Provider Compliance Forum- 2023

OCTOBER 20, 2023

PRESENTED BY: MAGELLAN BEHAVIORAL HEALTH OF PENNSYLVANIA, INC.

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Introduction/Housekeeping

Meet Our Team

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CAMBRIA COUNTY

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ALL COUNTIES

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SENIOR COMPLIANCE MANAGER/ PRIVACY OFFICER
ALL COUNTIES

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- 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 and will be posted on our website
- All participants are muted. Please submit questions utilizing the Q&A feature in Zoom.
- Poll Questions will be utilized throughout the training session
- Brief Survey Questions will be shared at the end of today's training- please stay on the line to give us feedback!

Agenda

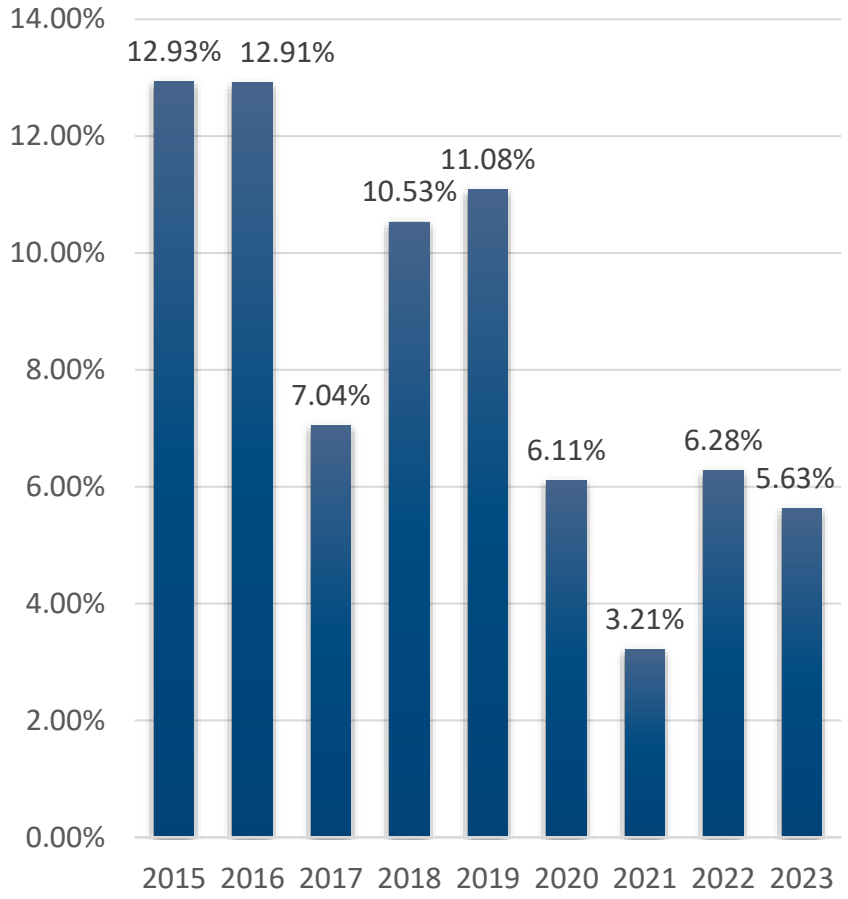
- Positive Outcomes and Audit Trends
- Center of Excellence (COE)
- Telehealth
- FWA Overview
- SIU Scheme Presentation
- General Reminders
- Authorization to Use or Disclose (AUD)/ Records Requests
- Closing Remarks
- Survey Questions

Positive Outcomes!

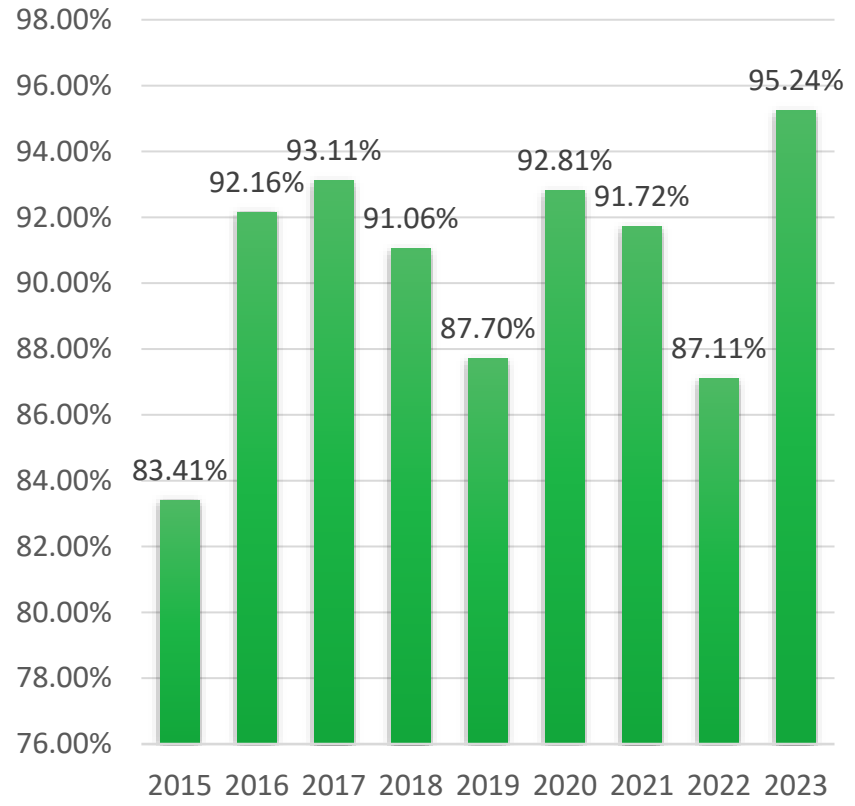

Leading
humanity to
healthy, vibrant
lives

Outcomes: 2015 – August 2023

Claims Error Rates



Compliance Program Scores



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Audit Trends

Compliance Program Audit Trends

Most Common Items Missing from Provider Compliance Plans

- Lack of Policy or Procedure on Internal Claims Audits
- Conducting periodic reviews, at least annually of the agency's Code of Conduct and Compliance Plan (Compliance Policies and Procedures)
- No Policy or Procedure on Collaborative Documentation
- Compliance should be included as an indicator on Employees' Annual Evaluations
- No Policy or Procedure on responding to and reporting of compliance concerns
- Policies are lacking inclusion of potential consequences for committing FWA including legal ramifications
- Missing a dedicated Compliance Officer
- Lacking a Compliance Committee

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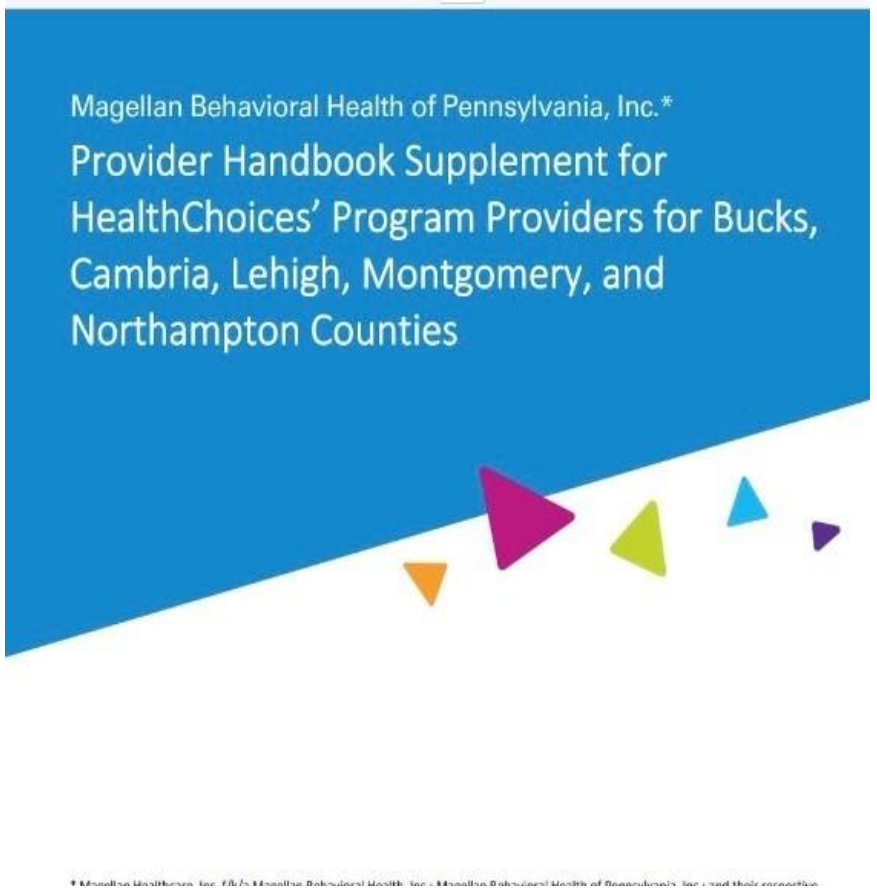
Overall Claims Audit Trends

