Provider Compliance Forum- 2024

OCTOBER 18, 2024

PRESENTED BY: MAGELLAN BEHAVIORAL HEALTH OF PENNSYLVANIA, INC.

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Introduction/Housekeeping

Meet Our Team

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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 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 during 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
- ✓ Audit Trends
- ✓ Telehealth Services
- ✓ Documentation Requirements
- ✓ Center of Excellence (COE) Guidelines
- ✓ Educational Requirements
- ✓ Billing Reminders
- ✓ Other Reminders
- ✓ Closing Remarks and Survey Questions

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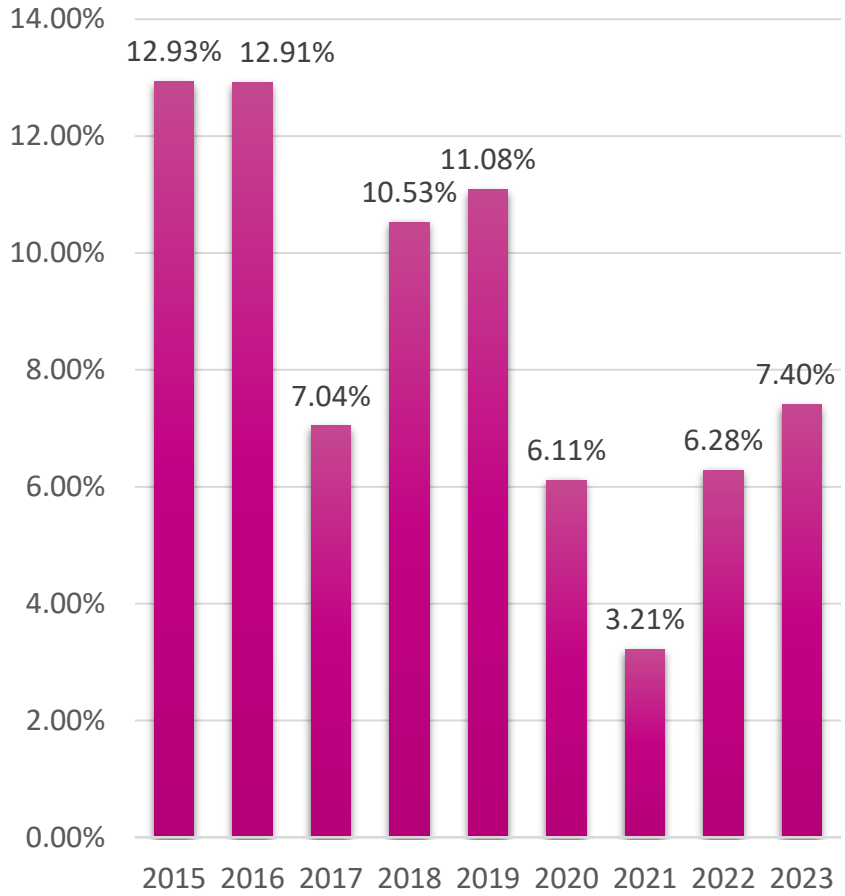
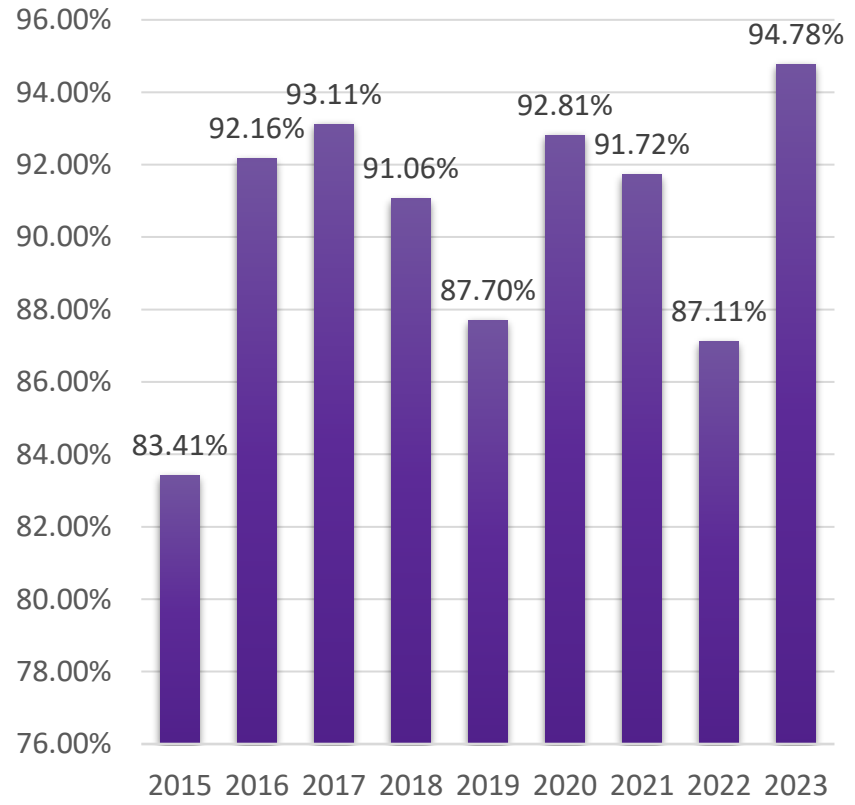
Positive Outcomes!

