Provider Compliance Forum- 2022

NOVEMBER 4, 2022

PRESENTED BY: MAGELLAN BEHAVIORAL HEALTH OF PENNSYLVANIA, INC.

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Introduction/Housekeeping

Meet Our Team

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COMPLIANCE AND CLAIMS AUDITOR
CAMBRIA COUNTY

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ALL COUNTIES

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COMPLIANCE AND CLAIMS AUDITOR
BUCKS & MONTGOMERY COUNTIES

Karli Schilling, MA
SENIOR COMPLIANCE MANAGER/ PRIVACY OFFICER
ALL COUNTIES

Housekeeping

- Magellan provides a focused Compliance Training for Providers annually
  - Prior trainings are posted on the Magellan of PA Compliance website page
- 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.

Agenda

Positive Outcomes

Audit Trends

Regulatory Reminders

Telehealth & Regulatory Suspensions

Special Investigations Unit

Evaluation and Management (E&M)/ Coding Resources

Confidentiality Reminders

Compliance Plans, Culture and Ethics

Other Resources and Reminders

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Positive Outcomes

OWN IT

DELIVER

WIN

TOGETHER

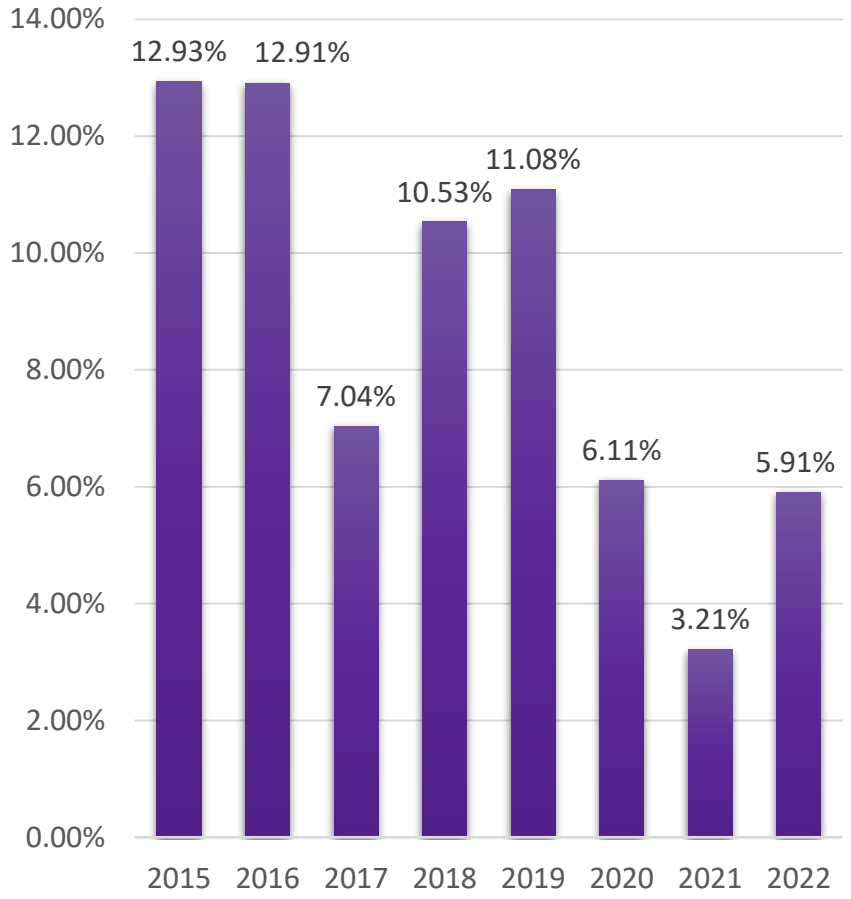
CARE

STAND TALL

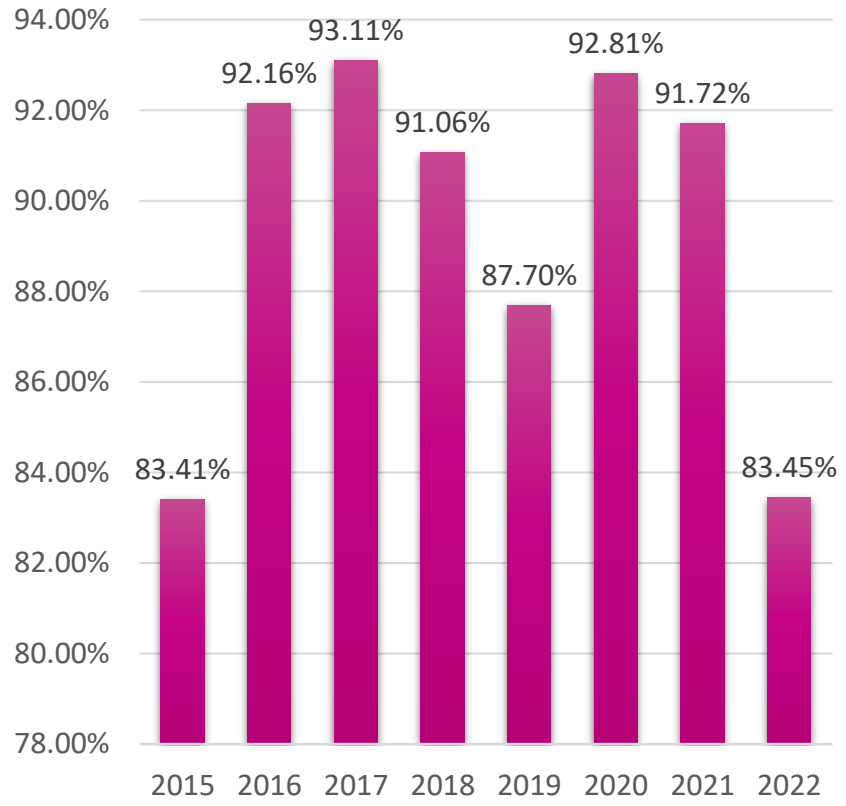
EVOLVE

Outcomes: 2015 – September 2022

Claims Error Rates



Compliance Program Scores



Audit Trends

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's PAHC Provider Handbook Supplement). Specifically:
  - Start and end times
  - Service date
  - Credentials
  - Legibility
  - Error Correction protocol
- Treatment/ Service Plan requirements
- Place of Service Coding