- Missing documentation
- Non-compliance with the minimum documentation requirements (please reference Magellan's PAHC Provider Handbook Supplement). Specifically:
  - Missing start and end times
  - Incorrect service date billed
  - Missing staff credentials
  - Signatures not dated
  - Location where service was rendered is absent
- Treatment/ Service Plan non-compliance
- Billing incorrect Place of Service codes
- Non-compliance with Collaborative Documentation requirements



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Overall Claims Audit Trends (continued)

- Non-adherence to Magellan rate sheet/reimbursement schedule (utilizing the correct procedure code/modifier combination and unit definitions)
- Electronic Health Record (EHR) time stamps preceding end time of the session
- All-inclusive contracts
- Billing for non-billable or non-covered services including:
  - Travel/Transportation
  - Social/Leisure activities
  - Paperwork/Administrative activities
- Duplication of services

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POLL QUESTION

Which of the following is NOT a documentation standard that is outlined in the Magellan PAHC Provider Handbook?

a) Legibility
b) Procedure Code/ Modifier
c) Start/ End Time of Session
d) Date of Service

ANSWER:

b) Procedure Code/ Modifier

IBHS Audit Trends

- ✓ 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 where services were provided.
- ✓ Hand-written notes were not consistently legible.
- ✓ Use correct error correction procedure.
- ✓ Written orders need to be updated annually.

- ✓ 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.
- ✓ Time in and out should be documented in real time and not clock hours.
- ✓ Lack of signed encounter forms.

Outpatient Audit Trends

✓ Advanced Practice Professional (CRNP and PA) Services in Outpatient Clinics

- Per Chapter 5200 of the PA Code, 50% of the required psychiatric time at a licensed outpatient clinic may be provided by a CRNP or PA.
- A Certified Registered Nurse Practitioner (CRNP) must a have a collaborative agreement with a physician who holds a current license to practice in this Commonwealth. A Physician Assistant (PA) must also have a written agreement with a supervising physician.
- CRNP Qualifications: per Chapter 1153 of the PA Code, a CRNP must have certification as either an Adult Psychiatric Mental Health Nurse Practitioner or a Psychiatric Mental Health Nurse Practitioner (formerly known as Family Psychiatric–Mental Health Nurse Practitioner).

✓ 992XX / E&M Codes (MDs, CRNPs and PAs)

- Both Medical Decision Making (MDM) and time should be considered when selecting the appropriate billing code. If you are meeting a specific level of MDM, it will take approximately “x” amount of time.
- Code Definitions:
  - 99211: 1 minute - 9 minutes
  - 99212: 10 minutes - 19 minutes
  - 99213: 20 minutes - 29 minutes
  - 99214: 30 minutes - 39 minutes
  - 99215: 40 minutes - 54 minutes

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Outpatient Audit Trends

✓ RN Services in Outpatient Clinics

- 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 Chapter 21 of 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).
- Bill for the activities above utilizing H0034 code combinations only.
- Under CMS, "Incident to" billing applies only to professional services billed to Medicare. This type of arrangement is not permitted for Medicaid reimbursement.

Outpatient Audit Trends

- ✓ Treatment Plans updates/signature requirements
- ✓ Individual Therapy Codes
  - 90832: 16 to 37 minutes
  - 90834: 38 to 52 minutes
  - 90837: 53 minutes or longer

- ✓ Group Therapy
  - Group psychotherapy (SUD OP Clinic) — Psychotherapy provided to no less than two and no more than 10 persons with diagnosed drug/ alcohol abuse or dependence problems for a minimum of one hour. These sessions shall be conducted by drug/ alcohol clinic psychotherapy personnel under the supervision of a physician.
  - Group psychotherapy (MH OP Clinic) — Psychotherapy provided to no less than two and no more than 12 persons.
  - Regardless of the number of provider staff co-facilitating or leading the group, the maximum allowable size without a waiver is 10 (SUD Clinics) or 12 (MH OP Clinics).
  - Providers must implement a sound tracking mechanism for group participation including arrival and departure time as well as structured breaks.

POLL QUESTION

When billing procedure code 99213, which time duration is required?

a) 15 minutes
b) 20 – 29 minutes
c) 10 – 19 minutes
d) 30 – 39 minutes

ANSWER:

b) 20 – 29 minutes

Case Management Audit Trends

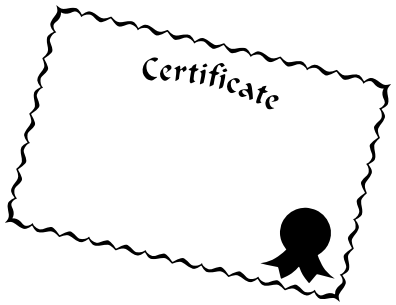
- ✓ Travel/Transportation:
  - Travel time & time spent transporting members (even when providing case management services) is not reimbursable or billable.
  - Documentation (e.g., progress notes) should clearly demonstrate the time spent traveling/ transporting members, and this time should be separate from time spent providing services (e.g., billable time).
  - Staff should comply with their own internal agency policies regarding transporting/ traveling with members; regardless of agency policy, these activities are not billable.
- ✓ Rounding- case management unit definition is 15 minutes or better part of the unit (at least 8 minutes).
- ✓ Progress notes must reflect Service Plans goals.
- ✓ Training-Western Psychiatric Institute and Clinics online case management training completed within 6 months of hire and then every 2 years thereafter (Case Management Transformative Initiative (CMTI) or Drexel Training is also permitted for Bucks and Montgomery Counties, respectively).
- ✓ Encounter Forms must include:
  - The start and end time of the session must be included for face-to-face services (the actual time in clock hours, not the duration; i.e., '2:00 PM-4:00 PM', not '2 hours').
  - The recipient's signature (or legal guardian's).
  - The rendering provider's signature. If the billable face-to-face contact is collateral (the member is not present), then the identified individual who the meets with the provider would sign the encounter verification form (i.e., school personnel/ teacher).

Family Based Mental Health Services (FBMHS) Audit Trends

- ✓ Encounter Forms must include:
  - The start and end time of the session must be included for face-to-face services (the actual time in clock hours, not the duration; i.e., '2:00 PM-4:00 PM', not '2 hours').
  - The recipient's signature (or legal guardian's).
  - The rendering provider's signature. If the billable face-to-face contact is collateral (the member is not present), then the identified individual who meets with the provider would sign the encounter verification form (i.e., school personnel/ teacher).
- ✓ Rounding- FBMHS unit definition is 15 minutes or better part of the unit (at least 8 minutes).
- ✓ Travel time should be clearly documented on the progress notes.
- ✓ Signatures on treatment plans (Per the PA Code 5260.43):
  - The initial plan shall be prepared, reviewed and approved by the program director and clinical consultant, if required within 5 calendar days of the initial service.
  - The plan shall be reviewed and updated at least once a month thereafter.
  - Progress notes shall clearly record the delivery of services and how the services relate to the attainment of the goals in the treatment plan.
  - The parent of a consumer who is a child shall sign the treatment plan and updates. An adolescent who is a consumer shall sign the treatment plan and updates.