Year-to-Year Outcomes

Claims Error Rates



Compliance Program Scores



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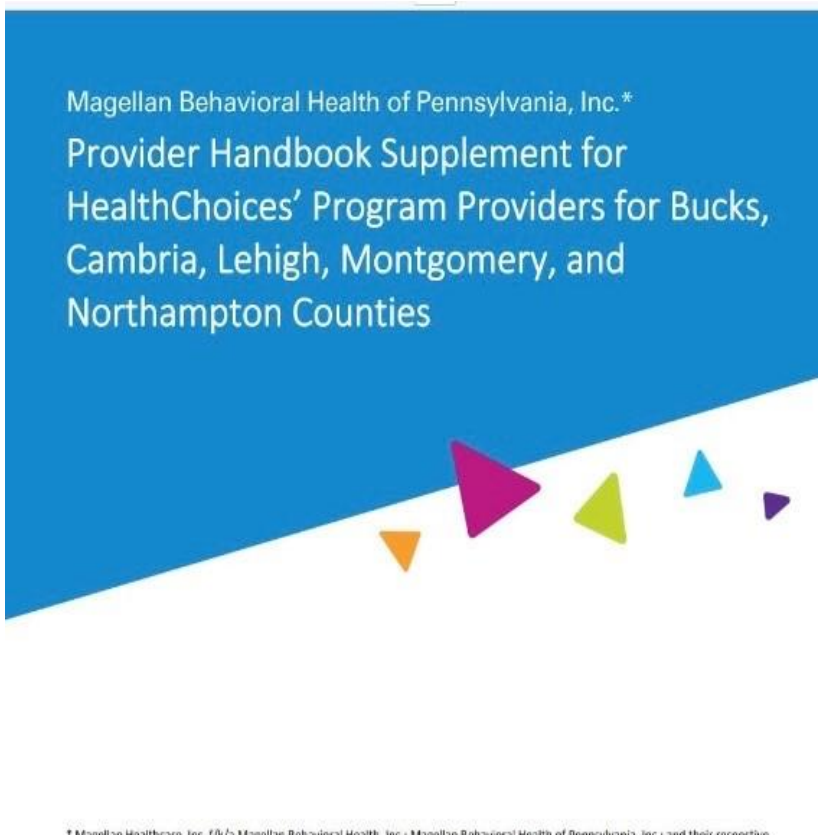
Audit Trends

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
- Non-adherence to Magellan rate sheet/reimbursement schedule (utilizing the correct procedure code/modifier combination and unit definitions)
  - Different payors, different expectations
  - H0004 code



Overall Claims Audit Trends (continued)

- Electronic Health Record (EHR) time stamps preceding end time of the session
- Missing encounter forms/service verification (telehealth & community-based services have slightly different expectations)
- Rounding: billing the better part of a unit is an exception in only limited cases:
  - Targeted Case Management
  - Family-Based Services
  - Crisis Intervention Services
  - ACT
- Treatment/ Service Plan Trends
  - Missing Tx/ Service Plan
  - Tx/ Service Plan not updated in accordance with regulations
  - Services provided do not align with Tx/ Service Plan goals.
- Billing incorrect Place of Service codes

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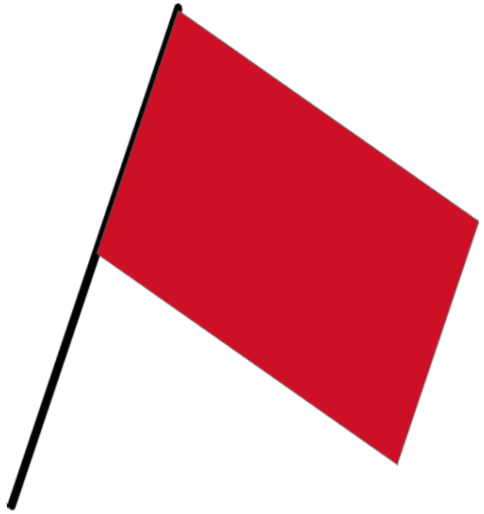
Red Flags for an Auditor

- Back-to-back-to-back services over the course of a day without any transition time between sessions
- Start and end times are always documented in whole/ exact numbers (e.g. 9:00 – 10:00, 11:15 – 12:15, 2:00 – 3:00, 5:30 – 6:30).
- Every contact or phone call spanning EXACTLY 8 or 15 minutes (whatever is necessary to justify a unit).
- Progress notes are very similar from session to session.
- Treatment plans goals remain the same throughout care.



Duplication/ Overlap of Services

- ***Services may be duplicative when they overlap with other ongoing services that share some of the same components or have one of the services embedded into the other service.***

- Examples:
  - CRS/CPS
  - COE & community base CRS/CM
  - ACT & CPS

- Prevention:
  - Ensure your intake process is robust and works to collect information about other services the member may be receiving.
    - Remember to check-in regularly with members about services they are receiving so that you can continually monitor all services received as they may change over time.
  - When members are receiving multiple services, please outreach to your Care Manager at Magellan to discuss possible duplication of services & clinical appropriateness of each.

- Allowable duplication:
  - Duplication of services or an overlap of services may take place for a certain time-period while the member is transitioning from one Level of Care (LOC) to another.
    - Please consult the regulations for the specific time-period allowed for billing of both services or reach out to Magellan for guidance.

