Audit Trends

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) has been conducting Claims/ Compliance Audits of network providers since 2010. Through our experiences, we have comprised a list of audit trends which may result in retraction and/ or an action plan.

**Please note that this is not an inclusive list of adverse audit findings that may result in an overpayment to Magellan; but merely a collection of common observations based on our ongoing auditing efforts.*

- Missing documentation (progress notes/treatment plans)

- The start and end time of the session must be listed on all progress notes for all services. The time-in and time-out must be indicated as the actual time in clock hours including AM and PM (e.g. 4:00 PM - 4:45 PM).

- Treatment/ Service Plan requirements:
    - Services do not relate back to the Treatment/ Service Plan (all services must be provided in accordance with the identified member's current treatment plan goals)
    - Expired Treatment/ Service Plans (the treatment plan has not been developed or updated in accordance with the minimum expectations per Pennsylvania Medicaid requirements)

- Adherence to Magellan rate sheet/ reimbursement schedule
    - Using appropriate procedure codes/modifier combination. All claims must be submitted in accordance with a provider's Magellan Rate Sheet/ Exhibit B Reimbursement Schedule(s).
    - Using appropriate unit definition (e.g. 15 minutes, 30 minutes)

- Duplicate billing
    - Receiving the same services from multiple different providers
    - Receiving community-based services that are already included in an all-inclusive level of care

- Rounding up (e.g. rounding up session end times). The Office of Mental Health and Substance Abuse Services, through level of care specific regulations and Medical Assistance (MA) Bulletins, has permitted exceptions for only three specific in-plan services. These include Mental Health Targeted/ Blended Case Management Services; Crisis Intervention Services; and Family-Based Mental Health Services.

- Documentation Standards- 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.
    - Documentation must also support the length of the session

- The correct place of service (POS) code must be indicated on the claim and relate back to the location of services on the documentation in the medical record.

- When submitting claims (whether electronically or on paper), providers are required to include specific information about the contracted service location in addition to the billing location, as these may not be the same.

- Encounter form deficiencies:
    - Encounter form times does not match the progress note.
    - Blank encounter forms should never be signed by members or a parent/ guardian.
    - Missing Encounter Forms (Encounter Forms must be obtained for all community based face-to-face services and telehealth services)

- Billing the incorrect dates of service (e.g. the date of service on the progress note does not match the date of service billed)

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

- Missing signatures or credentials on progress notes, encounter forms and/or treatment plans

- Charging out-of-pocket costs to members (i.e., for missed appointments)

- All-inclusive contracts- providers contracted with a per diem rate includes reimbursement for all the necessary ancillary and laboratory services needed to care for members. Separate billings for these services are not permitted.

- Telehealth audit trends include:
    - Missing consent to receive 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
    - Billing the correct telehealth place of service (POS) code (e.g., 02 or 10)
    - Billing the correct modifier for audio-only telehealth (FQ)
    - Documenting the mechanism for how services were delivered (e.g., telehealth, phone).
    - Documenting the telehealth platform that was utilized, if applicable (e.g., zoom)
    - Documenting the member's phone number that was utilized, if applicable.

- For providers who have are reimbursed under an Alternative Payment Arrangement (APA), zero pay encounters were missing or not submitted prior to the monthly rate.

- Billing for non-billable services including:
    - Travel/Transportation
    - Social/Leisure Activities

    - Administrative Duties

- Electronic Health Record Audit Trends including:
    - Cut-and-paste/ cloning
    - Clinician/ rendering staff electronic signature proceeds the end time of the session
    - Signature stamp conflicts with another session or activity
    - Empty data fields
    - Pre-populated code definitions that don't correlate to provider's contract or applicable regulations

- Other non-compliance with Magellan's minimum documentation standards (please reference the Magellan HealthChoices Provider Handbook Supplement)