Peer Services (PSS and RSS) Audit Trends

- ✓ Recommendation from a Licensed Practitioner of the Healing Arts (LPHA) must be present.
- ✓ Appropriate staff accreditation and trainings.
- ✓ Progress notes must reflect Individual Service Plans goals.
- ✓ Duplication of services: COE & CPS and CRS & CPS.



- ✓ Encounter Forms must include:
  - The start and end time of the session must be included for face-to-face services (the actual time in clock hours, not the duration; i.e., '2:00 PM-4:00 PM', not '2 hours')
  - The recipient's signature (or legal guardian's).
  - The rendering provider's signature.
- ✓ Rounding up is not permitted- the PSS and RSS unit definition is a full 15 minutes.
- ✓ Transportation is NOT a billable healthcare service (billing for the time spent in transit with a member may be reimbursable if in alignment with ISP goals).

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Peer Services (PSS and RSS)- Travel Audit Trends

Please note that clear documentation and rationale of PSS and RSS provided during transit with an individual must include:

- ✓ Services provided in transit must include the specific interventions that relate back to the specific goal in the member's ISP.
- ✓ The CPS or CRS should only transport a member when it is necessary and appropriate. The CPS/CRS should be mindful not to create dependence. Other methods of transportation should be explored and utilized whenever possible. If an individual needs assistance with acquiring a specific skill such as riding the bus to roster independence, it would be appropriate to include this as a time-limited goal on the ISP.
- ✓ Providers must document how much time is spent in transit with a member while providing an intervention from the ISP, in addition to other non-billable time in transit. If services provided during transit are not billable, the time spent in transit should be clearly deducted from the overall time billed and this distinction should be clearly documented.
- ✓ Providers should have policies and procedures in place that clearly outline their expectations and guidelines for staff around the general transportation of individuals as well as rendering services while in transit.
- ✓ PSS and RSS should only be provided during transit if it is safe and appropriate.

POLL QUESTION

In what level(s) of care may a provider round up the last unit when the better part of the unit is provided (at least 8 minutes)? Choose all that apply.

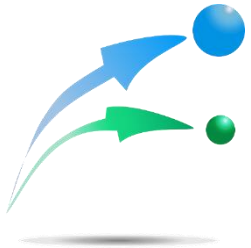
a) Intensive Case Management
b) Peer Support Services
c) Family-Based Services
d) Recovery Support Services

ANSWER:
a) Intensive Case Management
c) Family-Based Services

Centers of Excellence (COE)

Centers of Excellence (COE) Audit Trends

- Members must have an Opioid Use Disorder Diagnosis.
- COE services are being provided concurrently with Medication Assisted Treatment (MAT) and Outpatient Substance Use Disorder (SUD) Services. All COEs must provide at least one form of MAT, however, the sole purpose is not to provide MAT, instead you are to provide Case Management (CM) and RSS services.
- COE providers are not consistently submitting “zero pay” encounters (G9012 U9) to correspond to each additional community-based care management service that is rendered to HealthChoices members.
- Intakes are vague. No specific questions are asked during intake regarding other services that the member is receiving.
- Census levels at the COE providers are elevated and not conducive to optimal member support/ engagement. Under the grant funding, it was suggested that a census of 300 would help COEs obtain the full grant funding of $500,000. However, under HealthChoices funding, there is no minimum census requirement.



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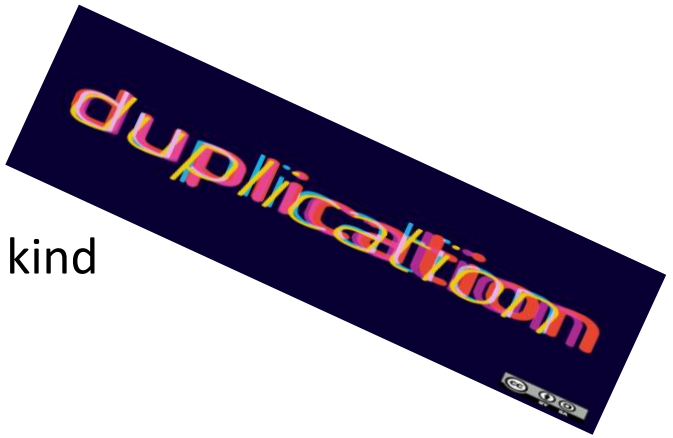
Centers of Excellence (COE) Audit Trends

The following activities are not billable as community-based care management COE services:

- Emails and/or texts with members or any collateral agency
- Travel without a member
- Supervision
- Staff Training
- Documentation, record-keeping or administrative activities of any kind
- A general “check-in” with the member



Service Duplication

- While active in a COE, members may not receive community-based peer services (RSS or PSS), nor may they receive Drug and Alcohol Case Management services outside of the COE.
- When a member is enrolled in community-based services and maintaining their recovery, it is not always necessary to enlist the services of the COE and/ or continue services in the COE once those community connections are established.

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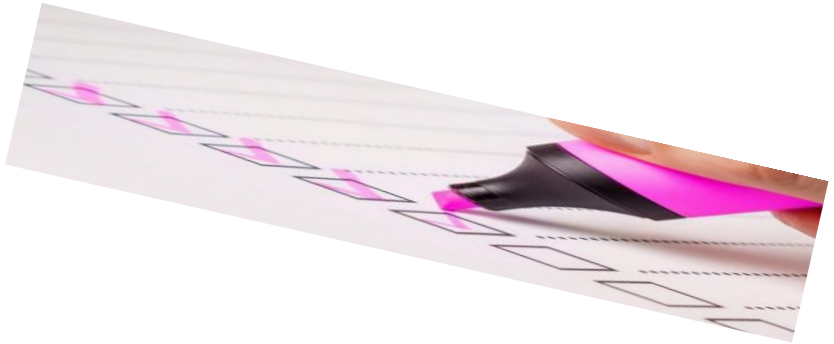
Centers of Excellence (COE) Best Practices

- The expectation is that six months should be adequate time for a COE Case Manager to make a referral and help a member become established with a community resource.
- The spirit of the COE is to be out in the community. Staff should be meeting our members in the community if a member cannot get to them and they should be taking referrals for the COE, regardless of a member's involvement in a methadone clinic.
- Documentation should include missed/cancelled appointments and/or nonbillable services.
- Freedom of member choice includes access to services not linked to the agency providing COE services. For example, if a COE is Provider A and Provider A also has an Outpatient SUD program, but the member chooses Provider B for Outpatient SUD instead of being required to receive Outpatient SUD services with Provider A.
- A Memorandum of Understanding should exist for various community organizations.
- Caseloads should be no more than 30:1 ratio.
- Providers need to have an admission, continued stay, and discharge criteria outlined for every member being served in the COE. Providers need to have documentation for re-evaluating each member served in the COE to ensure the ongoing member's needs are assessed and the member still meets the criteria for COE services.
- Utilization of Pennsylvania Department of Drug and Alcohol Program's Case Management Service Plan.

Centers of Excellence (COE) Reminders

- Per Member Per Month (PMPM) payment claim (G9012) represents the minimum required community-based care management service that is provided on a monthly basis for each member enrolled in COE services.
- Zero-pay encounters should be submitted throughout the service month for each additional community-based care management service that is provided.
- All claims, whether it's the PMPM payment code (G9012) or additional zero-pay encounters (G9012 U9), must be reflective of the exact date of each community-based care management service. In effect, all claim dates must match a service note date.
- Effective July 1, 2023, the unit definition for an Opioid Centers of Excellence (COE) encounters is 15-minutes. The full 15 minutes must always be provided to bill 1 unit. Rounding up is never permitted.
- The COE's plan of care should clearly outline how the COE is supporting members in connecting to treatment, community, and health services.
- Encounter Forms must be present.



