2016 Compliance Forum - *Fraud, Waste & Abuse Prevention and Monitoring*

September 16, 2016

Presented by:

Magellan Behavioral Health of Pennsylvania, Inc.

Magellan Health Special Investigations Unit

PA Office of Attorney General Medicaid Fraud Control Section

Presenters

Magellan Behavioral Health of Pennsylvania, Inc. and Magellan Health Special Investigations Unit

- Jackie Kline, Manager SIU Investigations
- Karli Schilling, PA Compliance Manager
- Lydia Briggs, Compliance & Claims Auditor
- Diane Devine, SIU Investigator
- Patty Marth, Compliance & Claims Auditor

OAG Medicaid Fraud Control Section

- Stephen Stahl, Special Agent
- Mark Brumaghim, Special Agent

Agenda

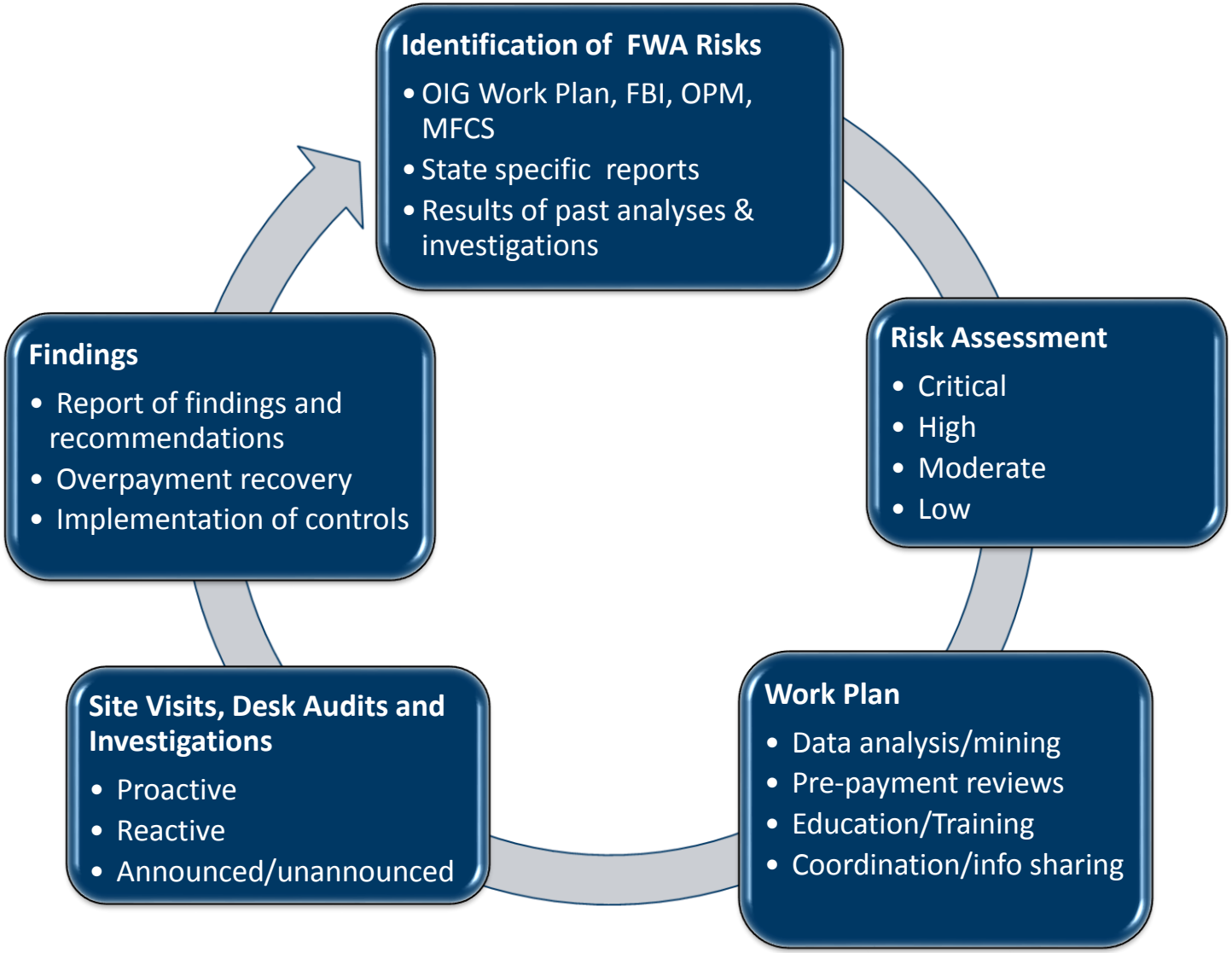
I. Overview of PA HealthChoices' Program Integrity
II. Magellan Special Investigations Unit Overview
III. Compliance & Claims Audit Trends
IV. Provider Self-Auditing
V. Auditing Electronic Health Records
VI. Medicaid Fraud Control Section Overview
VII. Panel Discussion