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Overall Audit Trends (continued)

- Adherence to Magellan rate sheet/ reimbursement schedule (utilizing the correct procedure code/modifier combination)
- EHR time stamps preceding end time of the session
- All-inclusive contracts
- Billing for non-billable or non-covered services including:
  - Travel/Transportation
  - Social activities
  - Paperwork/ administrative activities

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IBHS Audit Trends

- Issues with staff signatures:
  - Missing credentials
  - Staff signatures not dated.
  - Staff signatures did not include the full name- just initials.
- Progress notes were found not to support the number of units billed
- Progress note documentation did not relate back to the treatment plan
- Correct place of service (POS) code for the location that services are being provided
- Hand-written notes were not consistently legible.
- Time in and out should be documented in real time and not clock hours.
- Use correct error correction procedure.
- Magellan requires assessments to be updated every 6 months (even though the regs state 12 months) or when an authorization is requested to continue or a change needs made.
- The full contracted unit duration (e.g., 15 minutes, 30 minutes) must be provided to bill a unit. Rounding up to the better part of the unit is not permissible in IBHS.

Telehealth Audit Trends: Consent, Audio-only Telehealth & Place of Service (POS) Coding

- *Member consent to receive Telehealth*: During the initial period of the public health emergency, OMHSAS and Magellan permitted general verbal consent that was documented by the provider to accommodate rapid transition to telehealth for most providers. This general method of verbal consent is **no longer** permitted as an acceptable practice. OMHSAS-22-02 adheres to the expectations of Act 69 of 1999 Electronic Transactions Act in which an electronic sound is considered a type of electronic signature. 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. Providers using electronic signatures must have systems in place to ensure that there is an **audit trail** that validates the signer's identity. Providers are not required to get another signature for consent to telehealth during face-to-face contact.

- *Audio-only Telehealth*: Effective for dates of service July 1, 2022, and beyond, providers should add informational modifier **FQ** in the last available position along with your current contracted code and modifier combination every time a service is provided **over the telephone**. Providers who offer services that currently require the use of four modifiers should continue to use those modifiers in accordance with your contract (four modifiers are the maximum allowable, so in this case, providers would not be able to utilize informational modifier FQ).

- *Place of Service Coding*: In accordance with OMHSAS-22-02, providers must utilize either Place of Service Code 02 or 10 when rendering a service via telehealth. When telehealth is provided in the identified member's home, utilize POS 10. When telehealth is provided in a location other than the home of the member, utilize POS 02. **This corresponds to the physical location of the member, not the provider.** When a non-telehealth service is rendered, please use the appropriate POS as allowable.

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Telehealth Audit Trends: Documentation

- 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 following all of Magellan's Minimum Documentation Guidelines found in our Pennsylvania HealthChoices (PAHC) Provider Handbook Supplement.
- Providers must continue to adhere to the Unit Definition/ Description on their Magellan Reimbursement Schedule in order to bill a unit of service (e.g., 15 minutes, 30 minutes).
- Services must be provided in accordance with the member's Treatment/ Service/ Recovery Plan.
- 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 PAHC Provider Handbook Supplement, the following information must be included in the record for each rendered telehealth service:
    - **At intake**, the documentation must include the member's consent to receive services in this manner.
    - The documentation must indicate the mechanism for how services were delivered (e.g., telehealth, phone).
    - The documentation must include the telehealth platform that was utilized, if applicable (e.g., zoom)
    - The documentation must include the member's phone number that was utilized, if applicable.

Telehealth Audit Trends: Policies & Procedures

Section C: Provider Telehealth Policies & Procedures
1. Policy on the operation and use of telehealth equipment
2. Policy around staff training to ensure telehealth is provided in accordance with the guidance in any applicable MA Bulletin, any MCO specific requirements as well as the provider's established patient care standards.
3. 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.
4. 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.
5. Policy for how appropriateness for telehealth will be determined.
6. Policy that describes how interpretation services, including sign language interpretation, will be delivered for individuals being served through telehealth.

Centers of Excellence (COE) Audit Trends

- Individualized care plans were found to be non-existent, used from another program, or did not include the minimum standards listed below:
    - The member's treatment and non-treatment needs
    - The member's preferred method of care management, such as face-to-face meetings, phone calls, or through a secure messaging application
    - The identities of the member's community-based care management team, as well as the members of the member's support system

- Many contacts or service duration were an average 10 minutes or less and a "check in"

- Minimal community outreach or linkage to community supports

Centers of Excellence (COE) Audit Trends (continued)

- The COE must document the care management service encounter within the member's electronic health record, including the following information:
    - Date of encounter
    - Location of encounter
    - Identity of the individual employed by the OUD-COE with whom the member met
    - Duration of encounter
    - Description of service provided during the encounter
    - Next planned activities that the OUD-COE and the Member will undertake
- Serving members that are already connected to other services and duplicating services
- Case Management services only include handing out flyers or brochures for services
- Limited hours of operation

POLL QUESTIONS/ Q&A

Regulatory Reminders

Regulatory Reminders

- Group Requirements:
  - Psychiatric Outpatient Groups: No less than 2 & no more than 12 persons; group sessions must be conducted by a clinical staff person.
  - SUD Outpatient Clinics: no less than 2 & no more than 10 persons, for a minimum of 1 hour. Sessions are conducted by clinic staff under the supervision of a physician.
  - Adding an additional group facilitator does not allow a provider to double or expand the size of the group. **Regardless of the number of provider staff co-facilitating or leading the group, the maximum allowable size without an OMHSAS waiver is 10 (SUD Clinics) or 12 (MH Clinics).**
- LPHA Referral:
  - A recommendation from a Licensed Practitioner of the Healing Arts (LPHA) is required for Peer Support (PSS) & Certified Recovery Specialist (CRS) Services.
  - LPHA is limited to: a physician, physician's assistant, certified registered nurse practitioner, psychologist, licensed clinical social worker, licensed professional counselor, and licensed marriage and family therapist.
- Rounding of units:
  - Providers must bill for full units of service & rounding is not allowed per MA Bulletin 99-97-06. The number of minutes (i.e. 15 minutes, 30 minutes etc.) that equates to a billable unit is dictated by the state's covered services grid and your Magellan contract.
  - Exceptions: Targeted/Blended Case Management, Crisis Intervention, and Family Based Services. This does not include CPS, CRS, or D&A Case Management services.