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POLL QUESTION

What levels of care below are NOT considered a duplication of service?

a) Certified Recovery Specialist (CRS) & Certified Peer Specialist (CPS)
b) Psychiatric Rehabilitation Services & Certified Peer Specialist (CPS)
c) Centers of Excellence (COE) & Community Based CRS/ SUD Case Management
d) Assertive Community Treatment (ACT) & Certified Peer Specialist (CPS)

ANSWER:

b) Psychiatric Rehabilitation Services & Certified Peer Specialist (CPS)

Telehealth Services

Assessment to Receive Telehealth

- Licensed practitioners and provider agencies delivering services through telehealth must have policies that ensure that services are delivered using telehealth only when it is **clinically appropriate** to do so.
- The member's needs, including severity of condition, must be carefully considered in determining appropriateness of receiving telehealth services.
- The decision to use telehealth should be **based solely on the best interest of the member and never based on the preference or convenience of the provider or behavioral health practitioner**. The provider must assess the clinical appropriateness of utilizing telehealth for each member and situation.
- The **medical record must include the assessment of an individual's appropriateness to receive telehealth services by a qualified practitioner**, consistent with agency policy and procedure.

Telehealth Signature Requirements

Enforced effective January 1, 2024

- Effective January 1, 2024, the telehealth signature flexibilities specific to consent to treat, service verifications and treatment plans have ended.
- As outlined in Medical Assistance Bulletin OMHSAS-22-02, as well as OMHSAS Interim Telehealth Guidance dated March 20, 2023, providers are now expected to capture consent to treat, service verifications and approval of treatment plans in a manner that creates an auditable file and in accordance with the timelines outlined in the regulations.
- There are multiple ways that providers of telehealth can meet this requirement, including utilizing a Health Insurance Portability and Accountability Act (HIPAA) compliant audiovisual platform, in-person, e-mail, or United States Postal Service mail.
  - Effective August 10, 2023, providers were expected to be compliant with the requirement to use a HIPAA-compliant telehealth platform. If you are utilizing a HIPAA compliant telehealth platform, you should be able to capture the signature requirements outlined by OMHSAS-22-02.
- Magellan sent a Compliance E-mail Blast to all providers in January 2024 outlining these reminders and all the signature requirements.

Consent to Telehealth

- Consent for services and service modality, such as in-person or telehealth, should be obtained and documented **prior to** rendering services.
- Signatures for consent to telehealth treatment may be physical or electronic (unless prohibited by other laws).
  - 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.
  - Physical signatures for telehealth consent may be obtained through a variety of different mechanisms including: in person with the member; US Mail; or e-mailed forms to a member who has the capability to print and return the hard copies; or print, scan and e-mail copies.
  - Signatures can also include an audio recording of voice consent (i.e., the "sound") stored within a HIPAA-compliant telehealth platform. Recording means that the member's voice consent is stored within the medical record system.
- Consent to receive telehealth is required for each service/ level of care that is being provided via telehealth (remember, telehealth may not be clinically appropriate for all service modalities that an individual receives at an agency).

Consent to Telehealth

- The following information, at a minimum should be included in a consent for telehealth services:
  - The telehealth platform being utilized including if services are being rendered via two-way audio-video transmission or audio-only.
  - Identification of all persons who will be present at each end of the telehealth transmission and the role of each person.
  - The associated privacy risks related to the technology/ platform being utilized.
  - The associated risks of telehealth during crisis/ emergency situations.
  - The member's right to refuse telehealth and/or receive in-person services at any time.
  - Consent to be recorded, if applicable.

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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*.
- HIPAA-compliant 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.
- Signatures on treatment/ service plans may be physical or electronic signatures, unless prohibited by other laws.
- Physical signatures may be obtained through a variety of different mechanisms including: in-person with the member; US Mail; or 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 Encounter Forms

- Providers should follow all applicable Pennsylvania Medicaid Regulations/Bulletins and Magellan guidelines which outline encounter form requirements. MA Bulletin 99-89-05 outlines all the required components of an Encounter Form:
  - A Certification Statement which says the following: “I certify that the information shown is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements or documents, or concealment of material facts may be prosecuted under applicable federal and state laws.”
  - The Provider’s Name and their MA ID
  - The Recipient’s Name and their MA ID
  - The Date of service
  - The Member or guardian’s signature
- **Magellan also considers the inclusion of start and end times on encounter forms to be a best practice (this is a requirement for in-person community-based/ mobile services).**
- 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.

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Telehealth and Encounter Forms

- Per OMHSAS-22-02, signatures for service verification may include hand-written or electronic signatures, unless prohibited by other laws.
- As of January 1, 2024, providers must be able to capture service verifications in a manner that creates an auditable file and is in compliance with both MA Bulletin 99-89-05, as well as, the agency's policies and procedures on encounter form signatures.
- Physical signatures may be obtained through a variety of different mechanisms including: in-person with the member; US Mail; or e-mailed forms to a member who has the capability to print and return the hard copies; or print, scan and e-mail copies. Signatures should be obtained as *soon as possible and no later than 90 days after the service*.
- 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.
- Weekly/ Monthly Encounter Forms are okay.
- **Providers should not bill for services for which they do not have verification of service provision.**

Electronic Signatures

- Effective August 10, 2023, providers were required to be in compliance with the requirement to use a HIPAA-compliant telehealth platform. If you are utilizing a HIPAA compliant telehealth platform, you should be able to capture the signature requirements outlined by OMHSAS-22-02.
- 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.

Telehealth Documentation Requirements

- The documentation to support a telehealth transaction must include:
  - ✓ Member Consent to receive services via telehealth.
  - ✓ Assessment of the individual's clinical appropriateness for telehealth services.
  - ✓ Progress Note which includes the identification of a telehealth session.
  - ✓ Treatment/ Service Plan which includes the mechanism of telehealth for service delivery; and
  - ✓ Encounter Verification Form.
- 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).