PA HealthChoices Program Integrity

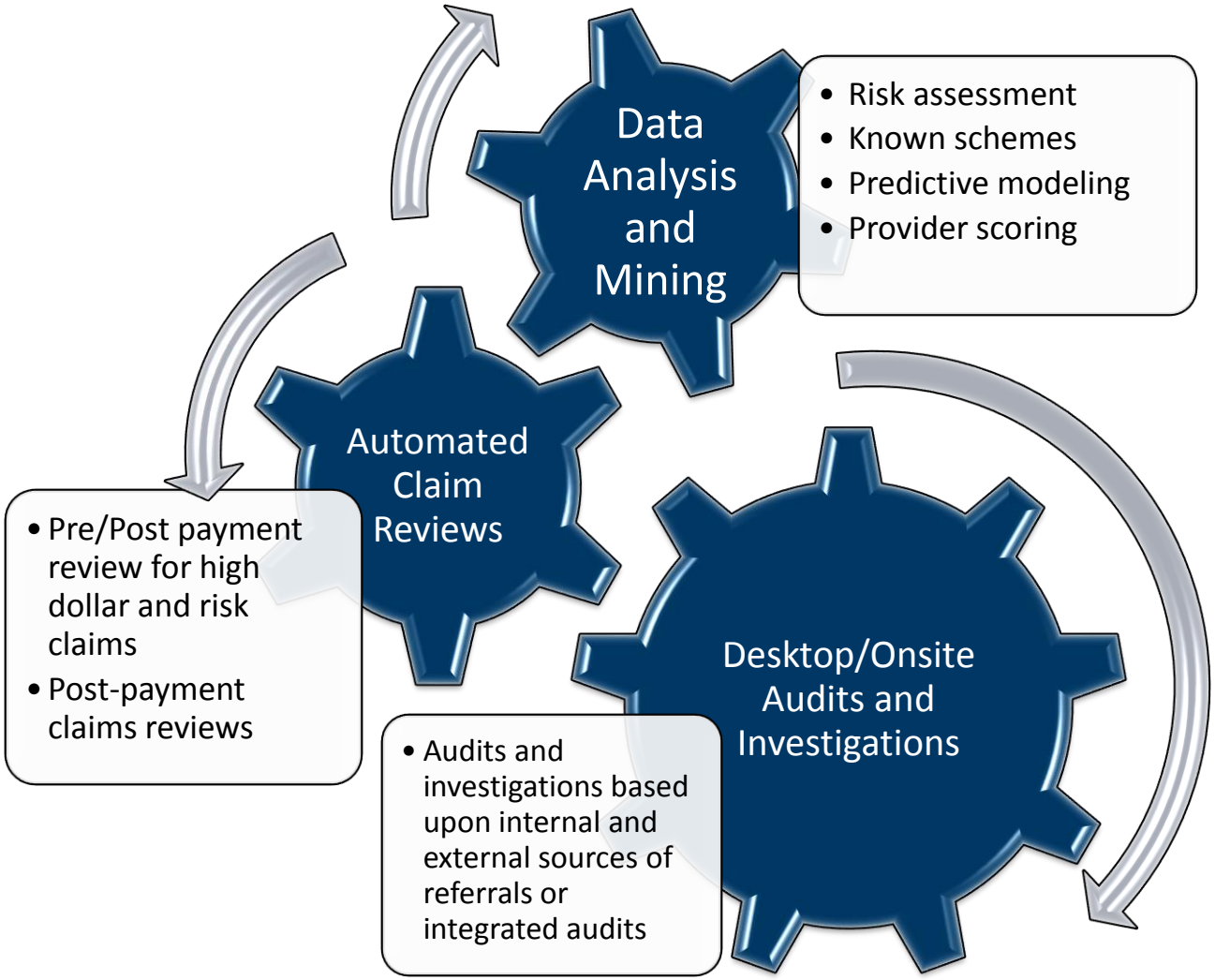
- **Magellan (Managed Care Organizations)**
  - Structure
  - Philosophy
- **Bureau of Program Integrity (BPI)**
  - Function
- **Office of Attorney General (OAG) Medicaid Fraud Control Section**
  - Function
- **Centers for Medicaid and Medicare Services (CMS)**
  - Function

