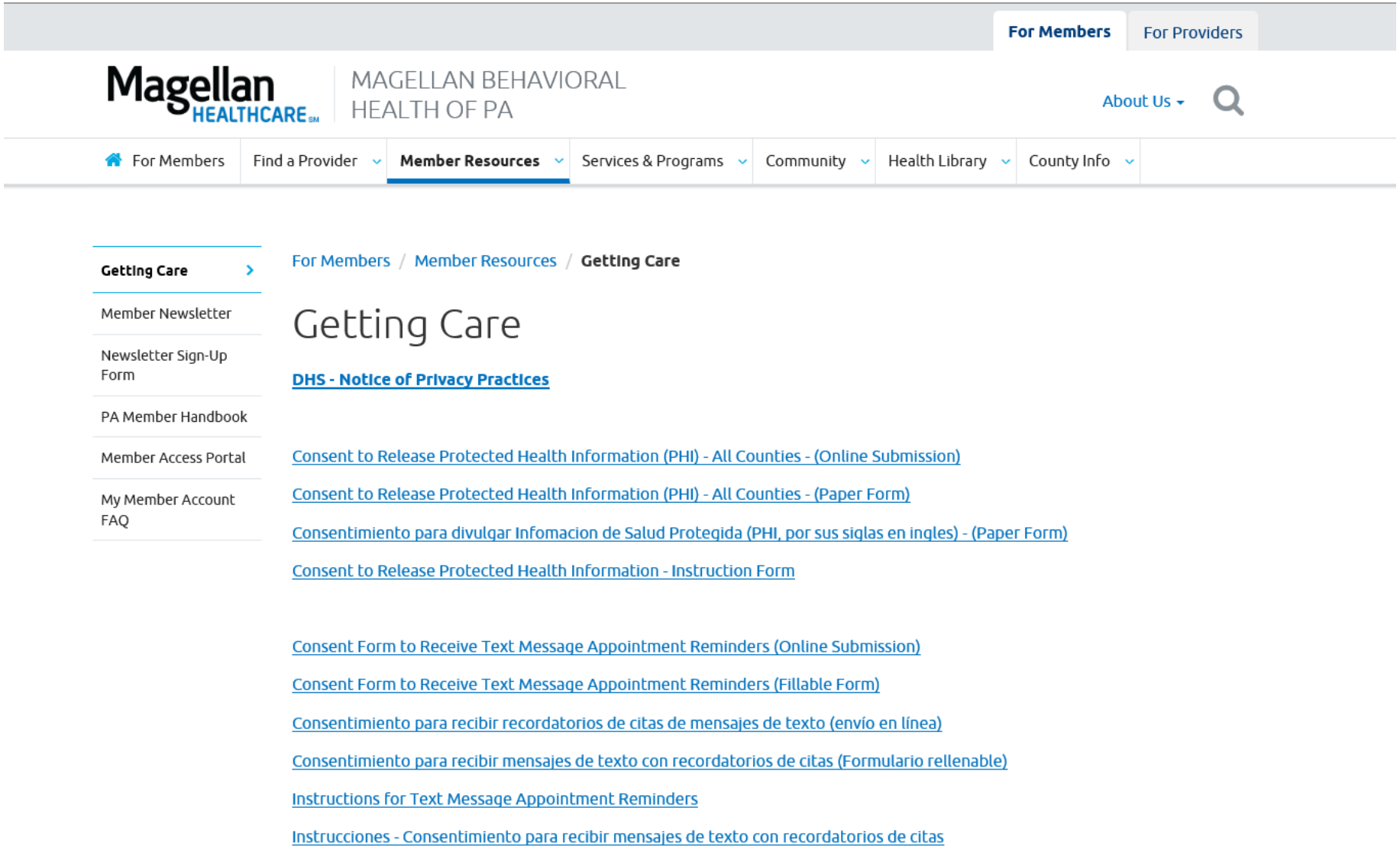
Consent to Release PHI Forms

https://www.magellanofpa.com/for-members/member-resources/getting-care/