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Regulatory Reminders

- Encounter Forms
  - Providers are required to obtain signed encounter forms to certify that a recipient received a service, per MA Bulletin 99-89-05.
  - Signed encounter forms should be present at the time of a Magellan audit or review.
  - Although providers may develop their own encounter forms, they must include the following information (at a minimum):
    - Certification statement
    - Provider name & MA ID #
    - The member's name and ID #
    - The member's signature (or signature of their agent, such as parent/guardian, teacher, etc.)
    - Date of service
    - Start & end time of service (in clock hours, not duration, i.e. "2:30-4:30 PM", not 2 hours).
    - Rendering provider/staff member's signature.
    - If a provider is unable to obtain a signature on the Encounter Form (including refusal), it must be documented why and attempts should be made to obtain a signature the following session.

* Providers of community-based services are required to obtain a signed encounter/ verification form for each face-to-face/ telehealth contact that results in a claim being submitted to Magellan (encounter forms for telehealth will be discussed in the next section of the presentation).

POLL QUESTIONS

Regulatory Reminders

- Travel/ Transportation:
  - Travel time & time spent transporting members is **not** reimbursable or billable in most levels of care.
  - Documentation (i.e., progress notes) should clearly demonstrate the time spent traveling/transporting members, and this time should be separate from time spent providing services (i.e., billable time).
  - Staff should comply with their own internal agency policies regarding transporting/traveling with members; regardless of agency policy, these activities are usually not billable
  - Some Exceptions: COE, Family Based Services.

- Documentation Standards (the full outline of documentation standards can be found in the Magellan PAHC Provider Handbook Supplemental):
  - Record must be legible throughout.
  - Member name/ID must be on each page.
  - Entries must be signed & dated by the rendering provider and include their credentials
  - Alterations must be signed & dated.
  - Progress notes/documentation of treatment, regardless of level of care, must include: the specific service rendered, the date of service, name of the staff who provided services, place where services were rendered, the relationship of the service to the member's treatment plan goals (including goals, objectives, interventions used), progress at each visit, changes/response to treatment, and the actual time in clock hours that services were rendered.

Regulatory Reminders

- Assertive Community Treatment
  - The minimum requirement is for all ACT Teams to average three face-to-face contacts per week across all members (OMHSAS-08-03)
  - ACT services are currently funded through an Alternative Payment Arrangement (APA). Providers are required to submit encounter data for members. Encounters should be submitted throughout the service month to reflect the ongoing services that are being provided to members. The claim that includes the bundled payment for the service month should be submitted the first week following the service month and may not be billed prior to the submission of Encounters from the prior month. If no Encounters are billed for a service month, the provider may not bill for the APA payment for that month.
- CRNP, PA, and RN Services in Outpatient Clinics
  - Outpatient Clinics may bill for Office Outpatient / Medication Management visits by a Certified Registered Nurse Practitioner (CRNP), Registered Nurse (RN) or Physician Assistant (PA). CRNP and PA prescribing practices are defined by licensing and regulatory requirements.
  - A CRNP must a have a collaborate agreement with a physician who holds a current license to practice in this Commonwealth. A PA must also have a written agreement with a supervising physician.
  - A CRNP must have certification as either an Adult Psychiatric Mental Health Nurse Practitioner or a Psychiatric Mental Health Nurse Practitioner. The PA Code allows a CRNP or PA 2 years to obtain a mental health certification.
  - RN activities in a licensed outpatient clinic may include medication administration including injections, BMI measurements, medication education, and assessment of medication effectiveness in consultation with a physician. Per the PA Code, an RN shall undertake a specific practice only if they have the necessary knowledge, preparation, experience and competency to properly execute the practice. Therefore, it's recommended that RNs working in behavioral health clinics are board certified by The American Nurses Credentialing Center as a Psychiatric-Mental Health Nurse (RN-BC).

POLL QUESTIONS

Regulatory Reminders

- Bed Holds and Therapeutic Leave
  - Magellan aligns with MA Bulletins 01-95-13 01-95-12, which outline the guidelines for reimbursement of time spent in therapeutic leave and hospital reserve days while in placement at an RTF.
  - When a member is admitted for a continuous 24-hour period to an acute care general hospital, rehabilitation hospital or rehabilitation unit of an acute care general hospital, psychiatric hospital/ unit and the child is expected to return to the RTF, Magellan will reimburse the RTF to reserve the bed for the child's return to the facility. Either the same or a comparable bed must be available for the recipient upon return to the facility.
  - Payment for a hospital reserved bed day is one-third of the facility's per diem payment rate and is limited to 15 days per child per calendar year. Providers should bill the designated code on their contracts that reflects the Bed Hold rate. The 15-day per calendar year limit is cumulative and applies regardless of whether the child received continuous or intermittent treatment at one or more RTFs or was admitted to one or more hospitals or units during the calendar year.
  - Therapeutic leave is a period of absence from an institutional setting directly related to the treatment of the individual's illness.
  - Therapeutic leave in excess of 48 days per calendar year is not billable.
  - Required documentation for therapeutic leave includes a physician or psychologist order; description of the desired outcome; start and end dates/ times of the therapeutic leave; and a written evaluation resulting from interviews with both the child and family or legal guardian after the leave period (the evaluation shall describe the treatment objectives of the leave and the outcomes).
  - The facility must report therapeutic leave usage when requesting prior approval for continued stay.
  - Therapeutic leave cannot exceed 4 nights/5 days per episode.
  - If the member does not return back to the RTF from a therapeutic leave, the date of discharge will be the date of the last night the member spent in the RTF, and reimbursement will not be provided for that episode of leave.