Magellan Special Investigations Unit

Risk Based Approach



Integrated Model



PA HealthChoices – Local SIU Plan

SIU Resources	• Local Investigator: Diane Devine • Local Auditors: Patty Marth, Lydia Briggs • Corporate Support: Analysts, Investigators, Data Mining
Coordination with Magellan Departments	• Compliance • Network • Clinical and Medical • Legal • Quality Improvement
Coordination with External Agencies	• Bureau of Program Integrity • Medicaid Fraud Control Section • Licensing Boards • Customers and other external stakeholders

Opportunities for Coordination

- Outcomes of data analysis
- Investigative findings
- Best practices from other Medicaid states
- Ongoing communication
- Information sharing where possible

Magellan Claims & Compliance Auditing

Magellan Auditing

- Why do we Audit?
    i. To ensure a consistent approach to treatment between providers, Magellan and our County partners
    ii. Proactive Patient Safety activity
    iii. To measure adherence to standards set by CMS, Pennsylvania DHS and Magellan's national and local teams
- How do we Audit?
    i. On-site Review
        - Integrated Audits
        - Compliance/ Claims Audits
    ii. Desk Audits

Recommendations for Monitoring Program Compliance

1. Accessibility to the Requirements
2. Documentation of the Requirements
3. Policies and Procedures
4. Tools to Monitor Compliance
5. Audit Plan
6. Measurements of Effectiveness
7. Mechanisms to Correct and Report Non-Compliance

Audit Trends

- Documentation Errors
- Upcoding
- Treatment/ Service Plan Requirements
- Adherence to Magellan's Contracted Rate Sheet
- Duplicate Progress Notes
- Overlapping Services
- Rounding
- Outpatient Group Therapy
- ICM/CPS Travel & Transportation
- BHRS - Excessive office work
- EHR Time Stamp

Documentation Errors

- ✓ Missing Progress Notes
- ✓ Missing Encounter Forms (including missing signatures on encounter forms)
- ✓ Progress Notes are not supported by the Encounter Form (i.e., the start and end times don't match)
- ✓ Billing the incorrect dates of service (i.e., the date of service on the progress note does not match the date of service billed)
- ✓ Missing Signatures (member and/or staff signature)
- ✓ The start and end time of the session must be listed on all progress notes for all services. (i.e., 4:00 PM-4:45 PM).

Upcoding

➢ **Using a CPT Code for a more expensive service than was performed.**

Common Examples:

- The units billed are not supported by the start and end time of the session as documented on the progress note and/or encounter form (i.e., the start time was 9:01 a.m. and end time was 9:42 a.m. = 41 minutes; however, provider bills the 45-minute code).
- Medication Management session is performed by a CRNP; however, the service is billed under the Physician code.