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Centers of Excellence (COE) Referrals

- Magellan expects that COE staff will actively facilitate referrals and coordinate responses of social service needs. This includes providing support to members that extends beyond sharing resource information (e.g., providing a list of phone numbers for resources).
- The COE should actively assist members with ongoing communications including but not limited to filling out applications, contacting resources on behalf of members, etc. COE staff should facilitate referrals to necessary and appropriate entities, including but not limited to clinical services according to the member's care plan.
- COE staff should also facilitate referrals to necessary and appropriate non-clinical services in accordance with the member's needs identified through a SDoH screening. This includes but is not limited to:
  - Stable housing
  - Employment
  - Re-establishing family/community relationships

Centers of Excellence (COE) Monitoring

COE staff should conduct ongoing monitoring to include:

- Individualized follow-up with members and monitoring of members' progress per the care plan, including referrals for clinical and non-clinical services.
- Continued and periodic re-assessment of a member's SDoH needs.
- Performing urine drug screenings at least monthly.
- Documentation should be evident in the chart that confirms the referrals made, the provider delivering the MAT service, and the type of MAT that the member is receiving.
- The BARC-10 must be re-administered at six-month intervals.
- COEs must both be able to make and receive warm hand-offs. In the event of a warm hand-off from an overdose event, the COE must provide education related to overdose risk and naloxone.

POLL QUESTION

True or False - A member can receive COE services and Peer Support services at the same time.

a) True
b) False

ANSWER:

b) False

Telehealth Services

Telehealth Documentation

- Adherence to all other regulations and requirements still apply to the service being delivered via telehealth 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: Audio-only & Place of Service (POS) Coding

- Audio-only services can **only** be provided when clinically appropriate and the individual served does not have access to video capability; or for an urgent medical situation. Member/Provider preference is not permissible rationale for providing ongoing audio-only telehealth.
- In accordance with Medical Assistance Bulletin OMHSAS-22-02, informational modifier FQ must be included on claims submissions when providing audio-only telehealth services.
- Providers must 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).
- The allowable POS codes for telehealth includes 02 and 10:
  - Telehealth provided in the identified member's home: POS = 10.
  - Telehealth provided in a location other than the home of the member: POS = 02.
  - This corresponds to the physical location of the member, not the provider.
  - Regardless of whether a provider adds modifier FQ to their claim for audio-only telehealth, the POS code must be represented with either 02 or 10.

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Telehealth: Signature Requirements

- OMHSAS has stressed the importance of developing appropriate systems to capture electronic signatures since February 2021. Given the options available to providers, OMHSAS expects providers to meet federal and state guidance.
- OMHSAS understands the challenges providers have experienced and therefore extended the suspension of bulletins identified in the February 18, 2021 OMHSAS memo to December 31, 2023 (please note this last extension was only for levels of care regulated by Bulletins such as Peer Support; for all levels of care with promulgated regulations, providers should already be in compliance).
- Effective on January 1, 2024, all providers are expected to capture consent to treatment, service verifications, and approval of treatment plans in a manner that creates an auditable file and is in accordance with the timelines expected within regulation.

Telehealth and Documentation of Consent

- 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.
- Signatures for consent may be **physical or electronic signatures**, unless prohibited by other laws.
- 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 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 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

- Providers should follow all applicable Pennsylvania Medicaid Regulations/Bulletins and Magellan guidelines which outline encounter form requirements.
- Per OMHSAS-22-02, signatures for service verification may include hand-written or electronic signatures, unless prohibited by other laws.
- Effective on January 1, 2024, all providers are expected to capture service verifications in a manner that creates an auditable file and is in compliance with the agency's policies and procedures on encounter form signatures.
- 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.**

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Telehealth 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.

Telehealth Resources

- Magellan's Telehealth FAQ (updated June 2023): https://www.magellanofpa.com/documents/2023/06/060123_updatedtelehealthfaq.pdf/
- Magellan's Telehealth Provider Performance Standards: https://www.magellanofpa.com/documents/2022/05/telehealth-provider-performance-standards-may-2-2022.pdf/
- Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth Medical Assistance Bulletin OMHSAS-22-02 (July 1, 2022): https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/OMHSAS%20Telehealth/Bulletin%20OMHSAS-22-02%20-%20Revised%20Guidelines%20for%20Delivery%20of%20BH%20Services%20Through%20Telehealth%207.1.22.pdf
- OMHSAS Telehealth FAQs (updated August 2022): https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/OMHSAS%20Telehealth/Final%20-%20OMHSAS%20Telehealth%20FAQ%202%208.16.22.pdf

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POLL QUESTION

True or False – Service Verification (Encounter Forms) are required for all Telehealth Services effective 1/1/2024.

a) True
b) False

ANSWER:

a) True

Fraud, Waste & Abuse (FWA) Overview

DID YOU KNOW?

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Definitions (HealthChoices Program Standards and Requirements)

- **Fraud=** any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State Law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting.
- **Waste=** the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.
- **Abuse=** means any practice that is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the Medical Assistance program, Behavioral Health Managed Care Organization, Primary Contractor, a Subcontractor, or Provider, or a practice that results in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or agreement obligations (including the Agreement, contracts, guidance issued in bulletins, and the requirements of State and Federal statutes and regulations) for health care.
- **Overpayment=** any payment made to a network provider by a Managed Care Organization to which the network provider is not entitled to under Title XIX of the Act.

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FWA Differences

Fraud requires **intent** to obtain payment and the **knowledge** that the actions are wrong.

Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to federal and state healthcare programs but does not include intent and knowledge.

FWA Examples

Fraud

- Therapist conducts a one-hour family therapy session for four family members but bills the Medicaid plan for fours hours of individual psychotherapy.
- A provider falsifies an individual's medical diagnosis to get coverage for the individual's treatment.
- A health care executive treats a date to a $300 meal using a company credit card then falsifies his expense report, listing a fictious business purpose and attendees.
- A psychiatrist rounding up the time spent with a member.
- A Behavioral Health Technician falsifying parent signatures on an Encounter Form.
- A hospital billing clerk altering claims forms.

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FWA Examples

Waste

- A residential substance abuse treatment facility unnecessarily requires every patient to submit urinalysis tests 3-4 times a week, costing between $6,000- $9,000 per test.
- Psychologist provides two individual therapy sessions per week for all clients when it's not medically indicated for all individuals.
- A provider orders excessive testing for an individual that isn't required.

Abuse

- A provider fails to maintain adequate medical or financial records of its patient care.
- A hospital mistakenly bills both the BH-MCO and PH-MCO for a laboratory service.
- An Acute Partial Program bills the secondary Medicaid health plan instead of an individual's private insurance company for a covered service.
- An Outpatient Substance Use Disorder Clinic providing group services with 15-20 people in a group when the regulations only allow a maximum of 10 people.
- Provider fails to refund or report an overpayment.

FWA Laws

- False Claims Act
- Whistleblower Protection Act
- Healthcare Fraud Statue
- Anti-Kickback Statue
- Stark Statue
- Civil Monetary Penalties Law
- Exclusions

False Claims Act and Whistleblower Protection Act

- The **False Claims Act** prohibits filing false information in order to increase the payment received or to avoid a fine or other obligation. Under the federal False Claims Act, it is illegal to file a claim for money from the government that the claimant is not entitled to receive or request.
  - For Example: *A provider or plan cannot request payment or money from the government for a service that was not provided.*
- The **Whistleblower Protection Act** makes it unlawful for an employee to retaliate against any employee for the employee's good faith assistance with an action that is filed under the False Claims Act.
  - If either the government or the whistleblower is successful, the whistleblower may be entitled to receive a percentage of the recovery.