Other Reminders

- Credentialing/Licensure/ MA enrollment
  - Providers are required to maintain both active licensure with OMHSAS and/or DDAP; and active Pennsylvania Medicaid Enrollment at the rendering and contracted site location for all contracted levels of care. If you anticipate moving your contracted location, you must notify your Magellan network specialist immediately to ensure the appropriate actions are taken to transition your contract and MA enrollment.
  - Providers must notify Magellan, in writing, within 10 days, of any changes to their facility license (suspension, revocation, limitation, initiation of investigation, etc.), charges of malpractice or professional/ethical misconduct brought against the facility or any staff members, and any changes to a staff member's licensure or privileges. Magellan must also be notified in writing within 10 business days of changes in ownership/executive management or any other information contained in your credentialing application.
- All-Inclusive Billing/ Rates and Documentation
  - Most 24-hour levels of care (e.g., Acute Inpatient Hospital Programs, SUD Detox/ Residential, Residential Treatment Facilities) are contracted with Magellan as "all-inclusive" rates. Inclusive rates include all clinical, ancillary services, diagnostic and professional services related to a behavioral health diagnosis.
  - Separate billings for any clinical, professional, laboratory or any other ancillary services are not permitted.
  - In compliance with the daily per diem rate that encompasses both Treatment plus Room and Board costs, it is Magellan's expectation that providers of all 24-hour levels of care including SUD providers implement behavioral health interventions for each day of service billed, including all weekends and holidays. Staffing patterns must align with all OMHSAS Regulations and Bulletins as well as DDAP Licensing Requirements to allow for meaningful treatment to be provided every day that the member is physically in the facility.
  - In accordance with this requirement that behavioral health interventions are provided on a daily basis, it is Magellan's expectation that each date of service that is billed have corresponding documentation in the member's record.

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Other Reminders

- POMS
  - Performance/Outcome Management System (POMS) is a database maintained and managed by the PA Dept. of Human Services (DHS) that contains raw data regarding MA enrollees & serves as a basis for producing performance measures & indicators.
  - Reporting of POMS data is mandated at certain points in treatment by PA DHS for mental health providers:
    - When you are seeing the member for the first time
    - When you are seeing the member for the last time
    - Whenever there is a change in any POMS element.
  - Magellan has a web-based tool for collecting POMS data. Effective 7/1/2022, information must be submitted online thru the Magellan Provider Portal (magellanprovider.com). Paper or hard copies are no longer accepted.

POLL QUESTIONS/ Q&A

Telehealth & Regulatory Suspensions

Federal Public Health Emergency (PHE)

Current Status:

- On October 14, 2022, The Department of Health and Human Services extended the Federal Public Health Emergency (PHE) an additional 90 days. If this is the last renewal, then the PHE would end on January 11, 2023.
- The federal government has reported that they will notify states 60 days before the PHE ends. If this is the last renewal, then the 60-day advance notice of the end of the PHE would be issued by November 12, 2022.
- In addition to this 90-day extension, under the Budget Act of 2022, President Biden created a built-in 151-day extension of these flexibilities at the end of any PHE. With that extension, the current flexibilities would be in effect until June 2023.
- Under the federal Public Health Emergency (PHE) declaration, Pennsylvania was required to continue Medical Assistance (MA) coverage for most people unless they moved out-of-state, passed away, or requested to terminate their benefits
- The PA Department of Human Services has a PHE landing page with many available resources: https://www.dhs.pa.gov/phe/Pages/default.aspx.

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Federal PHE and PA Regulatory Suspensions

- The Federal PHE does not impact suspension of regulations in Pennsylvania. Suspension of PA regulations is the domain of the PA Legislature.
- Pursuant to Act 30 of 2022, the suspensions of various regulatory provisions under the PA disaster emergency declaration were extended until October 31, 2022 (unless sooner reinstated).
- As of November 1, 2022, most suspended regulations have been reinstated. Full compliance with all regulations including those that were previously suspended must be in place when the suspension of regulations ends unless a waiver has been obtained from OMHSAS.
- OMHSAS will end the suspension of the following bulletins effective 12/31/22:

- Bulletin OMHSAS-19-05 Peer Support Srvs- Revised
- Bulletin OMHSAS-10-03 Blended Case Management- Revised
- Bulletin OMH-93-09- TCM Documentation Requirements
- Bulletin OMH-93-10 Crisis Intervention
- Un-promulgated Chapter 5240 Crisis Intervention Services
- Un-promulgated Chapter 5260 Family-Based Services
- Bulletin OMHSAS-08-03 Assertive Community Treatment
- Bulletin MAB 01-01-05 MT BSC and TSS
- Bulletin OMHSAS-17-01 MNC for ABA
- Bulletin MAB 01-94-01 Outpatient Psychiatric Services for Children Under 21
- Bulletin MAB 1157-95-01 RTF Psychiatric Evaluations

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PA Regulatory Suspensions

- *Breaking News*: On 10/28/22, Governor Wolf signed HB 1630 into law as Act 98. The law repealed the following sections of OMHSAS regulations effective immediately:
  - Outpatient Psychiatric Services (55 Pa. Code §1153.14) which prohibited the telephone delivery of services
  - Outpatient Drug and Alcohol Clinic Services (55 Pa. Code §1223.14) which prohibited telephone delivery of services
  - Psychiatric Rehabilitation Services (55 Pa. Code §5230.55) which required face-to-face supervision

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OMHSAS Waiver Process

- In March 2022 OMHSAS developed the "Request for Waiver Form" and a newly revised "Information and Guidelines for Providers Regarding Waiver Submission" document to assist providers when submitting a request to waive an OMHSAS licensing regulation or bulletin.
- Also reference Medical Assistance Bulletin OMHSAS-16-03 Revised Procedure for Waiver of OMHSAS Program Regulations and Standards:
  - Agencies first submit the request for a waiver to the County MH/ID Administrator of each county the agency will serve.
  - County MH/ID administrator(s) should respond in writing to the agency within 10 business days of receipt of the request with a decision to support or oppose the waiver request.
  - Agencies must include the written response from the MH/ID Administrator(s) with the waiver request and submit them to the regional Field Office Manager for that area.
  - The OMHSAS Regional Field office should forward the waiver requests to the Bureau of Policy, Planning, and Program Development within 15 days for review and processing.
  - OMHSAS Policy will make the determination within 60 days of the initial waiver request. Determinations may be delayed if any required information is missing or incomplete.
  - Agencies may also request renewal of an approved waiver. Requests for continuation of the waiver must be submitted to the Field Office Manager 60 days in advance of the approved waiver's expiration date or 60 days prior to the date of license renewal, whichever is earlier.