Treatment/ Service Plan Requirements

- Providers must follow all applicable PA Medicaid regulations for which they are licensed, enrolled and contracted. Per Chapter 55 of the PA Code §1101.51, Ongoing Responsibilities of Providers, “a proper record shall be maintained for each patient. Treatments, as well *as the treatment plan,* should be entered into the record.”

- Per Magellan’s Provider Handbook Supplement, “the documentation of treatment or progress notes for all services must include the relationship of the services to the treatment plan—specifically, any goals, objectives and interventions.”

Adherence to Magellan Rate Sheet

- Using the incorrect modifier combination per the service that was provided. All claims must be submitted in accordance with a provider's Magellan Rate Sheet/Exhibit B Reimbursement Schedule(s).

- Billing under a service location that is not contracted or the incorrect service location, based on where services were rendered.

Duplicate Documentation

- Duplicate Progress Notes & Treatment Plans (i.e., copying & pasting content or sections from one progress note or treatment plan to another).

Overlapping Services

- Overlapping sessions (i.e., individual therapy & medication management occurring at the same time on the same date)

Rounding Units

- Although the number of minutes (i.e., 15 minutes, 30 minutes, 45 minutes, 60 minutes, etc.) that equates to a billable unit is dictated by the state's covered services grid and your Magellan contract; OMHSAS, through level of care specific regulations and MA Bulletins, has permitted exceptions for 3 specific in-plan services.
  - These include: Targeted/ Blended Case Management services; Crisis Intervention services; and Family-Based Mental Health services. All three levels of care currently utilize a 15-minute unit definition (unless otherwise specified by your Magellan Reimbursement Schedule).
  - The exception states that, if the better part of the last unit is provided (i.e., at least 8 minutes), the provider may round up and bill 1 full unit.

Outpatient Groups

- Outpatient Group Therapy exceeds maximum number of participants (10 persons; or 12 with an approved waiver from OMHSAS)

  - PSYCHIATRIC OUTPATIENT CLINIC Group Psychotherapy is Psychotherapy provided to no less than two and no more than ten persons with diagnosed mental disorders for a period of at least 1 hour. These sessions shall be conducted by a clinical staff person (PA Code 55 § 1153.2).

  - OUTPATIENT DRUG AND ALCOHOL CLINIC Group Psychotherapy is Psychotherapy provided to no less than two and no more than ten persons with diagnosed drug/alcohol abuse or dependence problems for a minimum of 1 hour. These sessions shall be conducted by drug/alcohol clinic psychotherapy personnel under the supervision of a physician (PA Code 55 § 1223.2).

ICM/CPS Travel & Transportation

Question: Are Certified Peer Specialists (CPS) or Case Management (ICM/RC/BCM/TCM) permitted to bill for transportation? For example: transporting a consumer to a meeting, appointment etc.

Answer: No, transportation is not a billable service. The standards for Peer Support state "travel time, staff meetings, record-keeping activities, and other non-direct services are not compensable ." The regulations for Case Management state that "transporting or escorting consumers to appointments or other places is not identified under 42 CFR as a component of case management services."

BHRS

- ✓ Non-billable function of MT services which requires direct contact with the family or other involved professionals.
- ✓ BSC excessive time spent completing paperwork
- ✓ TSS excessive community time

EHR Time Stamp

- ✓ Signature Stamps pre-date end time of the session
- ✓ Signature Stamps conflict with another session or activity

Self-Auditing

Self-Audits

- Through Magellan's partnership with DHS, other PA HealthChoices' Behavioral Health Managed Care Organizations and our provider network, we encourage the practice of self-reporting Fraud, Waste & Abuse (FWA), with the common goal of protecting the financial integrity of the MA program.
- Magellan supports the notion that treatment providers have an ethical and legal duty to promptly return inappropriate payments that they have received from the MA Program.
- CMS Medicaid Integrity Program Pennsylvania Comprehensive Program Integrity Review 2014 Final Report identified "Expanded Use of Provider Self-Audits" as one of four *Effective Practices*. There are two types:
  - MCO/ BPI initiated
  - Provider initiated