Telehealth Progress Note Documentation Requirements

- 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 also clearly document a telehealth session. In addition to the above guidelines, the following information must be included in the record for each rendered telehealth service:
  - The documentation must indicate the mechanism for how services were delivered (i.e., telehealth, phone).
  - The documentation must include the telehealth platform that was utilized, if applicable (i.e., Zoom)
  - The documentation must include the member's phone number that was utilized, if applicable.

Telehealth: Audio-only

- Technology used for telehealth, whether fixed or mobile, should be capable of presenting sound and image in real-time and without delay. Telehealth equipment should clearly display the practitioners' and participants' faces to facilitate clinical interactions. The telehealth equipment must meet all state and federal requirements for the transmission or security of health information and comply with the Health Insurance Portability and Accountability Act (HIPAA).
- Audio-only refers to the delivery of behavioral health services at a distance using real-time, two-way interactive audio only transmission.
- Magellan has recently observed a trend of providers consistently providing audio-only telehealth services for all members and all sessions.
- 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.

Telehealth Billing

- 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.

PLACE OF SERVICE CODE LOOKUP

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Telehealth Billing- Important Announcement

- In accordance with Title 55 Chapter **§1153.14. Noncovered services** from the PA Code, Telehealth may not be provided for Group Services under a MH OP Clinic if the member is located in their home:

§ 1153.14. Noncovered services.

Payment will not be made for the following types of services regardless of where or to whom they are provided:

(17) Group psychotherapy provided in the individual's home.

- Therefore, POS 10 is not allowable for MH OP Group Services.
- Effective immediately, MH OP Group via Telehealth is not allowable and providers must cease providing and billing for this type of session.

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Telehealth Virtual Office Clarification

- Per OMHSAS-22-02:

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

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

- A temporary office space does NOT satisfy the requirement to maintain office space that is discussed in the telehealth bulletin.

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Members Temporarily Out-of-State

- Per OMHSAS-22-02:

Pennsylvania Residents Temporarily Out-of-State

Behavioral Health Services may be provided using telehealth to meet the behavioral healthcare needs of Pennsylvania residents who are temporarily out of the state as long as the delivery of services out-of-state is consistent with the authorization for services and treatment plan, the individual continues to meet eligibility for the Pennsylvania MA Program, and the Pennsylvania provider agency or licensed practitioner has received authorization to practice in the state or territory where the individual will be temporarily located.

- *"… the Pennsylvania provider agency has received authorization to practice in the state or territory where the individual will be temporarily located"*.
- Is the provider licensed in the state that the member will be traveling to? If not, you will need to obtain permission from that state.

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

- Compliance E-mail Blast on Telehealth Documentation and Signature Requirements (January 2024): https://www.magellanofpa.com/documents/2024/01/013124_compliancenotebookforjan2024.pdf/
- Magellan's Telehealth FAQ (updated June 2023): https://www.magellanofpa.com/documents/2023/06/060123_updatedtelehealthfaq.pdf/
- Magellan's Telehealth Provider Performance Standards (updated July 2024): 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

Allowable rationale for audio-only services includes:

a) Member/Provider Preference
b) Individual served does not have access to video capability
c) An urgent medical situation
d) All of the above
e) Both b & c

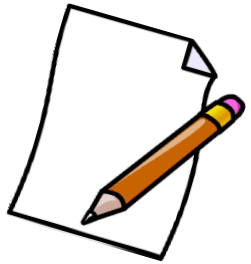
ANSWER:

e) Both b & c

Documentation Requirements

Minimum Record Keeping Requirements

- Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations & are published in the Pennsylvania HealthChoices (PAHC) Provider Handbook Supplement (page 57- 58):



  - The record must be legible.
  - Identify the member on each page.
  - Documentation must be signed by the rendering provider.
  - Alterations must be signed & dated. A *correction* to a medical record should never be written over or deleted when an entry error occurs. Corrections should be crossed out, yet still legible, signed, or initialed and dated stating the reason for the correction. Information added to the record should be signed or initialed and dated, referencing the original entry.
  - The record must include a preliminary working diagnosis, as well as a final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
  - Treatments, as well as the treatment plan, must be entered in the record.
  - The record must indicate the progress at each visit, change in diagnosis, change in treatment, and response to treatment.

Minimum Documentation Standards

- The documentation of treatment or progress notes for all services, at a minimum, must include:
  - Specific services rendered
  - Date of service
  - Name(s) of the individual(s) rendering service.
  - Places where services were rendered.
  - The relationship of the services to the treatment/service plan - specifically, any goals, objectives, and interventions.
  - Progress at each visit, any change in diagnosis, changes in treatment, and response to treatment.
  - The actual time in clock hours that services were rendered (start & end time in clock hours, i.e., 10:00 AM-11:00 AM).
  - In addition to the above requirements, providers must follow the applicable MA regulations and bulletins for the services for which they are licensed and enrolled. Retractions may be pursued if documentation does not meet Magellan or the state's minimum expectations.

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Encounter Forms

- According to Medical Assistance Bulletin 99-89-05, providers are required to obtain signed encounter forms to certify that the recipient received a service.
- Encounter forms may be developed by the provider. May also be embedded as part of the progress note. **However, they must meet all the DHS and Magellan requirements.**
- <u>Must contain the following information</u>:
  - A certification statement: "I certify that the information shown on this invoice is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statements or documents, or concealment of material facts, may be prosecuted under applicable federal and state laws."
  - Provider name and MA ID number
  - Recipient name and ID number
  - Recipient's signature, or the signature of the recipient's agent
  - Date of Service

- Crisis Services (Mobile, Telephone, and Site-Based):

  While every effort should be made to obtain a signature from the beneficiary or a parent, legal guardian, relative, or friend, when such signature cannot be obtained due to the nature of the situation, crisis intervention service providers are permitted to insert "Signature Exception" on the signature line of the encounter form.