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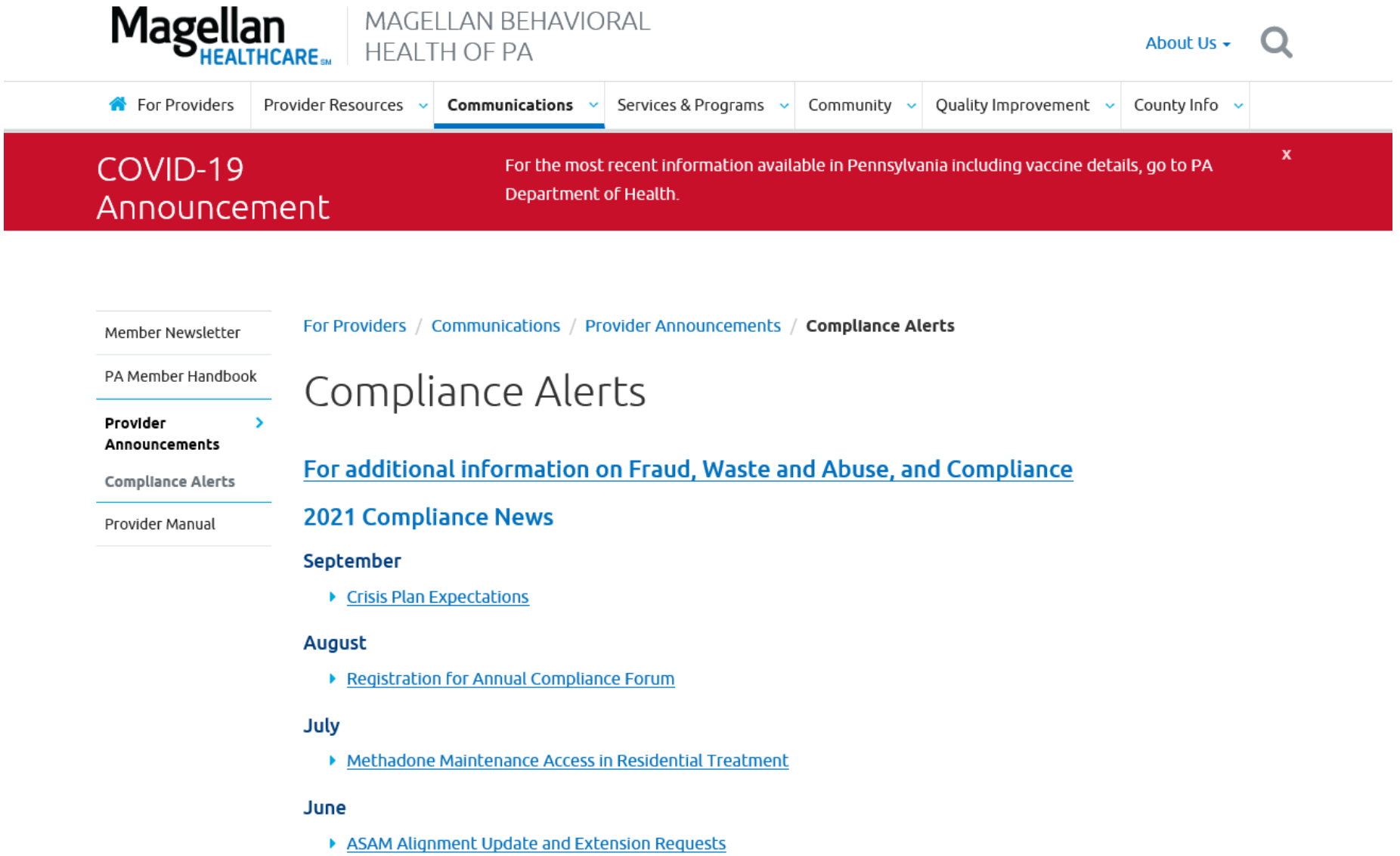
Compliance Alerts