History of Telehealth in PA MA

- In 2011, OMHSAS first issued guidance on the use of telehealth through OMHSAS-11-09 Guidelines for the Approval of Telepsychiatry. This bulletin limited the availability of telehealth to MA enrolled psychiatrists and licensed psychologists in the Behavioral Health HC Program.
- In 2014, OMHSAS issued updated guidance in OMHSAS-14-01 Guidelines for the Approval of Telepsych Services in HealthChoices, which clarified and reissued the guidelines that the Department uses to approve telepsych (i.e., telepsychiatry and telepsychology) programs.
- In February 2020, right before COVID-19 became a worldwide pandemic, OMHSAS issued OMHSAS-20-02. This bulletin expanded the use of telehealth to include CRNPs, PAs, LCSWs, LPCs and LMFTs.
- On March 15, 2020, OMHSAS issued Memorandum Telehealth Guidelines Related to COVID-19, which added temporary flexibilities for telehealth service delivery, in order to ensure ongoing access to behavioral health services under social distancing guidelines, quarantines, and stay-at-home orders. This Memorandum was revised and re-issued as Telehealth Guidelines Related to COVID-19 (Updated) on May 5, 2020.
- OMHSAS incorporated most of the flexibilities introduced during the COVID-19 pandemic into non-COVID-19 related policy with the issuance of OMHSAS-21-09, Guidelines for the Delivery of Behavioral Health Services Through Telehealth, issued August 26, 2021, and re-issued on September 30, 2021.

New Telehealth Bulletin & OMHSAS Telehealth FAQ

- On 7/1/22, OMHSAS issued updated Telehealth Bulletin OMHSAS-22-02 which replaced OMHSAS-21-09.
- The purpose of this bulletin was to update the guidelines for payment of behavioral health services delivered using telehealth technology previously issued in OMHSAS-21-09.
- Key changes:
  - Clarified Telehealth Place of Service (POS) Coding:
    - POS 02= telehealth provided in a location other than the home of the individual being served
    - POS 10= telehealth provided in the home of the individual being served
  - Expanded ability of licensed practitioners who serve less than five individuals to request approval to deliver services using telehealth where they do not maintain a physical location in Pennsylvania within 60 minutes or 45 miles (which-ever is greater) of the area served.
  - Clarified continued allowance of verbal consent as well as the allowable documentation of consent

Telehealth and HIPAA

- 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).
- U.S. DHHS will not seek punitive action against a provider who is not utilizing a HIPAA compliant platform until the end of the public health emergency. When the PHE ends, punitive action may be taken against entities not adhering to appropriate privacy protections.
- U.S. DHHS includes some vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA Business Associate Agreement.
  - ✓ Microsoft Teams (Skype for Business)
  - ✓ Updox
  - ✓ VSee
  - ✓ Zoom for Healthcare
  - ✓ Doxy.me
  - ✓ Google G Suite Hangouts Meet
  - ✓ Cisco Webex Meetings / Webex Teams
  - ✓ Amazon Chime
  - ✓ GoToMeeting
  - ✓ Spruce Health Care Messenger

Telehealth and Consent

- Licensed practitioners and provider agencies must obtain consent from the individual receiving services (or their legal guardian) prior to rendering a service via telehealth.
- Consent to receive telehealth is required at the onset (for each level of care being delivered via telehealth), not for each session. However, licensed practitioners and provider agencies must also allow individuals to elect to return to in-person service delivery at any time. Individuals may refuse to receive services through telehealth.
- Ongoing assessment for the appropriateness for telehealth is also required.
- As with services delivered in-person, providers must obtain consent from the individual served or their legal guardian, as applicable, to make any recordings of the provision of services through telehealth appointments.

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Telehealth and Documentation of Consent

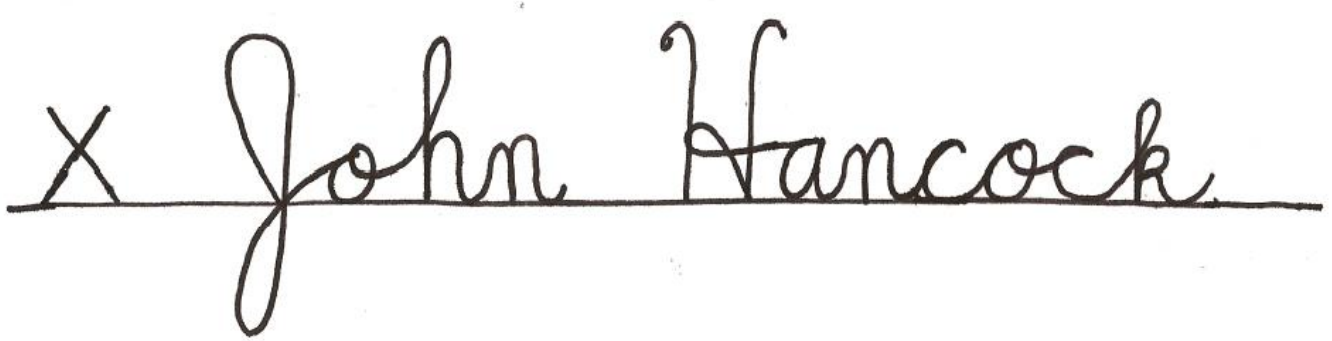
- Signatures for consent may be **physical or electronic signatures**, unless prohibited by other laws.
- During the public health emergency, OMHSAS allowed general verbal consent that was documented by the provider to accommodate rapid transition to telehealth for most providers. OMHSAS is no longer permitting this general method of verbal consent to treat as an acceptable practice.
- Per OMHSAS, providers do ***not*** need to retroactively document consent from clients who gave verbal consent to begin services under the previous Telehealth Bulletin OMHSAS-21-09 (September 30, 2021).
- Physical signatures may be obtained through a variety of different mechanisms:
    - In-person with the member
    - US Mail
    - E-mailed forms to a member who has the capability to print and return the hard copies; or print, scan and e-mail copies

