Magellan Compliance Notebook

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) strives to be proactive and use education as a preventative tool to help ensure our members receive the highest quality of care through you, the provider. The Compliance Department at Magellan is committed to sending monthly e-mails to targeted providers regarding a Compliance-related subject.

This e-mail communication is specific to your HealthChoices (Pennsylvania Medicaid) Contract with Magellan.

This month's communication includes important reminders and guidelines for Magellan contracted Opioid Centers of Excellence (COE) providers.

Opioid COE teams are integral to Magellan's delivery of care spectrum of services. COEs ensure that individuals receive the assistance they need while remaining in the community and working toward recovery.

Currently, COE services are funded through a directed payment arrangement, using the G9012 Code. Additionally, Magellan requires that COE providers submit zero-pay encounters for each date of service that community-based care management services are rendered in accordance with the individual's member care plan.

Please review the below reminders as it relates to the billing and documentation of COE services rendered to Magellan members:

Billing

Zero-pay encounters should be submitted throughout the service month. The Per Member Per Month (PMPM) payment claim (G9012) should be submitted the first week following the service month.

For example:

For service month June 2023, "zero-pay" encounters (G9012 U9) should be submitted throughout the month of June to reflect each time a member is seen for community-based care management services. Magellan understands that there is a lag between service delivery, documentation, and billing. Therefore, zero pay encounters can be submitted after the service

month, but for real time reconciliation of service intensity and accurate reporting, encounters should be submitted as close to the actual service month as possible.

Following submission of all zero pay encounters (G9012 U9) for the month of June, the PMPM payment claim (G9012) may be submitted.

All months of service should be billed according to this example.

Also, please note that all zero-pay encounter claims (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.

Unit Definition and Rounding

Effective July 1, 2023, the unit definition for an Opioid COE encounter (G9012 U9) is 15-minutes. The full 15 minutes must always be provided to bill 1 unit. Rounding up is never permitted.

Encounter Description

Per Appendix G and Magellan's expectations, the following services, when provided as clinically appropriate and included or reflected in the individual member's care plan, constitute community-based care management services as defined in the State Plan. This includes:

- Face to face encounters with the member.
- COE care management services may be provided via telemedicine in accordance with OMHSAS-22-02 Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth.
- Telephonic engagement with the member that meet the standards established.
- Transportation with the member that meets the standards established.

Screening and Assessment

- The level of care assessment, including ASAM, should be part of the COE record whether the assessment was performed by the COE or by another assessment provider.
- If a level of care assessment results in a recommendation of MAT, the COE must provide education related to MAT.
- Assessments to identify a member's needs related to Social Determinants of Health (SDoH), administered in home and community-based settings whenever practicable.
- Screenings for clinical needs that require referrals or treatment.
- The Brief Assessment of Recovery Capital (BARC-10) to each COE client must be administered within 30 days of the initial encounter with the COE Provider.

Care Planning

The COE's plan of care should clearly outline how the COE is supporting members in connecting to treatment, community, and health services. Per Appendix G, development of integrated, individualized care plans should include at minimum:

- The member's treatment and non-treatment needs.
- The member's preferred method of care management, such as face-to-face meetings, phone calls, or through a secure messaging application.
- The identities of the member's community-based care management team, as well as the names of the member's support system.
- Care coordination with a member's PCP, mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician or gynecologist, and BH-MCO, as applicable.
- In the COE records, the COE should maintain copies of release of information permissions from member to coordinate care with those involved in the member's care and recovery plan(s).

In addition to the above, Magellan would expect the following to be included in the COE's care plan:

- Signatures from the member and COE staff member supporting the care plan.
- Notation of the expected frequency of contact with member.
- Measurable objectives or goals.

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:

- Primary care, including screening for and treatment of positive screens for: HIV, Hepatitis A (screening only); Hepatitis B; Hepatitis C; and Tuberculosis.
- Perinatal Care and Family Planning Services.
- Mental Health Services.
- Forms of medication approved for use in MAT not provided at the OUD-COE Provider's enrolled service location(s).
- MAT for pregnant women, if the OUD-COE Provider does not provide MAT to pregnant women.
- Drug and Alcohol Outpatient Services.

- Pain Management.
- Facilitating referrals to any ASAM Level of Care that is clinically appropriate according to a Level of Care Assessment.

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

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.
- BARC-10 must be re-administered at six-month intervals.
- Making and receiving warm hand-offs. In the event of a warm hand-off from an overdose event, the OUD-COE must provide education related to overdose risk and naloxone.

What is not included (not billable as community-based care management services)?

- Emails and/or texts with members or any collateral agency
- Transportation without member
- Supervision
- Staff Training
- Documentation, record-keeping, or administrative activities of any kind

Service Duplication

While active in a COE, members may not receive community-based CRS services, nor may they receive Drug and Alcohol Case Management services outside of the COE. Of note, 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.

Documentation

A COE must utilize electronic records to document care management activities. Ideally, this should be an Electronic Health Record (EHR) or Electronic Medical Record (EMR) system. Paper records are not acceptable. COEs must comply with relevant federal and state confidentiality laws concerning protected information. The COE must document all care management service encounters including the following information:

- Date of encounter
- Location of encounter
- Identity of the individual employed by the OUD-COE with whom the member met.
- Duration of encounter
- Description of service provided during the encounter.
- Next planned activities that the OUD-COE and the Member will undertake.

In addition, the following are important to follow and align with the minimum Medical Assistance documentation requirements:

- The record must be legible throughout.
- The record must identify the member on each page.
- Entries must be signed and dated by the responsible provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, as well as final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as the recovery plan, must be entered in the record. Medications prescribed as part of treatment, including quantities and dosages, must be entered in the record. If a prescription is telephoned to pharmacist, the prescriber's records require a notation to this effect.
- The disposition of the case must be entered in the record.
- The record must contain documentation of the medical necessity of a rendered, ordered or prescribed service.

The documentation of treatment or progress notes for all services, at a minimum, must include:

- The specific services rendered.
- The date the service was provided.
- The name(s) of the individual(s) who rendered the services.
- The place where the services were rendered.
- The relationship of the services to the recovery plan – specifically, any goals, objectives and interventions.
- Progress at each session, any change in diagnosis, changes in treatment and response to treatment.
- The actual time in clock hours that services were rendered.

At Magellan, we will continue to educate our providers with updated MA Bulletins, regulations, and other pertinent information to ensure Compliance. Although providers are ultimately responsible for knowing and complying with all applicable regulations, we proactively engage providers on an ongoing basis to make sure they are aware of compliance related requirements and expectations. Medicaid Program Integrity is truly a collaborative effort between our providers, county customers, Magellan, Bureau of Program Integrity (BPI) and other oversight agencies. The monthly e-mail blast topics are generated from audit results and trends; however, are also sent in response to recent Magellan policy updates; newly released or relevant MA Bulletins and Policy Clarifications; or Regulation changes. The intention is to afford our providers with as many resources as possible to combat FWA and reduce overpayments.

Thank you for your ongoing hard work and dedication to our members!

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