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Encounter Forms

Encounter Forms for community-based services: Magellan further requires that all providers of community-based services obtain a signed encounter verification form for each face-to-face contact that results in a claim being submitted to Magellan.

- Community-based providers may also develop their own encounter forms; however, at a minimum, they must include:
  - Certification Statement
  - Date of service
  - **Start and end time of the session (actual time in clock hours, not the duration)**
  - Recipient's signature (or legal guardian). 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).
  - **The rendering provider's signature.**
- Encounter Forms must be available for review at the time of a Magellan audit or review.
- 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.
- **For electronic health records, the record must include all applicable elements of an encounter form.**

Treatment Planning

- Treatment planning must be informed by a comprehensive case formulation and must include goals that are identified issues in the biopsychosocial assessment.
- Treatment plans must be individualized and center around the member's goals for their treatment.
- When behavioral descriptions are incorporated, they must include information about the function of the behavior and describe the proposed replacement behavior. Goals are to be concrete, specific, realistic, measurable, stage-of-change specific and based on the strengths of the member.
- Members must be actively involved in the development of their own treatment plans.
- Magellan requires that treatment adhere to all applicable ethical standards.
- Treatment plans should be created/reviewed/updated in the appropriate time frames (or sooner, if clinically appropriate).
- Progress notes should reflect how the services rendered are related to treatment plan goals & objectives, the member's progress on the identified treatment plan goal (or lack thereof), etc.

Progress Notes

- Progress notes/ documentation should support the units billed.
  - Limited/minimal documentation for lengthy sessions with high number of units.
- Information in progress notes must correlate to treatment plan goals.
- Session start and end times should represent the actual billable/ face-to-face time with the member.
- Electronic time stamps on signatures may not precede the end time of the session. This includes both the rendering clinician's signature on the progress note and any member signatures that are collected to validate the session.
- Resources:
  - Magellan Compliance Alert April 2024: Progress Note Documentation and Electronic Signatures
  - Collaborate Documentation: https://www.magellanofpa.com/documents/2024/04/042624_collaborativeguidelines.pdf/

Timely Completion of Documentation

- Magellan's minimum-record keeping requirements include that all "Entries are dated and signed by appropriately credentialed provider."
- Providers should complete, sign, and date progress notes & other records as soon as possible after services occur to ensure accuracy in the documentation in process.
- Delays can make remembering essential details and events more difficult, which may result in incomplete or inaccurate notes. We encourage timely notetaking and recommend finishing the notes within 24 to 48 hours of the session if feasible.
- Providers should not bill for services unless and until you meet the documentation signature requirements.
- Create an internal medical record documentation policy for your practice specifying a timeframe in which records are expected to be signed and dated.
- Conduct regular self-audits on medical records to ensure you have appropriately signed and dated amendments and medical records.
- Do not backdate or post-date entries. Do not create new records or alter existing records when receiving an audit or record request.
- Additional information: https://www.magellanproviderfocus.com/issues/spring-2024/features/ensure-timely-signing-of-medical-records.aspx

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POLL QUESTION

Electronic time stamps on signatures may precede the end time of the session. This includes both the rendering clinician's signature on the progress note and any member signatures that are collected to validate the session.

a) True
b) False

ANSWER:

b) False

Centers of Excellence (COE) Guidelines

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.

Progress notes state “no needs identified” but no discharge criteria.

Centers of Excellence (COE) - Nonbillable Tasks

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
- ✓ A general “check-in” with the member
- ✓ Documentation, record-keeping or administrative activities of any kind
- ✓ Services rendered by a CRS who does not meet the certification requirements within the 6 months of hire.