Telehealth and Documentation of Consent

- Per OMHSAS-22-02 and 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.
- Providers using electronic signatures must have systems in place to ensure that there is an audit trail that validates the signer's identity.
- The requirement is to create a permanent record of consent. The easiest way to capture telehealth compliant consent is use a consent feature embedded in a telehealth electronic platform.
- An example of allowable electronic process for electronic signature includes a telehealth platform, where there is an option for a recipient to check a box to express consent. Checking a box is an example of a process.
- A sound could be someone providing their consent verbally, if that consent specifically is recorded electronically or witnessed by a second employee of the provider, and the providers have systems in place that allows an audit trail to validate the signer's identity.
- Services cannot be provided audio-only if there is not the ability to document that consent as outlined above. Providers will not be held accountable to meeting these requirements until 12/31/22, however providers should be meeting or working to meet these expectations currently.

Telehealth and Treatment Plan Signatures

- Treatment plans are required to have an individual's or parent's signature attached to the record. Signatures may be obtained using a telehealth platform or by acquiring signatures via U.S. mail or email as *soon as possible and no later than 90 days after the service*.
- Telehealth platforms that utilize a check the box for the recipient of services to agree as a method of capturing consent for treatment plans are permitted provided there is also the option to not accept the treatment plan provided.



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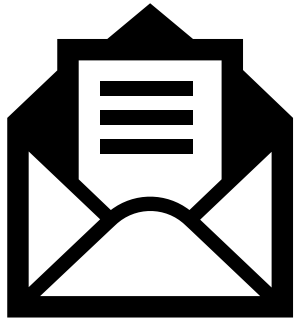
Telehealth and Encounter Forms

- Audio-only verification for service encounters must be obtained either by having another employee of the entity hear (meaning two people) and documenting that consent or by utilizing a mechanism such as a telehealth platform or U.S. mail or email to secure consent.
- Services cannot be provided audio-only if there is not the ability to document the verification of service as outlined above.
- Providers should not bill for services for which they do not have verification of service provision.



Telehealth FAQs and Provider Performance Standards

- On 8/16/22, OMHSAS issued an updated Telehealth FAQ based on 7/1/22 updated Telehealth Bulletin.
- On 8/25/22, Magellan issued a communication titled Telehealth Updates. This included links to OMHSAS-22-02, the OMHSAS Telehealth FAQ as well as important billing Magellan billing guidelines:
  - POS Coding: 02 vs. 10
  - Audio-only modifier FQ
- On 10/6/22, Magellan issued our updated Telehealth FAQ to align with the recent OMHSAS changes.
- As a reminder, Magellan has Telehealth Provider Performance Standards posted on our website.

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POLL QUESTIONS/ Q&A

Special Investigations Unit (SIU) Presentation

Our Objective

Is to Identify and mitigate fraud, waste and abuse (FWA) in all of our service delivery programs using a dedicated, cross-functional team and a coordinated approach. Our efforts serve to support a high-quality network of providers and reduce risk of FWA in the Medicaid system.

Our Challenge

The current estimates of fraud, waste and abuse in health care range from 3-10% of expenditures, which could be as high as three hundred billion dollars according to the National Health Care Anti-Fraud Association.

Our Resources

We apply and include clinical, investigative, administrative, data mining, data analytics, and programming resources to aid in the planning development and execution of our FWA program.

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SIU Tools

- The SIU uses referrals, hotline calls, whistleblower reports, data analytics, results from audits and identified trends from data mining as the basis for investigations.
- The SIU work plan is created in collaboration with corporate leadership and examines new and existing program risk.
- The SIU develops and maintains a library of contractual and regulatory references that are considered during medical record reviews, audits and data analysis.
- The SIU coordinates with the Network and Quality Departments as well as Claims and Compliance Auditors to employ mitigation strategies such as provider education and Corrective Action Plans.
- The SIU conducts root cause analysis when issues are identified to control process weaknesses and maintain the integrity of investigations and recovery of overpayments identified as a result of FWA.

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Data Analytics & Minimizing Risk

ABA Services and Risk Ranking Application

Services Date Range: 01/01/2021 - 09/30/2022
Last Refresh Date: 10/11/2022 07:57:54 AM
The Perspective/SIRIS Refresh Date is the 6th-7th of Each Month

Risk Ranking Criteria

By Paid Provider:

1: Cross Reference Perspective
2: % Members Billed More Than Eight Hours a Day
3: % Members Billed More Than 40 Hours Per Calendar Week
4: % Members Billed More Than 30 Hours Per Week for Members Between 1-3 Years Old
5: % Members Billed 25 Units Per Day For Members 7 Years Or Older
6: % Members With Multiple Codes On Same Day
7: % Services Billed On US Holidays
8: % Services Billed On Weekends
9: % Services Billed With HO Modifier
10: % Services Billed With HM Modifier
11: % Services Billed With HN Modifier
12: % Services Billed With HP Modifier
13: % Services Billed With GT/95/GQ Modifier
14: Total # Members Seen
15: Average Cost Per Member
16: Average Hours Per Member All Codes
17: Average Hours Per Member/Week
18: Total # Units Billed For All Codes
19: Total Paid Amount