Healthcare Fraud Statute and Anti-Kickback Statue

- The **Healthcare Fraud Statute** states that “whoever knowingly and willfully executes or attempts to execute a scheme to… defraud any health care benefit program… shall be fined under this title or imprisoned not more than 10 years or both.” Conviction does not require proof the violator had knowledge of the law or specific intent to violate the law.
- The **Anti-Kickback Statute** prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or to generate healthcare program business. For example:
  - Referring members for diagnostic tests in exchange for money
  - Paying a psychiatrist to sign treatment plans in order to bill for services that were not provided.

Stark Statute

- Stark Statute: prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship. Designated health services includes:
  - Clinical Laboratory Services
  - Physical Therapy
  - Radiology
  - Home Health Services
  - Outpatient Prescription Drugs
  - Inpatient and Outpatient Hospital Services
- The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required.
- The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

Civil Monetary Penalties Law (CMPL)

- The Office of Inspector General (OIG) may seek civil monetary penalties and sometimes exclusion for a wide variety of illegal or unethical conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation.
- CMPs may also be imposed for violating healthcare laws such as the Anti-Kickback Statute and False Claims Act.
- Some examples of CMPL violations include:
  - Arranging for services or items from an excluded provider
  - Providing services or items while excluded from participation in Medicaid
  - Failing to grant OIG access to records
  - Knowing of or failing to report and return an overpayment
  - Making false claims
  - Paying to influence referrals
  - Providing false or misleading information expected to influence a decision to discharge
  - Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs

Exclusions

- Exclusion refers to the temporary or permanent debarment of an individual or entity from participation in any federal or state healthcare program.
- The OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses:
  - ✓ Medicaid Fraud
  - ✓ Patient Abuse or Neglect
  - ✓ Felony Convictions for other healthcare related fraud, theft or misconduct
  - ✓ Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances
- Excluded providers may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.
- All providers are responsible for ensuring that they do not employ or contract with excluded individuals or entities.

Special Investigations Unit (SIU) Presentation

Magellan's SIU

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.

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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FWA Scheme

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The Model of Care Introduced by the Provider

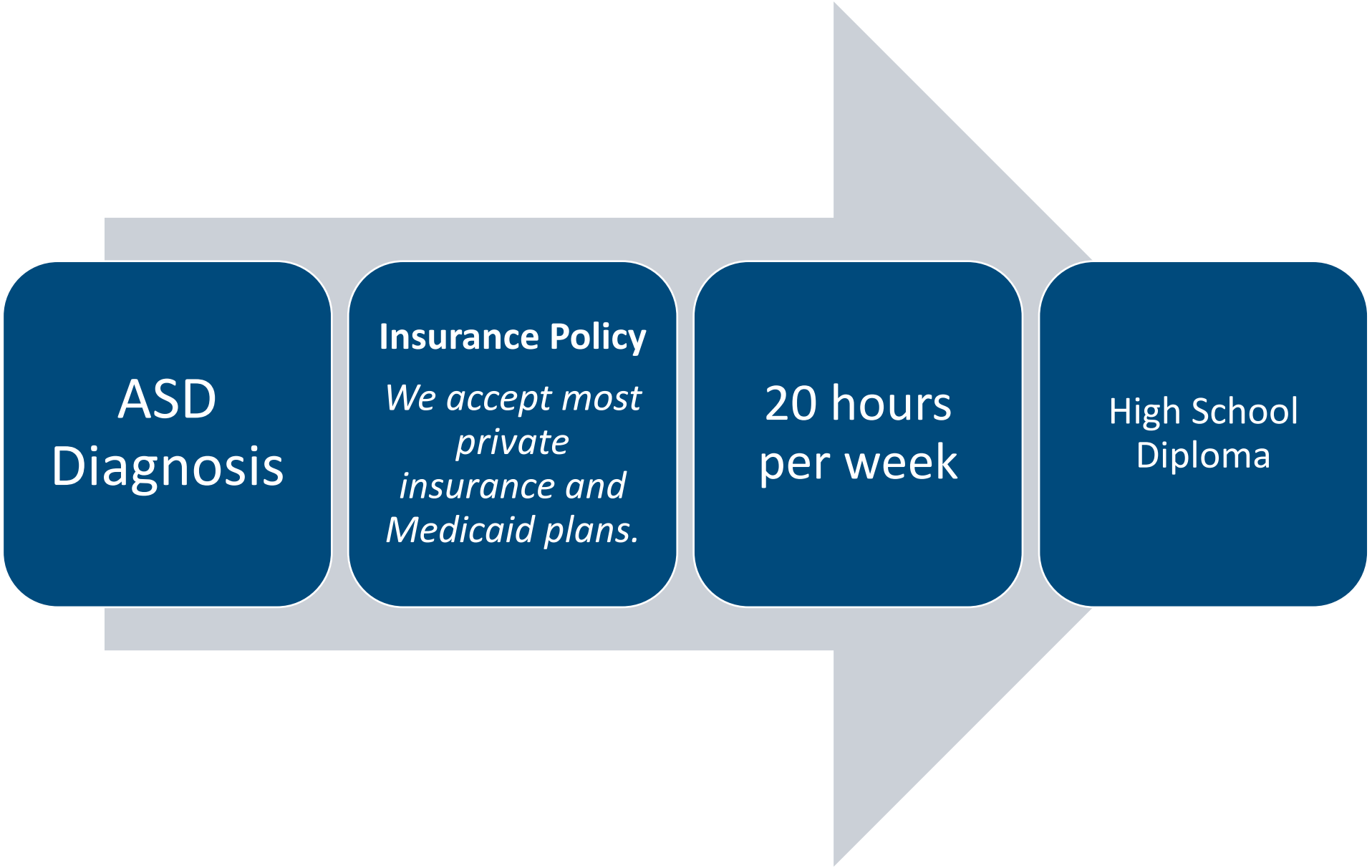
How It Works

A large nationally operated provider developed a parent led model of autism treatment. This provider has over 200 locations throughout the nation. In this model of service delivery parents are being trained by the provider to deliver services to their own children. They are being called BT (Behavior Technicians) while being sent for the thirty required hours of training. Following successful completion of the exam they are then retitled as RBT's and are paid by the provider.

The Path to become an RBT led by the Provider

1. Complete 40-hour online training +
2. Become a Behavior Technician +
3. Parent-led ABA therapy +

The Steps


ASD Diagnosis
Insurance Policy
We accept most private insurance and Medicaid plans.
20 hours per week
High School Diploma