Guidelines for Self-Audits

- ✓ The Centers for Medicare & Medicaid Services' (CMS') Compliance Program Guidelines includes a component on provider self-auditing.
- ✓ Magellan's Compliance Program Audit Tool includes a requirement for providers to develop and maintain a Claims Audit Policy.
  a) Comparison of claims or potential claims to medical records
  b) Regulatory and contractual requirements
  c) Frequency of claims audits
  d) Number or percentage of claims or records to be reviewed
  e) How records are selected
  f) Procedure when errors are identified
  g) Prospective, Retrospective, or both

Magellan Claims Screening Tool

Claim Info (name, date, claim #, diagnosis, etc)	Staff	Date of note match date of claim?	Time-in & Time- out ?	Time in	Time out	Duration match Proc Code and Units Billed?	Service Provided Service Billed?	Regulations Met?	Encounter present and match?	Clinical support service?	Retract?	Units Overpaid	Overpayment Amount	Comments

DHS Self Audit Protocol

- ✓ The Department of Human Services (DHS) Provider Self-Audit Protocol can be reviewed in full by accessing the below link. There are 3 options (http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/#.VtRsBk1OUdU):
  1. 100 Percent Claim Review
  2. Provider Developed Audit Work Plan
  3. Pre-Approved Work Plan with Statistically Valid Random Sample

Self Audits → Self-Reports

- In the event that a provider self-identifies inappropriate payment during the course of a self-audit or via another mechanism (i.e., Compliance Hotline):
  - Contact designated Compliance representative at Magellan immediately, upon identification of the aversive finding(s).
  - Conduct thorough and comprehensive self-audit utilizing the DHS Self-Audit Protocol
  - BPI is available for consultation as well
  - Upon completion, the following documents must be submitted to Magellan:
    1. Spreadsheet of Claims
    2. Investigative Report
    3. Corrective Action

Auditing EHR

Electronic Health Records (EHR)

An **electronic health record (EHR)**, or **electronic medical record (EMR)**, refers to the systematized collection of electronically-stored health information, in a digital format, about an individual patient or a population.

Electronic Health Records (EHR)

EHRs replace traditional paper medical records with computerized recordkeeping to document and store patient health information.

EHRs may include patient demographics, progress notes, medication logs, medical history, and clinical test results from any health care encounter.

PROs and CONs of EHR

Advantages

- ❑ *Quality of Care*
- ❑ Legibility
- ❑ Efficiency
- ❑ Accuracy
- ❑ Standardization
- ❑ More Timely Information
- ❑ Reduced Loss of Paperwork
- ❑ Research
- ❑ Continuously Updated
- ❑ Other Capabilities

Disadvantages

- ❑ *Quality of Care*
- ❑ Cost
- ❑ Privacy Issues
- ❑ Workflow changes
- ❑ Temporary loss of productivity
- ❑ Other Technological Issues
- ❑ Software quality and usability deficiencies
- ❑ Cut-and-paste/ cloning techniques

Auditing

The Differences between Paper Files and EHR

Clues identified when reviewing paper files

- Differences in Handwriting
- Missing Signatures
- Altered Documentation
- Changes in Date of Service