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Case-by-Case

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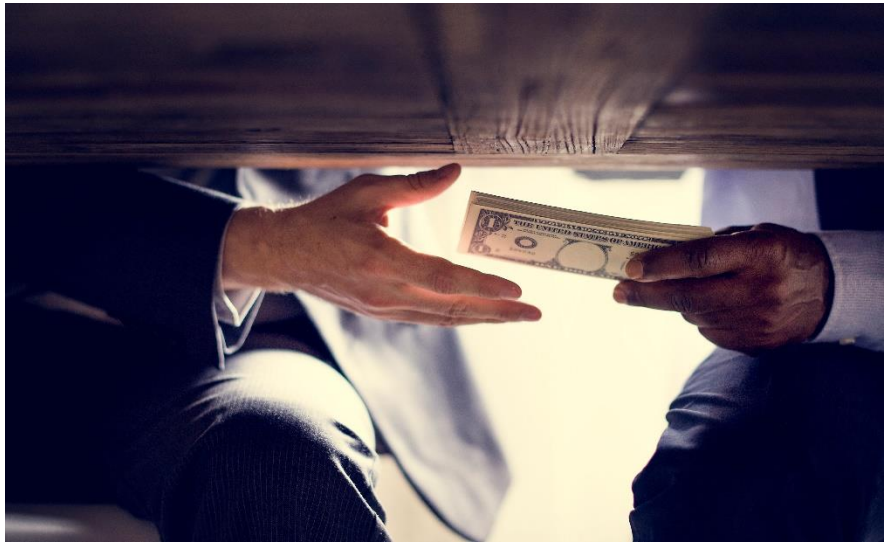
Kathy's Story

Kathy was an individual outpatient practitioner. Her story started when one of her members got an EOB in the mail. The member knew she only saw Kathy occasionally and never for more than fifteen or twenty minutes. This did not match what was on her EOB. Kathy was audited and provided acceptable documentation for most of the records that were requested. A small overpayment for missing documentation was collected.



Later that year there was another referral about Kathy. A member reported to their care coordinator that Kathy contacted the family on Facebook and requested that they open a bank account so the provider could charge Medicaid $1,000 for services and would reimburse the family $600. It could not be confirmed as a credible allegation of Fraud, so the investigator verified with the member and his family that all the services that were paid for were received by the member. They obtained a signed service verification that all the services were rendered by Kathy.

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Kathy's Story (continued)

Two years later…

Another member reports that she does not see the provider as frequently or as long in duration as her EOB states. A new investigation determined that the provider was billing for couples and/or family therapy with CPT Code 90847 but rendering individual therapy services instead. Documentation received did not support that more than one person was present or discussed during the session. Further investigation determined that the provider was fraudulently billing Medicaid for children's counseling sessions, when in fact, public school records showed that the children were in class attending school during the alleged counseling sessions.

The provider was accused of illegally billing the Medicaid program and faced 15 felony charges, including multiple counts of fraud over $20,000; obstruction of investigation; Medicaid Fraud; and theft of identity.

Kathy ultimately was sentenced to three years in the Department of Corrections and immediately remanded to custody following her trial.

Due Diligence

The SIU investigates every allegation we receive about fraudulent activities.

" I ran into one my former patients and she told me the name of her new therapist. I thought it was strange because I knew that person had left years ago……"

"they alter their records they have charting parties; they don't supervise anyone, or update treatment plans and I know two people I work with who don't have credentials…"

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We have ways to prevent and detect Fraud, Waste and Abuse, but we can’t do it without YOU.

IT IS EVERYONES JOB TO REPORT FRAUD !
WE HOPE YOU WILL JOIN US IN FIGHTING FRAUD, WASTE AND ABUSE !

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Q&A

Coding and Evaluation & Management (E&M) Resources

Coding and Evaluation & Management (E&M) Resources

Magellan's stance on E&M coding follows what can be found in the American Medical Association's (AMA) Code and Guidelines. We want to specifically call attention to the fact that E&M Medical Decision Making is meant to be determined by the medical or behavioral professional, and an EHR should not be configured to replace the decision-making component. Likewise, time spent, in of itself, has never been the only consideration in meeting certain code criteria.

Instructions for Selecting a Level of Office or Other Outpatient E/M Services Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, or
2. The total time for E/M services performed on the date of the encounter

The key component is that however a medical/ behavioral professional establishes the appropriate E&M Code in accordance with these guidelines, the documentation in the medical record must support and justify that determination.

Coding and Evaluation & Management (E&M) Resources

Codify by AAPC:

https://www.aapc.com/codes/em-calculator-2021/

Advizehealth E&M Calculator:

http://emcalc.advizehealth.com/

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Q&A

Confidentiality Reminders

Confidentiality Basics

Disclaimer: In providing information regarding confidentiality, Magellan is not furnishing legal advice.

- ✓ 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 Federal Substance Abuse Laws may be more stringent than HIPAA. You must follow the most stringent 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.

- ✓ 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).

Confidentiality and Coordination of Care

Benefits of Care Coordination

- Avoids:
  - Waste: Duplication of services or rework
  - Over, under or misuse of prescription medications
  - Conflicting plans of care or treatment plans

- Improves:
  - Access: allows for coordination between providers and could assist in removing any barriers to referral to higher levels of care
  - Comprehensive treatment
  - SDoH Needs (i.e., supports access to resources and referrals)
  - Members support system (i.e., families and loved ones can be involved in crisis and discharge planning)
  - Transition and discharge planning

Confidentiality and Coordination of Care- Release of PHI Forms

- Providers must develop and implement their own release of PHI forms in order to coordinate care with other treatment providers, service systems and member supports.
- Authorization to Use and Disclose (AUD) form, Magellan's consent form to share information with a third party should be completed by the member (or member's personal representative).
  - Fillable Form: https://www.magellanofpa.com/documents/2022/07/070122_pahcaudform.pdf/
  - Online Submission*: https://www.magellanofpa.com/consent-to-release-protected-health-information-phi/
- Important Reminders about Magellan's AUD:
  - Use the online submission option* whenever possible as it reduces invalid forms (personal representatives can also upload supporting legal documentation when applicable)
  - If using the fillable form and faxing, e-mailing or mailing to Magellan, please complete all sections in full or the form will be returned.
  - In most cases, members aged 14 and older control the release of their records and thus MUST sign the AUD.
  - For members under 14, the **legal** guardian must sign the AUD. If someone other than the biological parent has legal custody of the child, proof of custody MUST be provided.
  - Control of records is with the consenting party. Per Act 65, if a member's legal guardian has consented to treatment for a child aged 14-17, the legal guardian would control the records (and thus sign AUDs) for that treatment episode.