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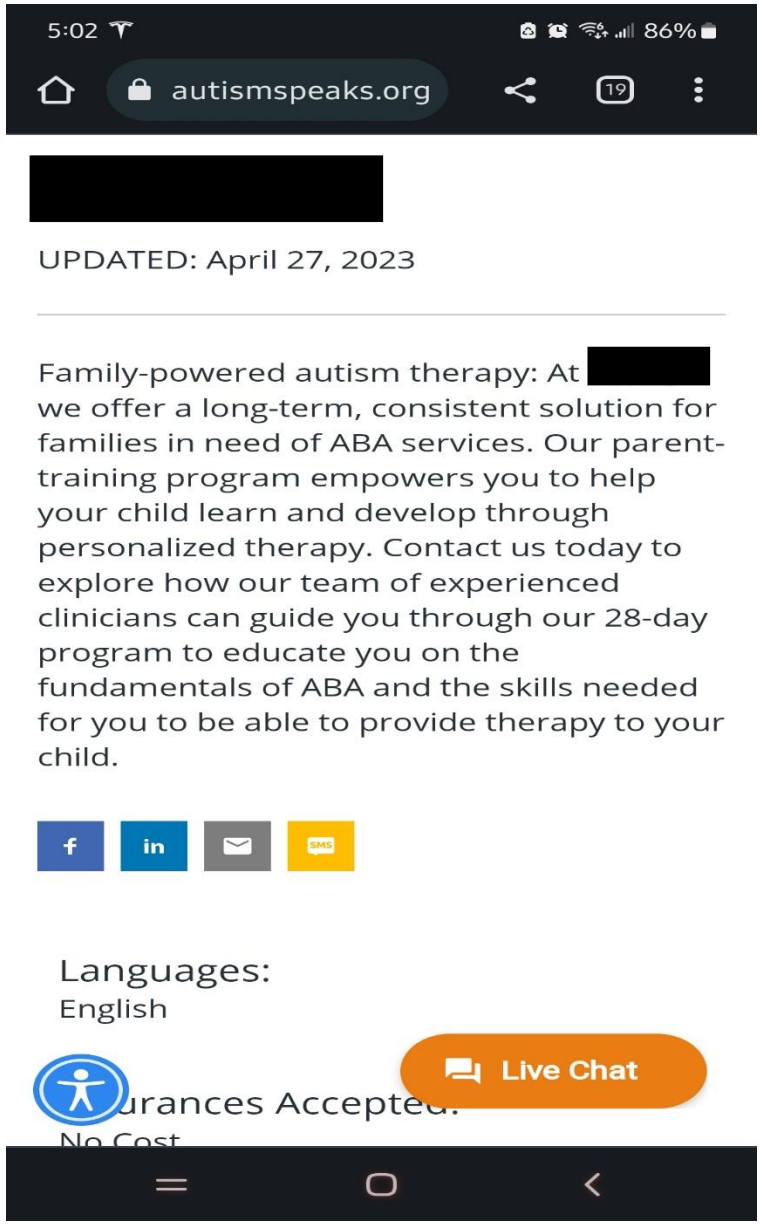
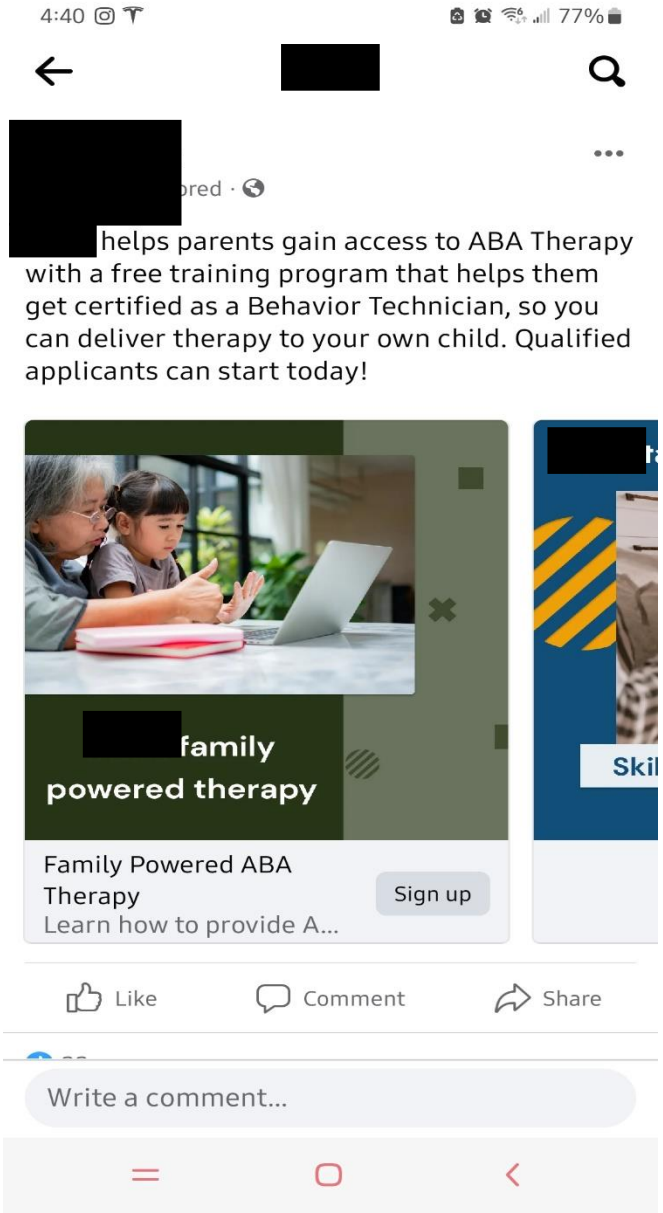
The Allegations

- ✓ This is a large roll out by the provider. We have spreadsheets that list the parents/ employees and their status in the process.
- ✓ The provider has numerous national agreements with numerous payers across the nation including Magellan.
- ✓ It is reported that the provider's intent is to employ parents as RBT's. This has been reported to numerous Managed Care Organizations, and insurance plans as well as several regulatory oversight agencies.

Advertisements





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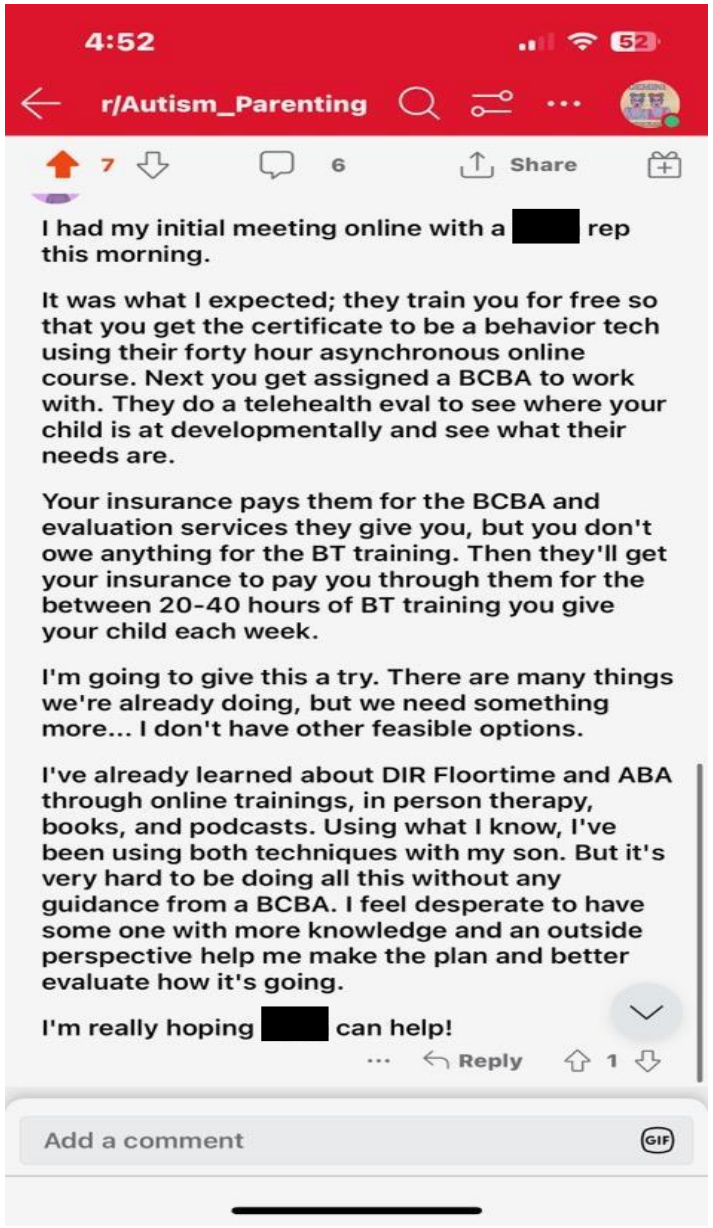
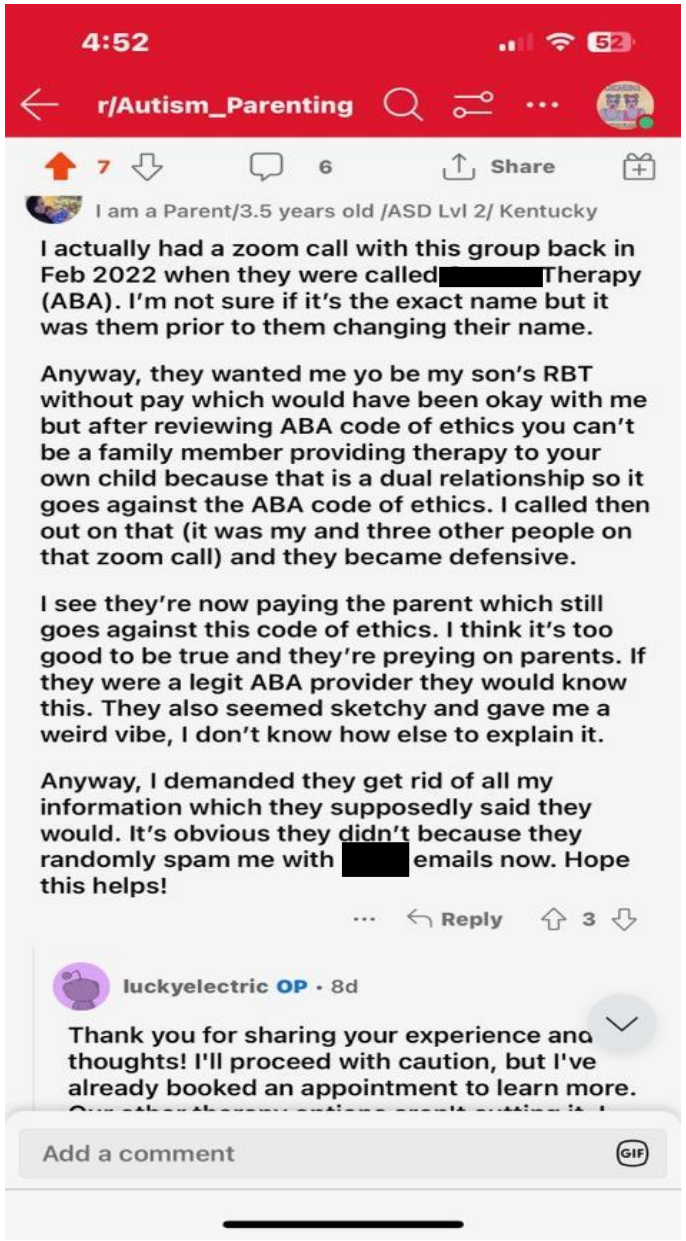
Parent Conversations