Service Duplication

- ➢ While active in a COE, members may not receive community-based CRS or SUD case management services from another provider.
- ➢ 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) 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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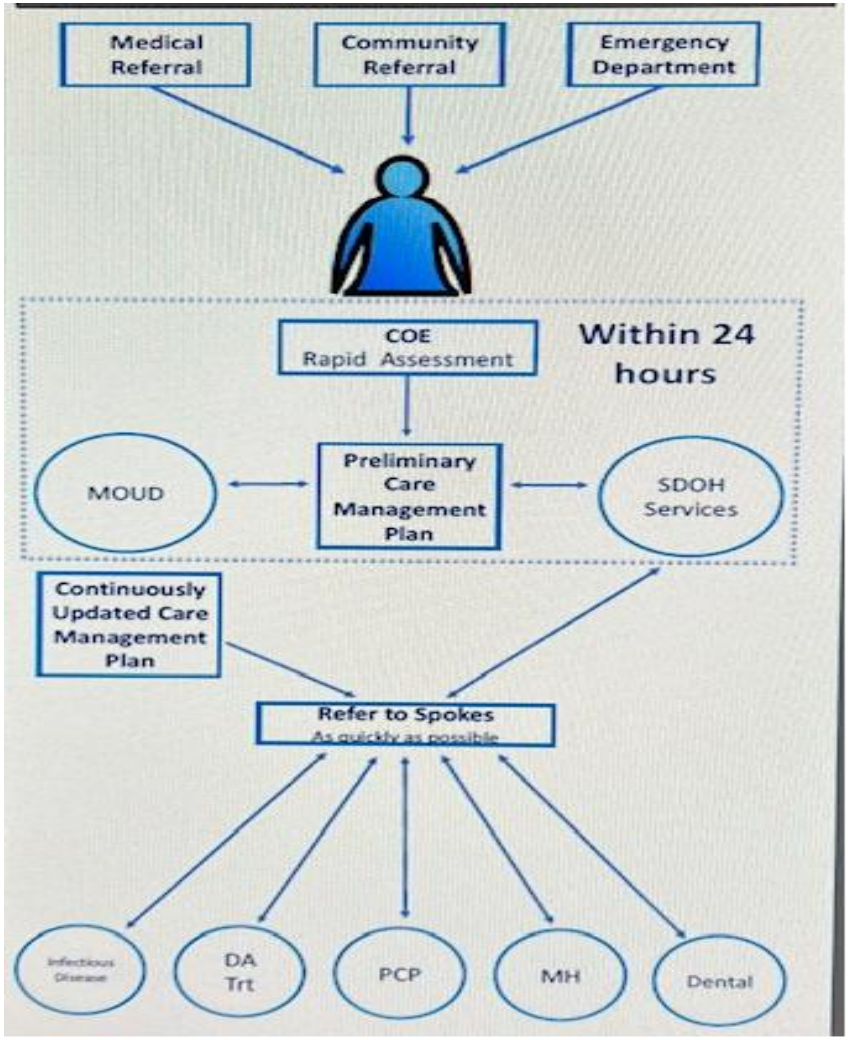
COE Fidelity Guidance- August 2024

- The primary goal of the COE is to provide comprehensive care and support to clients with specific needs, particularly related to Medications for Opioid Use Disorder (MOUD) and Social Determinants of Health (HRSN/SDOH).
- This image illustrates a structured and systematic approach taken by the COE to cater to the complex needs of clients, ensuring they receive comprehensive care through a network of specialized providers and social support services.



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Introduction to the Fidelity Guidelines

Standard guidelines ensure that all Pennsylvania Centers of Excellence (COEs) provide consistent, evidence-based care to individuals seeking treatment for opioid use disorder.

Following established guidelines helps ensure that individuals receive the most effective and up-to-date treatments, increasing the likelihood of successful recovery.

Standard guidelines facilitate better coordination among healthcare providers within the COE, this coordinated approach ensures that individuals receive comprehensive and integrated care, addressing both their medical and psychosocial needs.

Guidelines help streamline workflows and procedures within the Center of Excellence, leading to more efficient and effective care delivery. Consistent procedures promote staff efficiency and reduce variability in care.

Establishing standard guidelines promotes client safety, care coordination, regulatory compliance, and data-driven improvement efforts, ultimately leading to better outcomes for individuals and strengthening the overall response to the opioid crisis.

Providers should consider an approach to the implementation of the Fidelity Guidelines that shows commitment to high-quality enhanced care management and supports the delivery of evidence-based practices that facilitate each community member's ability to achieve optimal health, well-being, recovery, and choice.

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COE Fidelity Guidance

Letter from Anita Kelly, August 2024

Good morning,

I am reaching out to follow up on the message you received recently from the Department of Human Services regarding the new COE Fidelity Guidelines. At Magellan, we are committed to supporting COEs as they work to implement these guidelines and encourage you to reach out to us if you have any questions about how we plan to monitor the guidelines moving forward.

We understand that it may take your COE time to make changes to your COE processes to reach full alignment with these new guidelines. Over the next several months, we will meet with each COE individually to review each aspect of the guidelines. This will include at least three meetings covering these three topics: Inclusion, Identification, and Enrollment; Initial assessment and care management; Discharge and Transition. Of course, I am always available to discuss any concerns that you may have. I will be contacting each of you to set up these Guideline sessions.

Please reach out to Anita Kelly at alkelly@magellanhealth.com or at CenterofExcellenceCOEInquiries@magellanhealth.com with questions or concerns.

Thank you,

Anita Kelly, MA, LPC, CAADC
Clinical Contract Advisor
Magellan Behavioral Health of PA

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POLL QUESTION

Encounter Forms must be present for Centers of Excellence.

a) True
b) False

ANSWER:

a) True

Educational Requirements

Staff Credentials & Qualifications

- Staff must document their credentials on progress notes (e.g., educational credentials/degree, licensure, etc.).
- Providers must demonstrate that the individuals are qualified to deliver the services that are being billed.
- **If the rendering provider staff does not meet eligibility requirements, all services paid under that staff person are subject to recovery.**
- New assessment tools are being utilized for audits.

Peer Support Services

- In early 2024, OMHSAS & CMS made several changes to eligibility requirements for Certified Peer Specialists (CPS).
  - Elimination of the self-identification requirement for Serious Mental Illness, replaced with an attestation of a mental health diagnosis and a stage of recovery to support others;
  - Removal of the high school diploma requirement and instead, as part of the Pennsylvania Certification Board (PCB) application, applicants will be providing narratives on how they achieved recovery and wellness; and
  - The mandatory recent employment or volunteer experience within the last three (3) years has been removed.
- Current requirements:
  - Be a self-identified individual with a mental health diagnosis and who has reached a point in their recovery pathway where they can positively support others in similar situations.
  - Be eighteen (18) years of age or older.
  - Have completed a peer support services training approved by the Department.
  - Obtain and maintain, current, valid, and in good standing the CPS credential through a certification entity identified by the Department.