Confidentiality and Coordination of Care- Release of PHI Forms (Continued)

- Providers or other third parties requesting **written** information from Magellan related to an individual's past treatment history or other information must submit requests in writing and have the member (or member's personal representative) complete an AUD.
- Completed AUDs may be now be submitted via e-mail (online submission is preferred) to: PAHC_AUD@magellanhealth.com
- Record Requests and other supporting legal documents may now be submitted via e-mail to: PAHCCompliance@magellanhealth.com

Substance Use Confidentiality Regulation Changes

- On 7/7/22, Act 33 of 2022 was signed into law. Act 33 made significant changes to the SUD confidentiality provisions under Pennsylvania law.
- Act 33 makes PA's SUD confidentiality requirements consistent with federal law. Federally-assisted programs for the diagnosis, referral, or treatment for SUD are covered by the federal regulations at 42 CFR Part 2.
- Any provider who receives federal assistance (which is all PA Medicaid Providers) is impacted by Act 33.
- The PA Department of Drug and Alcohol Programs (DDAP) is also restricted from implementing any new regulations that exceed the federal regulation and that they cannot cite any provider during a licensing review for disclosures permitted by 42 CFR Part 2.

Substance Use Confidentiality Regulation Changes

What does this mean for Magellan?

- ✓ 42 Part 2 CFR still requires that members sign consents to release information. There are no exceptions for treatment or care coordination or payment. The only exceptions are for medical emergencies, certain research, or certain audits.
- ✓ Magellan has always required an AUD signed by the member, which includes special permission to share SUD info before we would share any SA information with a third party including a treating provider.
- ✓ Providers will need to obtain signed releases from members during admission in order to share information with Magellan including submitting a claim.
- ✓ Due to the elimination of 4 Pa Code 255.5, we are no longer restricted to sharing limited information (whether client is in treatment; prognosis; nature of the project; description of progress; relapse or at risk of relapse)

POLL QUESTIONS/ Q&A

Compliance Plans, Culture, and Ethics

8 Components of Effective Compliance Programs

1. Written policies and procedures
2. Designate a compliance officer and committee
3. Develop an effective compliance training, education and awareness program
4. Establish open lines of communication
5. Establish and maintain disciplinary policies
6. Establish and maintain a process for routinely evaluating and identifying potential and actual non-compliance (internal auditing and monitoring)
7. Establish and maintain a system for responding to compliance issues
8. Assessing effectiveness and developing a timeline for compliance program activities

Prevention **Detection** **Corrective Action**

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Compliance Culture

- **Creating a culture of compliance within your agency is CRITICAL to success**
- Compliance is about process improvement, NOT punishment for doing something wrong (staff should be feel comfortable raising concerns)
- Ask the questions:
  - What do we do well?
  - What don't we do well?
- Having a designated compliance officer (who has no other functions) helps create a culture of compliance
  - Many agencies combine the job functions of Compliance and Quality
- Compliance has overlap with a lot of departments. Some problems may be solely compliance related, but most issues overlap with HR, finance, clinical, quality, etc.

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Compliance Culture

- Know where to find/ get the information even if you don't have all the actual regulations or requirements memorized.
- A successful compliance culture is strongly influenced by how much staff trust management.
- Compliance is more than just billing: training and culture helps make your team aware of all the components.

Increased compliance= increased quality

Increased quality= provider of choice

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Compliance Audit Trends:
Most Common Items Missing from Provider Compliance Plans

- ❑ Policy or Procedure (P&P) on Internal Claims Audits (e.g., comparison of clinical documentation vs. accuracy of billing)
- ❑ Conducting periodic reviews, at least annually, of the Code of Conduct & Compliance Policy & Procedures
- ❑ Collaborative Documentation Policy
- ❑ Compliance as an element of the employee's annual evaluation
- ❑ P&P regarding responding to and reporting of compliance concerns including:
  - Plan that addresses how internal investigations should be conducted
  - Time limit for closing a compliance investigation
  - Options for corrective action that the agency can take
  - Reporting to State and BH-MCO
  - When to have an investigation performed by an outside, independent investigator
- ❑ Outside resources to report FWA
- ❑ Potential consequences for FWA including legal ramifications
- ❑ Designation of a dedicated Compliance Officer

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Compliance Interviews Reminders

- 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.

POLL QUESTIONS/ Q&A

Other Reminders

Self-Reports of FWA

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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Self-Reports vs Corrected Claims

- The Provider Self-disclosure Claims Recovery Template should only be utilized in those cases of potential Fraud, Waste or Abuse.

- Billing mistakes or errors should be corrected by following Magellan's Claims Resubmission process whereby a provider can submit a Corrected Claim (see Magellan's Provider Handbook Supplement page 74 for details). Resubmitting Claims with provider billing errors are called "resubmissions." Resubmitted claims must be received by Magellan within 60 days of the date of determination.

Other Resources/Reminders- PAHC Website

- **FWA Compliance Page**: includes FWA Resources, Compliance Best Practices, Audit Tools, Trainings/Education, and How to Prepare for an Audit.
- **Compliance E-mail Blasts**: issued monthly via e-mail and also posted under "Compliance Alerts" section on the Provider Page of Magellan's website. Address important regulatory and PAHC guidelines including recent audit trends and policy changes.
- **Provider Trainings**: ongoing training materials are available for both new and existing providers.
  - All new PAHC providers are required to complete the "PA HealthChoices New Providing Training" prior to contract execution. Providers will be sent a link to this pre-recorded webinar when they receive their contract; ALL provider staff must complete the training. The Compliance Dept. has its own dedicated module.
- **Provider Handbook Supplement**: important requirements and guidelines for all providers.

POLL QUESTIONS/ Q&A

Magellan Compliance Contacts

- SIU Claims and Compliance Auditors:
  - **Patty Marth, CFE (Lehigh & Northampton Counties)**
    610-814-8009
    PMarth@magellanhealth.com
  - **Caitlin Vossberg, LSW (Bucks & Montgomery Counties)**
    267-895-5678
    VossbergC@magellanhealth.com
  - **Tina Davis, M.Ed., CFE (Cambria County)**
    814-961-0689
    TMDavis1@magellanhealth.com
- SIU Team Lead:
  - **Diane Devine, CFE (All Counties)**
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    ddevine@magellanhealth.com
- SIU Manager:
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    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

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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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