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

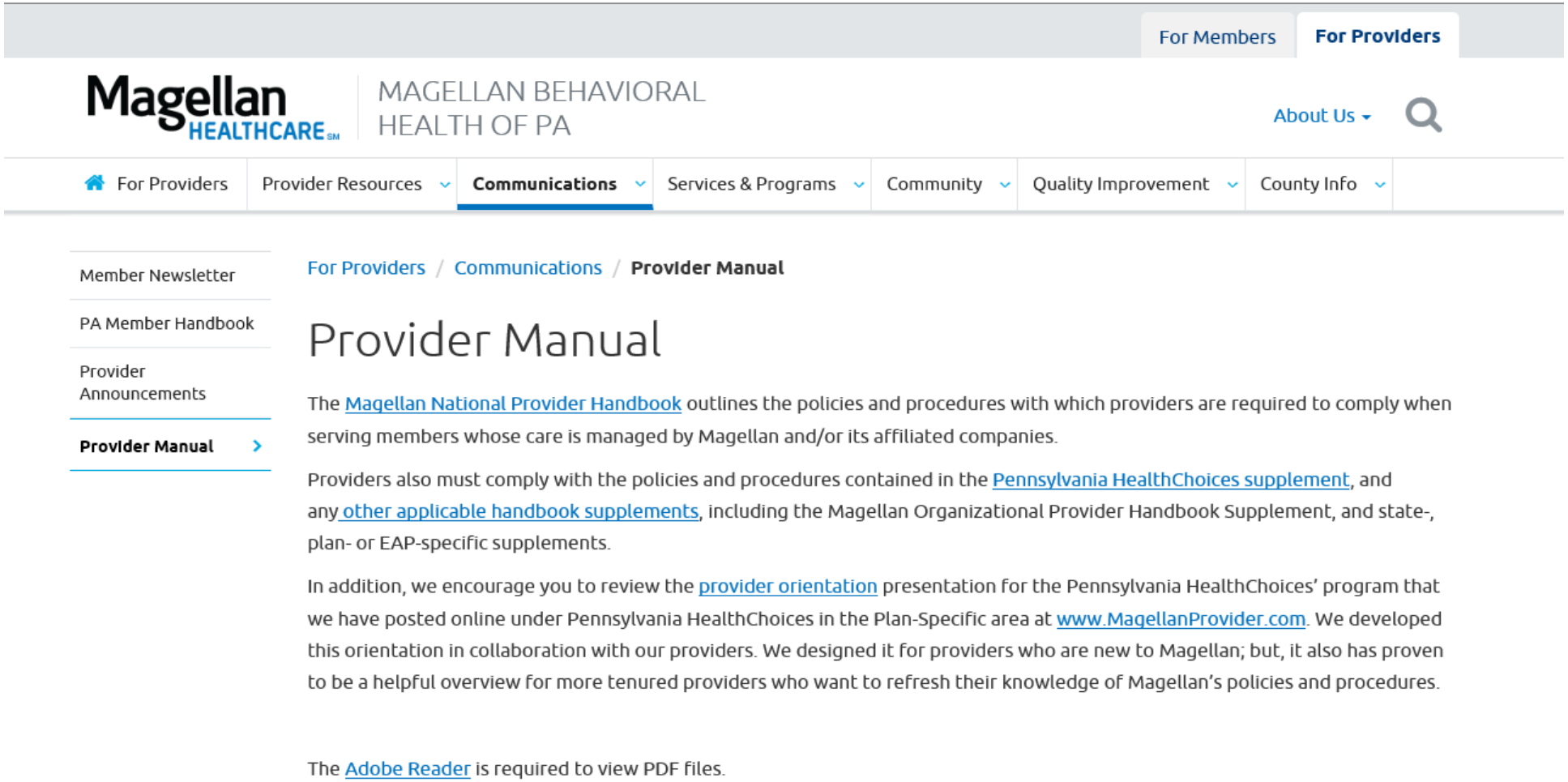


Fraud, Waste & Abuse Resources

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

Magellan Provider Handbooks

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



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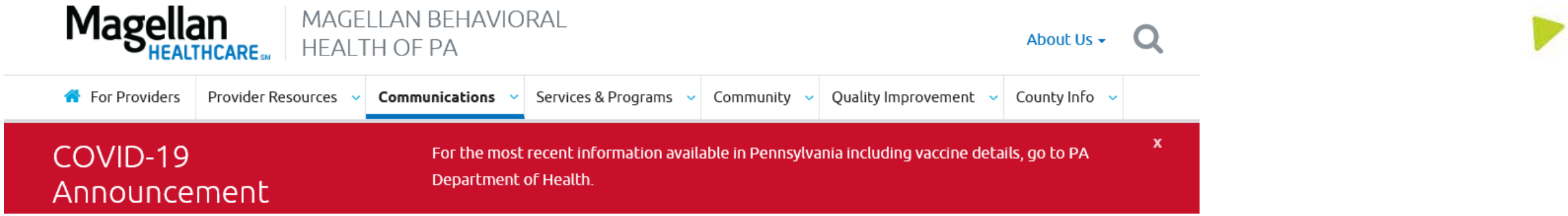
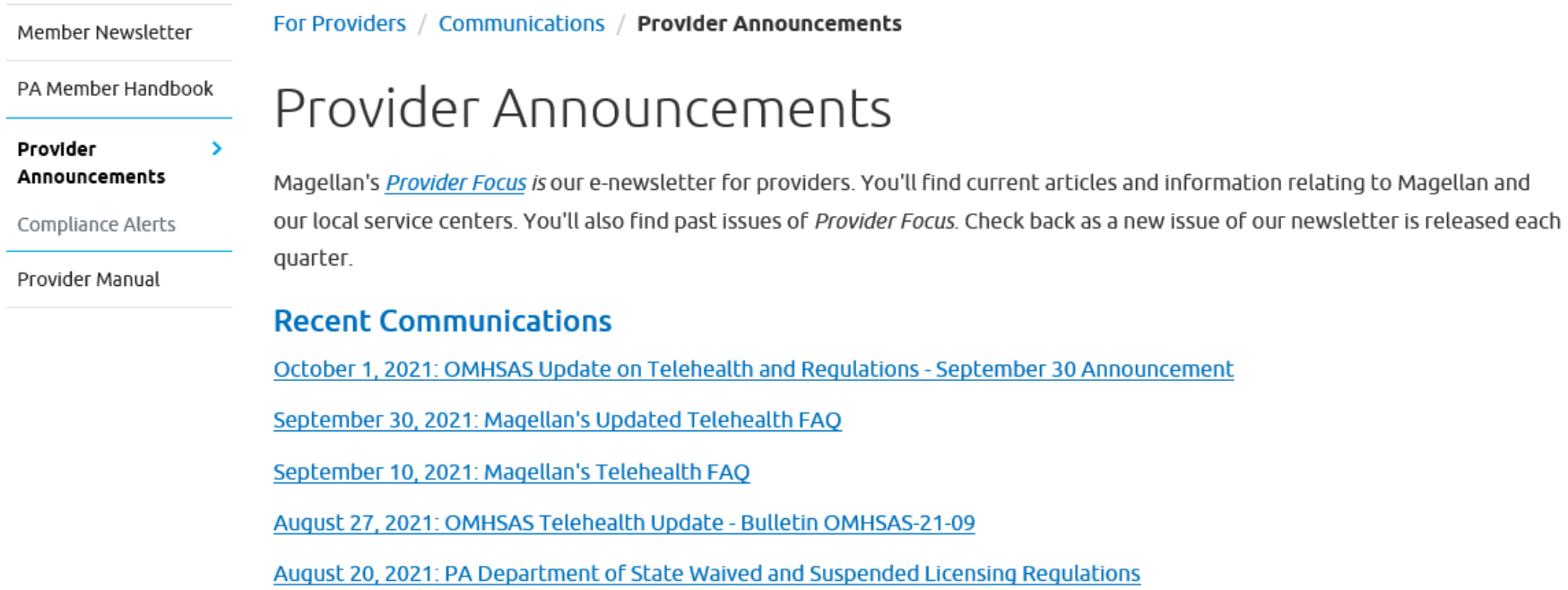
COVID-19 Announcements

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





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Other Resources

- The Centers for Medicare and Medicaid Services (CMS) provides information about the importance of compliance in documentation and self-audits: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf
- On January 17, 2017, a group of compliance professionals and staff from the Department of Health and Human Services, Office of Inspector General (OIG) met to discuss ways to measure the effectiveness of compliance programs. The intent of this exercise was to provide a large number of ideas for measuring the various elements of a compliance program: https://oig.hhs.gov/documents/toolkits/928/HCCA-OIG-Resource-Guide.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 at hire and ongoing. Licensure status and disciplinary history can be viewed online at: https://www.pals.pa.gov/#/page/search
- As a reminder, providers are also required to monitor monthly all federal and state exclusion lists including: HHS-OIG List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database and the PA Medicheck Exclusion list.