Billing Reminders

Billing Reminders

- Different payors have different expectations:
  - Remember to review your Magellan contract and fee schedule and bill claims accordingly.
- H0004 Code
  - Individual practitioners and group providers contracted with the H0004 code are required to provide a full 15 minutes of service for each unit billed of this CPT code. The better part of a unit (or the “8-Minute Rule”) does not apply to this code.
- Nurse / CRNP/ MD Codes
  - Ensure that CPT code H0034 is billed when a nurse provides services during a medication management appointment such as med education. Consult your Magellan contract for CPT code and modifier combinations when billing medication management/ administration appointments conducted by MDs CRNPs, PAs and RNs.

Billing Reminders

- Unit definitions vary:
  - Unit definitions require a service to take place for a specific length of time (Ex. 15 minutes) or they could allow for a span of time (Ex. 38-52 minutes).
- Upcoding or billing the better part of a unit (rounding)
  - Most codes/ services do **NOT** permit the “8-Minute Rule”, also known as the better part of a unit.
  - Exceptions for Crisis, FBS, MH Case Management and ACT only
- *If ever in doubt, reach out. If you have any questions on how a claim should be billed, be sure to reach out to your Network Provider Relations contact to ask.*

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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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ACT 62

Act 62 Billing Reminders

- If a Medicaid beneficiary has private health insurance, providers must:
  - Identify the procedure codes that are on the private health insurer's fee schedule. Private health insurance may require specific procedures codes for billing purposes. Those codes should be utilized when billing the primary insurer to ensure proper processing and payment of the claim. You should use the Magellan HealthChoices contracted code when billing us as secondary.
  - Submit claims to the private health insurance prior to billing Magellan HealthChoices, even if a denial was previously received for that service or a similar service. If a service is not covered by the primary, it may be necessary to obtain this denial on an annual basis.
  - Submit evidence of exhaustion of benefits or denials of coverage when billing Magellan HealthChoices.
- Magellan will work with you and primary payers to coordinate benefits, ensure member and family care continuity, and issue timely payment.
- Information about Act 62 (page 24) and provider responsibility to coordinate benefits/Third Party Liability (page 69) is located in the Magellan Provider Handbook Supplement .
- Additional information on ACT 62 can also be found on the DHS website.

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POLL QUESTION

Upcoding or billing the better part of a unit (rounding) is NOT allowed for the following:

a) Crisis Intervention Services
b) Family Based Mental Health Services
c) Substance Use Disorder (SUD) Case Management
d) Both a & b

ANSWER:

c) Substance Use Disorder (SUD) Case Management

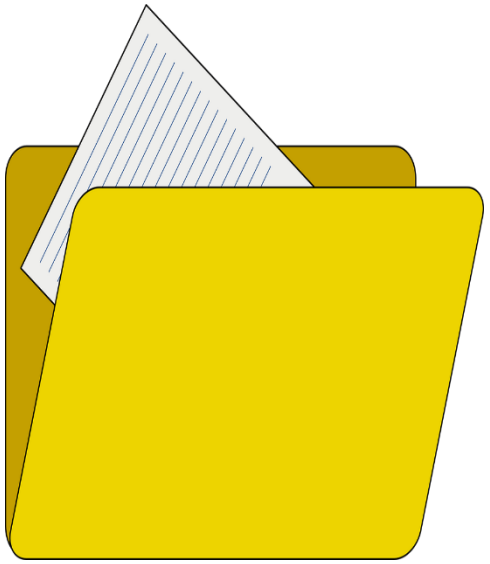
Other Reminders

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.
- 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.
- Benefits to self-audits:
  - Helps identify issues early and reduces financial and administrative burden
  - Provider controls the review, not an oversight agency
  - When the provider properly identifies an inappropriate payment and reports it, and the acts underlying such conduct are not fraudulent, DHS will not seek double damages, but will accept repayment without penalty.

Self-Reports of FWA

Submit materials to: PAHCSelfreport@magellanhealth.com



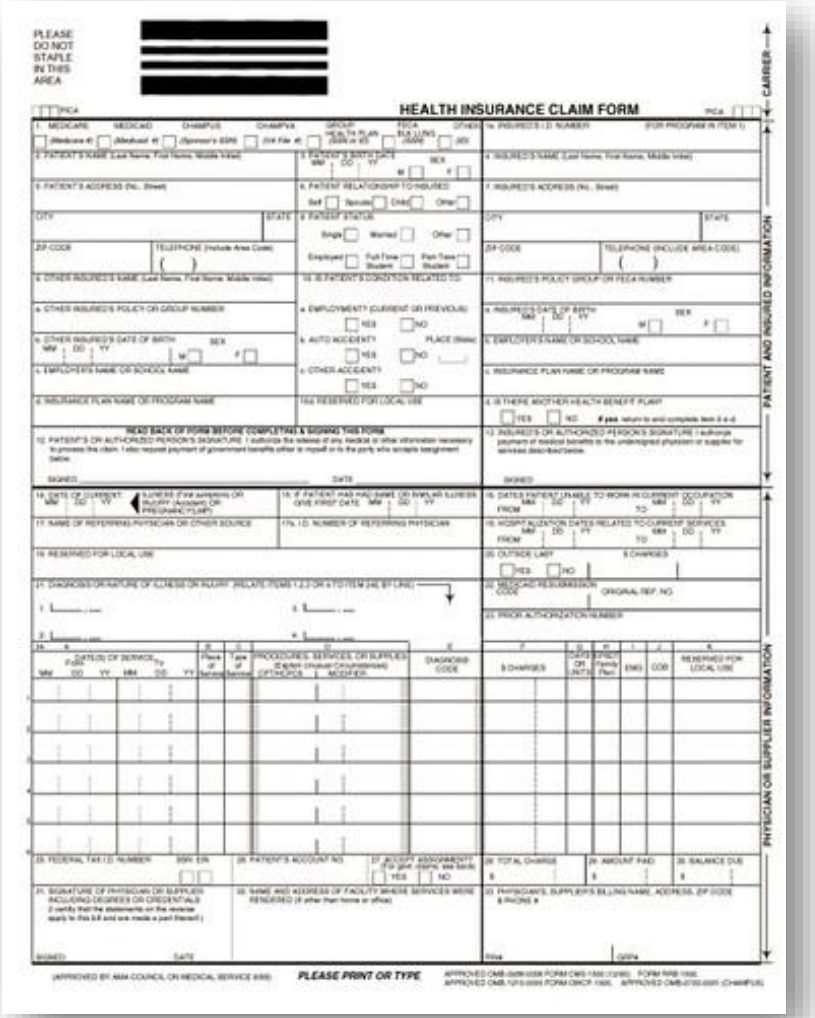
Please Include:

- 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.



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.

Interpreter Services Reminder

- Reference MA Bulletin 99-17-11 and Policy Clarification #3-96-268 & 11-97-185.
- The MA program, which receives federal financial participation, pays enrolled providers for Medicaid Services. MA enrolled providers are considered covered entities due to their receipt of federal Medicaid funds. As such, MA providers must comply with the regulations and requirements related to services to individuals with Limited English Proficiency (LEP), vision limitations, and/or auditory limitations, including providing interpretation and translation services free of charge to MA beneficiaries.
- Requirements:
  - MA providers must provide language assistance services, which may include translation services.
  - MA providers must provide appropriate auxiliary aids and services, such as alternative formats and sign language interpreters, free of charge where necessary for effective communication.
  - MA providers have a responsibility to provide interpretation and translation services free of charge to all individuals who have LEP, vision limitations, and/or auditory limitations, and the federal guidelines that must be followed to accomplish this.
  - MA providers are required to post taglines in the top 15 non-English languages spoken by individuals in the Commonwealth.
- As a reminder, interpreter services are not classified as behavioral health/mental health services and thus not eligible for direct reimbursement by the Behavioral Health-Managed Care Organizations. Policy Clarification #3-96-268 & 11-97-185 further establishes the requirement for providers to accommodate the specialized needs of HealthChoices members, which may include securing interpreter services.

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Confidentiality Reminders – Release of PHI Forms

- Authorization to Use and Disclose (AUD) form, Magellan's consent form to share information with a third party can 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 (except IP SUD) and thus MUST sign the AUD.
  - For members under 14 or for Magellan to disclose SUD Inpatient information, 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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Confidentiality Reminders – Legal Paperwork

- In order for someone to be a member's Personal Representative for HIPAA/PHI purposes, they must have the authority under state law to make health care decisions on behalf of the member.
- Magellan requires proof to demonstrate that an individual has this authority. This includes:
  - Children and Youth Services
  - Step-parents
  - Other family members outside of biological parents
- Legal paperwork can be submitted electronically via Magellan's online AUD form. It can also be sent via e-mail to: PAHCCompliance@magellanhealth.com

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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Magellan Compliance Contacts

- PAHC 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
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  - **Diane Devine, CFE (All Counties)**
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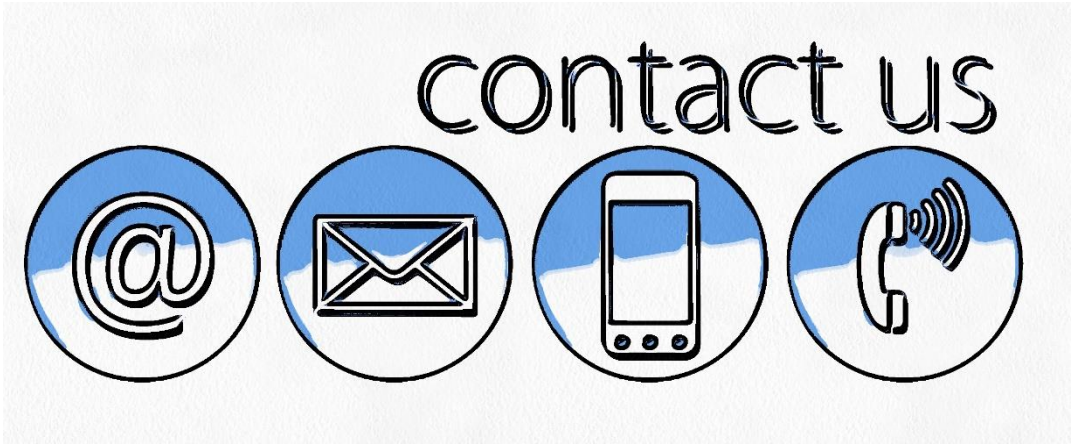
    ddevine@magellanhealth.com
- SIU Manager:
  - **Tanya Pennington, CFE (All Counties)**
    410-953-4812
    TMPennington1@magellanhealth.com
- PAHC Compliance Officer:
  - **Karli Schilling, MA (All Counties)**
    215-504-3967
    kmschilling@magellanhealth.com
- PAHC Compliance Coordinator:
  - **Holly McQuiggan (All Counties)**
    215-504-3952
    hlmcquiggan@magellanhealth.com



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Questions

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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.

SURVEY QUESTIONS

THANK YOU!

Confidentiality statement

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