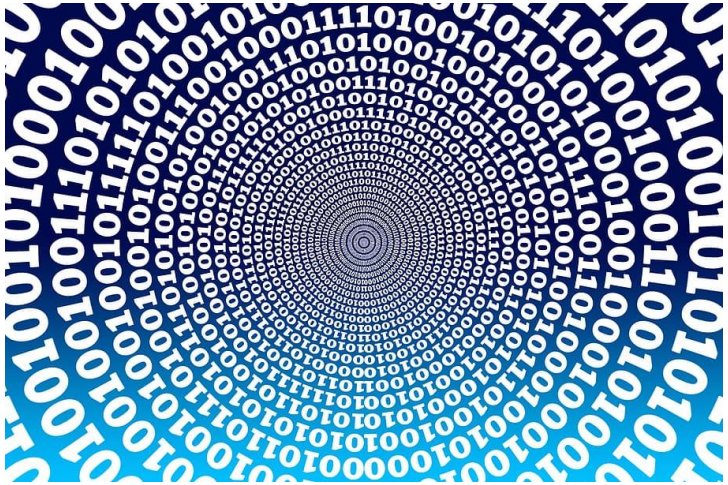


What We Know

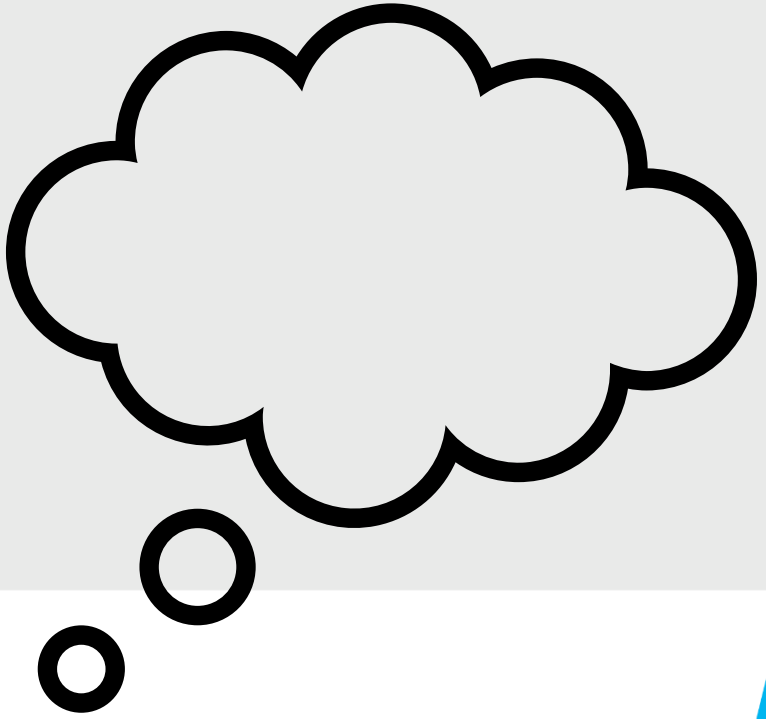
- There are precedents in Medicaid and Medicare for a family member who is paid to render services to the member. The Personal Care level of service allows for this.
- It appears to violate ethics (subsequently license and certifications) and run afoul of the dual relationship issue: *The concept of hiring parents as RBTs is fundamentally flawed and very likely will not survive a review by the Board. Since the parents are paid by the company, they would then have to pay a BCBA to supervise them which would create a dual relationship which is not allowed by the Board. The alleged dual relationship/fraud in billing occurs when a parent is paid to provide therapy to their own child.*
- The skills transfer from the BCBA is said to occur with whichever parent is the non-RBT parent.
- Payers are not told the RBT is also the parent, and the payer would have to investigate to determine this as the RBT does not have billing credentials. This will require a roster/records review to determine.

What We Are Working On

- We are looking at regulatory or contractual language that prevents this. This would be a state by state and contract by contract examination.
- We are identifying all the associated provider profiles with this scheme and data mining for possible issues.
- Magellan could potentially prohibit this model of care in their national handbook.



Questions or Comments?



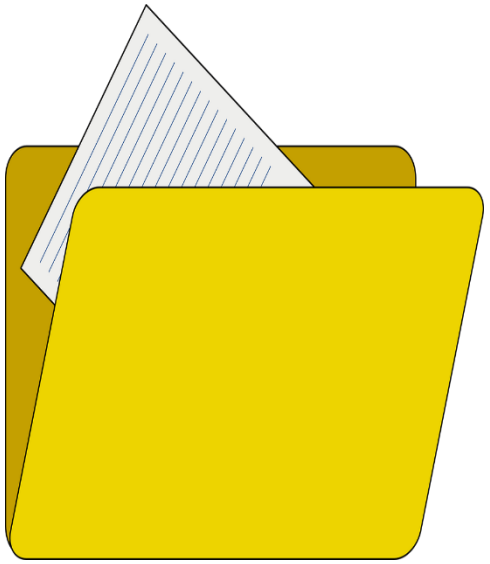
General Reminders

Claims Self-Audits

- The cornerstone of any strong compliance program is a comprehensive self-auditing process. Self-auditing (the comparison of claims to documentation in the medical record) can help to identify potential overpayments. However, in the long run it will save agencies from significant recoveries if the issue is not identified until much later either internally or by an oversight agency.
- It's a best practice to conduct self-audits both **before** claims are submitted to payer AND **after** receiving payment.
- Without strong internal auditing, self-reports would not be possible.
- Since 2020, Magellan has observed an overall decline in the number of voluntary provider self-reports. Although the landscape of how behavioral health services are rendered has shifted dramatically through the emergence of Telehealth, the importance of self-auditing and monitoring has intensified. Many providers no longer have a direct line of sight to their staff or their medical records. Providers must therefore ensure that auditing and monitoring practices have been updated to align with the new circumstances and evolving regulations.