Magellan Compliance Contacts

- SIU Claims and Compliance Auditors:
  - **Patty Marth, CFE (Lehigh & Northampton Counties)**
    610-814-8009
    PMarth@magellanhealth.com
  - **Andrew Searles (Bucks, Delaware & Montgomery Counties)**
    267-450-1491
    searlesa@magellanhealth.com
  - **Tina Davis, M.Ed., CFE (Cambria County)**
    814-961-0689
    TMDavis1@magellanhealth.com
- SIU Senior Investigator:
  - **Diane Devine, CFE (All Counties)**
    610-814-8052
    ddevine@magellanhealth.com
- SIU Manager:
  - **Tanya Pennington, CFE (All Counties)**
    410-953-4812
    TMPennington1@magellanhealth.com
- Magellan PAHC Compliance Manager/ Privacy Officer:
  - **Karli Schilling, MA (All Counties)**
    215-504-3967
    kmschilling@magellanhealth.com
- Magellan PAHC Compliance Coordinator:
  - **Holly McQuiggan (All Counties)**
    215-504-3952
    hlmcquiggan@magellanhealth.com

Next Steps

- **Magellan will send a copy of the Power Point Presentation and Zoom Recording to all participants.**
- **Providers should submit any additional questions to Magellan utilizing the contact information on the previous slide.**
- **Providers should also look for an upcoming survey to provide feedback and input for future training opportunities.**

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THANK YOU!

Confidentiality statement

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