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.

In order to assist providers to better understand all the telehealth documentation and signature requirements, Magellan is outlining the expectations. These reminders have been shared previously in a variety of communications and trainings; however, there continues to be a high volume of provider inquiries regarding the requirements.

The Office of Mental Health and Substance Abuse Services (OMHSAS) and Magellan have stressed the importance of developing appropriate systems to capture electronic signatures since February 2021. Given the options available to providers, we expect providers to meet federal and state guidance. 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 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.

Providers may only utilize audio-only telehealth when the individual served does not have access to video capability or for an urgent medical situation. Rationale for audio-only telehealth must be documented in the record. Audio-only consent may be obtained by having another employee of the entity hear (meaning two employees hearing consent) and documenting that

consent. Telehealth services cannot be provided audio-only if there is not the ability to document consent and verification as outlined here.

For additional telehealth guidance, please also reference:

- Magellan's Telehealth FAQs
- Telehealth Provider Performance Standards

Telehealth Documentation Requirements

Regardless of how services are rendered (e.g., face-to-face, audio-video telehealth, audio-only), the documentation in the medical record must align with all Office of Mental Health and Substance Abuse Services (OMHSAS) and Magellan documentation requirements. Magellan's minimum documentation requirements for all services are outlined in our Magellan Provider Handbook Supplement for HealthChoices.

The documentation to support a telehealth transaction includes, at a minimum:

- 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.

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 signatures, unless prohibited by other laws. 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. 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.

When the initial telehealth guidelines were issued, providers had to obtain consent from the individual receiving services (or their legal guardian) each time they rendered a service via telehealth. The updated telehealth guidance has clarified that consent to receive telehealth is required at the onset of services but is not required to be documented for each telehealth

session. Consent to participate in telehealth services must be obtained from the member's legal guardian if the child is under 14 years of age.

Please also note that consent to receive telehealth is required for each service/ level of care that is being provided via telehealth. So, for example, if a member is receiving Outpatient, Case Management Services and Peer Support Services and all three services are being rendered at least partly through a telehealth platform, then member consent to receive services via telehealth must be on file for each of those three services. Telehealth may not be clinically appropriate for all service modalities that an individual receives through any agency. Additionally, licensed practitioners and provider agencies must also allow individuals to elect to return to in-person service delivery at any time. Individuals may refuse to receive services through telehealth and providers cannot use such refusal as a basis to limit the member's access to in-person services.

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.

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).

Assessment

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 and that licensed practitioners are complying with standards of practice set by their licensing board for telehealth where applicable.

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. Appropriateness of telehealth services may vary for members over the course of treatment.

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. The

assessment also must meet all other regulatory requirements depending on the service/ level of care including timeliness, material and prescriber credentials.

Please refer to Magellan's Telehealth Provider Performance Standards for additional guidelines and factors to consider when determining an individual's appropriateness for telehealth.

Progress Note

All services, regardless of the modality, or whether billable or not require a progress note documenting the session. In alignment with Magellan's minimum documentation requirements in our Pennsylvania HealthChoices Handbook Supplement, the documentation of treatment or progress notes for all services, at a minimum, must include:

- The specific services rendered.
- The date that the service was provided.
- The name(s) of the individuals(s) who rendered the services.
- The place where the 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. For example: the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 a.m. to 11:00 a.m.

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.

Providers must also clearly document their ongoing assessment, consistent with agency policy and procedure, of the individual member risk factors, the provider's decision if telehealth continues to be recommended, how the member was informed if telehealth is not recommended (or if an in-person visit is requested), that the member was informed of the reasons why an in-person visit is recommended, and that the member was informed of the risks if they opt to receive telehealth services when in-person services are recommended.

Treatment/ Service Plan

In accordance with Title 55 Chapter § 1101.51 of the Pennsylvania Code, treatments as well as the treatment plan must be entered in the medical record. The treatment/ service plan must be a separate, written document and not embedded into other components of the medical record, such as progress notes. The minimum treatment/ service plan requirements including timeliness for completion and updates as well as signatures are typically outlined in level of care specific regulations and bulletins. Treatment/ service plans must be developed in collaboration with the individual being served and the documentation in the record must indicate whether the member agrees with the plan.

HIPAA compliant telehealth platforms that utilize a check 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.

In addition to provider signatures, treatment/ service plans are required to have an individual's and/or parent's signature attached to the record. Signatures may be obtained using a HIPAA-compliant telehealth platform or by acquiring signatures during in-person visits; or via U.S. mail, email, or some other mechanism as soon as possible but no later than 90 days after the service date.

Signatures on treatment/ service plans may be physical or electronic signatures, unless prohibited by other laws. 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. 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 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.

Encounter Verification Form

Encounter Verification Forms offer an extra check and balance for an agency to ensure that services delivered to Medicaid recipients are done so as billed. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services.

In accordance with Medical Assistance (MA) Bulletin 99-89-05, a recipient signature is required for MA services unless the service is signature exempt (please reference details in the bulletin).

Per MA Bulletin 99-89-05, the following information must be recorded on the encounter form:

- Certification Statement: “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.”
- Provider Name and MA ID
- Recipient Name and MA ID
- Date of service
- Member/ guardian 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.

Per OMHSAS-22-02, signatures for telehealth service verification may include hand-written or electronic signatures, unless prohibited by other laws. 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. 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 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. Signatures are to be obtained as soon as possible and no later than 90 days after the service.

Magellan does permit encounter signatures on multiple dates of service, for example, a weekly/ monthly encounter form for all services rendered during the prior week/ month, as long as the minimum requirements outlined above are met. Signed encounter forms should be available at the time of a Magellan audit or review. The signed encounter form must match all other supporting documentation of the session (i.e., progress note).

Billing Reminders

In accordance with OMHSAS-22-02, providers must utilize either Place of Service Code 02 or 10 when rendering a service via telehealth. When telehealth is provided in the identified member’s home, utilize POS 10. When telehealth is provided in a location other than the home of the member, utilize POS 02. This corresponds to the physical location of the member, not the

provider. When a non-telehealth service is rendered, please use the appropriate POS as allowable.

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

Please note that providers should also use the FQ informational modifier to bill for telephonic services that have always been billable. For example, to bill for case management services that are conducted telephonically (audio-only) with a member, a provider should utilize the appropriate procedure code and modifier combination according to their contract with Magellan. They should also include informational-modifier FQ in the last position to reflect audio-only services. Providers would not utilize either of the telehealth POS codes in this scenario; but instead utilize POS 11 (office) or 99 (other) depending on where the case manager is physically located.

Other Reminders

- Telehealth services should not be billed unless/ until the signature requirements outlined above are met.
- Providers are required to follow all documentation compliance requirements along with level of care-specific requirements that are outlined in the regulations.

Providers who are not able to meet the minimum regulatory requirements outlined by OMHSAS including telehealth signature requirements should consider requesting a waiver. Please refer to the OMHSAS waiver request process and form at:
https://www.dhs.pa.gov/providers/Clearances-and-Licensing/Documents/MH%20Residential%20Licensing/OMHSAS_Request_for_Waiver_Form_March_2022_Attachment_1.pdf

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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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