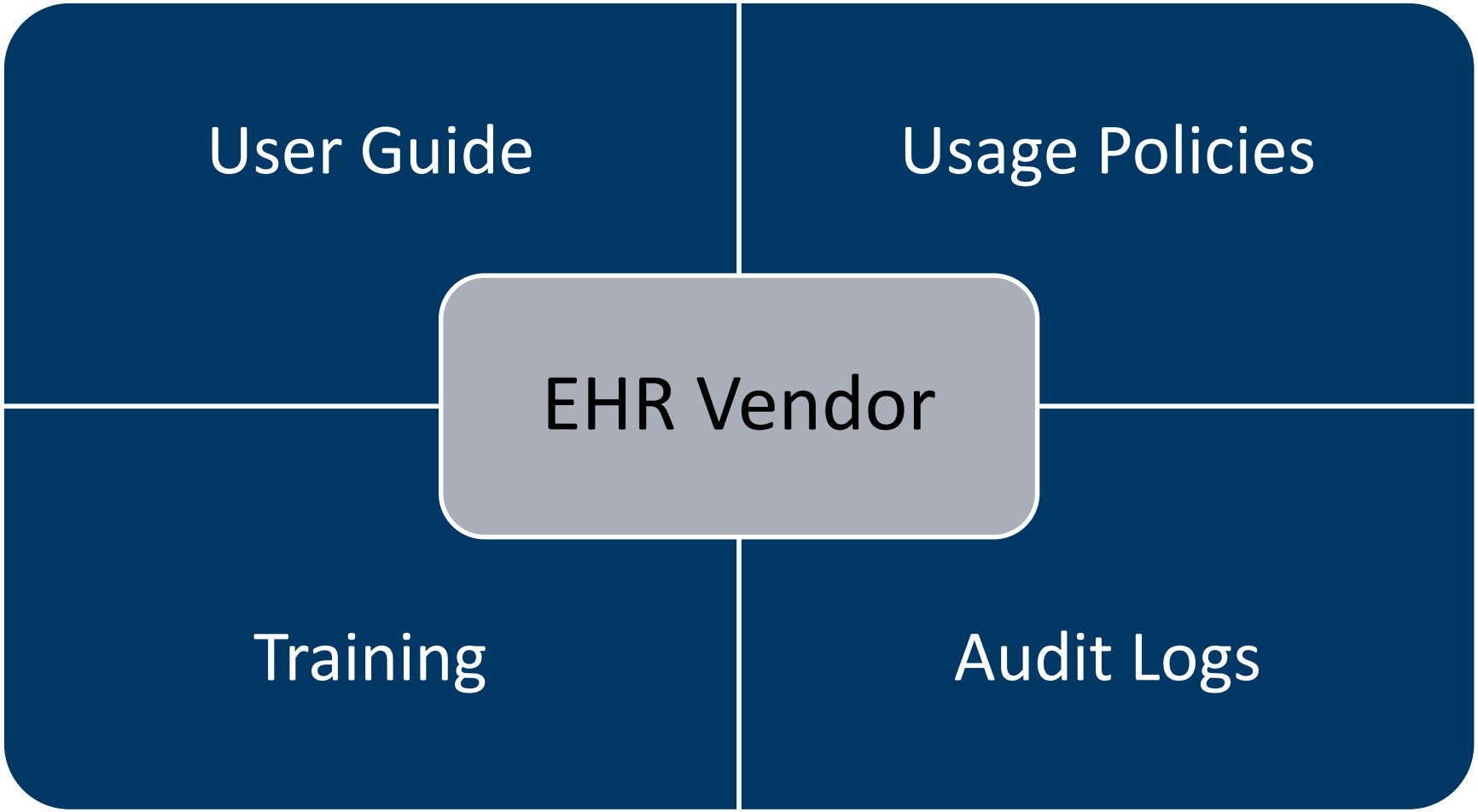
Clues identified when reviewing EHRs

- Copy and Paste
- Electronic Signatures
- Over-Documentation
- No proof of authorship

Audit Trends

- Cut-and-paste/ cloning
- Clinician/ rendering staff signature stamps proceed the end time of the session
- Signature stamps conflict with another session or activity
- Empty data fields
- Pre-populated code definitions that don't correlate to provider's contract or applicable regulations
- Credentials not populated on progress notes

Implications for Providers using EHR



MFCS Presentation

Panel Discussion

THANK YOU!