Self-Reports of FWA

Submit materials to: PAHCSelfreport@magellanhealth.com



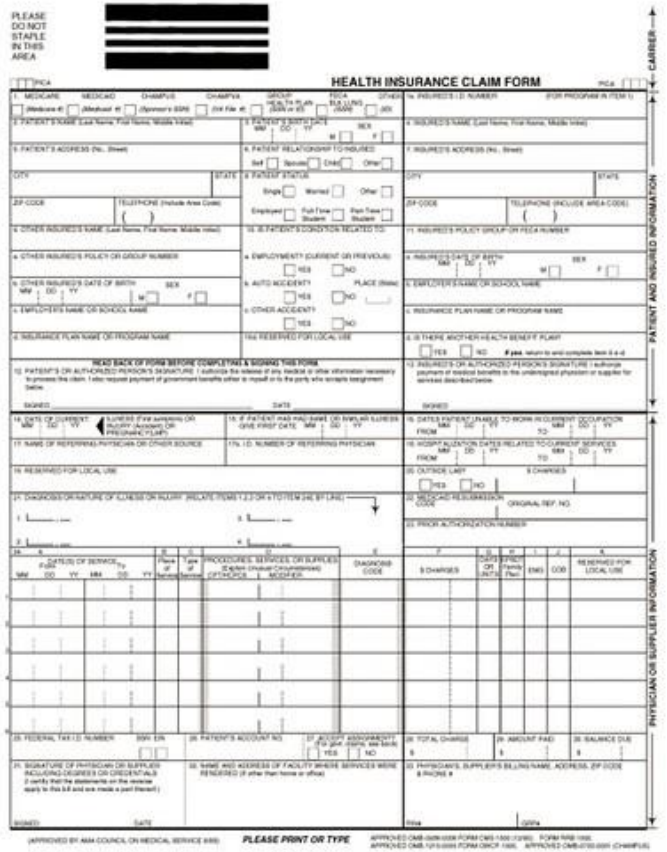
Please Include:

- 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.

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.



Monitoring of Federal/State Exclusionary Lists

- In accordance with Medical Assistance Bulletin 99-11-05, providers are required to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in Medicare, Medicaid or any other federal health care program.
- In order to protect the MA Program against payments for items or services furnished, ordered, or prescribed by excluded individuals or entities; to establish sound compliance practices, and to prevent potential monetary and other sanctions, providers must:
  - Develop policies and procedures for screening of all employees and contractors (both individuals and entities), **at time of hire or contracting**; and, thereafter, on an **ongoing monthly basis** to determine if they have been excluded from participation in federal health care programs.
  - The following databases are used to determine exclusion status:
    - Pennsylvania Medicheck List
    - List of Excluded Individuals and Entities (LEIE)
    - System for Award Management Exclusion Watchlist (SAM)
    - National Plan and Provider Enumeration System (NPPES)

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Exclusionary List Databases

- **List of Excluded Individuals/Entities**: database maintained by the OIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although the Department makes best efforts to include on the Medicheck List all federally excluded individuals/entities that practice in Pennsylvania, providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program.

- **Pennsylvania Medicheck List**: database maintained by the Department of Human Services that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program. If an individual's resume indicates that he/ she has worked in another state, providers should also check that state's individual list.

- **System for Award Management (SAM):** federal database used to identify and verify providers that are excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and non-financial assistance and benefits.

- **National Plan and Provider Enumeration System (NPPES):** The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

POLL QUESTION

After hire, how often must providers monitor the federal and state exclusionary list databases:

a) Monthly
b) Every 3 months
c) Every 6 months
d) Annually

ANSWER:

a) Monthly

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.

Compliance Resources on 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.

- **Provider Handbook Supplement**: important requirements and guidelines for all providers.

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FWA Reporting Mechanisms

- Providers have multiple options for reporting FWA externally to oversight agencies:
  - Report to the Magellan Special Investigation Unit Hotline at 800-755-0850 or SIU@MagellanHealth.com
  - Report to PA Medical Assistance Provider Compliance Hotline at 866-379-8477
  - Report to the Office of Inspector General (OIG) at 800-447-8477 or https://oig.hhs.gov/fraud/report-fraud
- Additionally, all providers should develop internal reporting mechanisms for their provider staff including an anonymous option.
- All provider staff must be trained on the FWA reporting options, both internal and external.
- During intake, all members and families should be educated about FWA, red flags to be aware of (i.e., being asked to sign blank forms) and the available FWA reporting mechanisms.

POLL QUESTION

True or False – Providers should train members and families on FWA concepts, potential red flags of FWA and reporting options.

a) True
b) False

ANSWER:

a) True

Third Party Liability (TPL)/ Billing Reminders

- Medicaid is always the last payer; therefore, **providers must exhaust all other insurance benefits first** before pursuing payment through Magellan HealthChoices.
- Providers are responsible for checking member eligibility, including the presence of other insurance throughout a member's treatment. If you become aware that a member has another insurance benefit, you **MUST** report it to Magellan and request that the family update their eligibility information with the appropriate County Assistance Office.
- As a Magellan provider, you are required to hold HealthChoices' members harmless and cannot bill them for the difference between your contracted rate with Magellan and your standard rate. This practice is called balance billing and is not permitted.
- It's also against Medicaid regulations and your Magellan contract to charge members **any out-of-pocket costs** for covered services including no-shows and missed appointments.

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Authorization to Use or Disclose (AUD)/Record Requests

Confidentiality and Coordination of Care- Release of PHI Forms

- 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 invalid.
  - Completed AUDs may also be submitted via e-mail to: PAHC_AUD@magellanhealth.com
  - 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.
- 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.

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PHI Records Requests

- 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.
- A new Record Request Form is now available on our website: https://www.magellanofpa.com/documents/2023/10/member-right-to-request-access-to-phi-request-form.pdf/
- Record Requests and other supporting legal documents may be submitted via e-mail to: PAHCCompliance@magellanhealth.com

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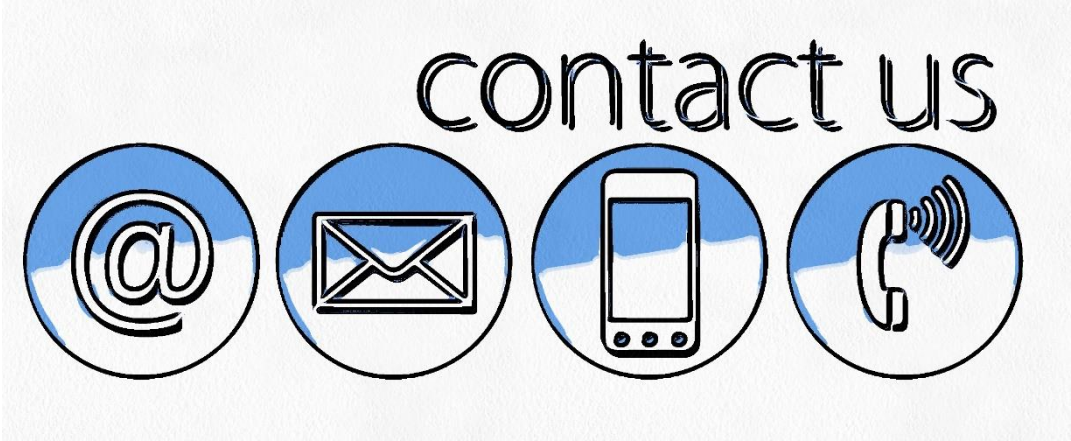
Magellan Compliance Contacts

- 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 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

- Participants should remain on the conference line for a few minutes to provide instant feedback and input for future training opportunities.
- In the near future, 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.

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Questions

SURVEY QUESTIONS

THANK YOU!

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