Compliance Best Practices

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) has been conducting Compliance Audits of network providers since 2010. Through our experiences, Magellan has comprised a list of suggestions to aid providers in the development and enhancement of their Compliance Programs.

**Please note that this is not an inclusive list of compliance best practices, but merely a collection of observations based on our review of existing provider compliance programs/ plans.*

Compliance Program Best Practices:

- Providers should establish and maintain a strong "Culture of Compliance" that includes among other things hosting an annual Anti-Fraud Week; designating a dedicated Compliance Officer who has no other functions; doing the right thing even when it's not easy or has negative implications; keeping promises; and ensuring consistency in rules and enforcement.

- Compliance starts at the top. Requiring the Board of Directors to complete the agency's annual compliance training and ensuring that compliance is a standard agenda item for all board meetings helps promote a "Culture of Compliance".

- Assemble a Compliance Committee that includes a cross-section of employees and departments (including clinical, HR, legal, quality, IT). Ensure that staff understand that the responsibility for compliance essentially belongs to everyone. A team approach can be an effective way to extend the approach to compliance beyond the designated Compliance Officer. This group should set up a group charter and meet at least quarterly.

- Providers should define and document Conflicts of Interest. All staff including the Board of Directors should be asked to sign a Conflicts of Interest statement as part of the agency's Compliance Plan and keep these documents on file.

- Many providers require staff to review and attest to the agency's Compliance Program Manual and/ or Code of Conduct on an annual basis. All staff, including billing and administrative personnel, should also receive a **formal** training (either in person or online) on compliance at hire and at least annually thereafter. The training content should be updated on an annual basis and include an assessment or quiz with a minimum standard for passing.

- In addition to the annual required Compliance Training, providers should include compliance as a topic in team meetings, staff supervision and employ other communication strategies such as routine e-mail blasts.

- Include a section of Definitions and Examples (such as for Fraud, Waste, Abuse, etc.) within the Compliance Plan. Ensure that employees/ staff review these definitions/ examples on at least an annual basis by incorporating them into a training and attestation process.

- Reference Federal, State and Local laws related to Fraud, Waste & Abuse within a Provider's Code of Conduct and/ or Compliance Plan.

- Maintain a library of all applicable Pennsylvania Medicaid Regulations and Bulletins. Include references to specific level of care regulations within ongoing compliance trainings and educational opportunities.

- As part of any policy that describes disciplinary actions to employees who fail to comply with Medicaid regulations and employer's compliance standards (HR related actions), include a statement that acts of Fraud in the Medicaid Program are punishable in a court of law. Provide recent examples from the news.

- Many agencies utilize an Electronic Health Record (EHR) system that is intrinsically set up with a lot of compliance controls (e.g. the minimum documentation requirements are set-up as required fields). Such controls should be explained in a written policy and be included as part of the agency's Compliance Plan.

- Providers are required to have a mechanism for staff to report suspected non-compliance (e.g. hotline, email, drop box). The mechanisms should be well publicized throughout office locations (such as flyers posted in hallways). There should always be an anonymous mechanism available for reporting as well.

- Members should be educated about Fraud, Waste & Abuse and the agency's Compliance Hotline during intake. Ensure that families and members know that they should never sign a blank Encounter Form. Some providers have members and their guardians sign an

attestation to verify their understanding of this information.

- Some providers release an Annual Corporate Compliance Report. This practice upholds a provider's commitment to comply with Medicaid standards/ regulations. It also ensures that periodic reviews of a Provider's Code of Conduct and/ or Compliance Program are taking place.

- Providers that utilize Collaborative Documentation (when a counselor/ doctor and member write the progress note together as a clinical intervention during the session) are required to maintain a policy and corresponding training.

- All providers should employ a service verification process (contacts with members and/ or guardians to verify that services were delivered as indicated). Providers with strong service verification procedures employ some additional strategies including:
    - Implement both random and routine checks via phone, mail, text or other electronic mechanism
    - Community-based levels of care (e.g. IBHS, Peer Support, Case Management) should have a weighted distribution
    - Increase surveys around telehealth and phone sessions
    - Compare survey responses to progress notes, encounter forms, and claims
    - Outline investigation process when discrepancies are identified
    - Quality indicators should also be included on the service verification surveys

- Providers who offer community-based services should utilize GPS technology on company-owned vehicles or iPads as an additional mechanism to provide oversight and/ or audit staff documentation.

- Conducting internal claims audits (comparing documentation to claims submissions) is a requirement for all providers; however best practice would include completing these audits prior to claims being submitted to Magellan.

- Many providers have a peer review process in place when conducting documentation audits/ reviews- the more eyes the better.

- Sign-up to receive Magellan's monthly Compliance E-mail Blasts and participate in our annual Compliance Trainings. Ensure that a mechanism is in place to share the resources with provider staff (you may outreach Magellan's Senior Compliance Manager Karli Schilling at kmschilling@magellanhealth.com to be added to the compliance distribution list).

Documentation Best Practices:

- **One** progress note template should be used consistently throughout an agency or practice. This helps to reduce errors and ensure compliance with Pennsylvania Medicaid documentation requirements. Some agencies allow staff/ clinicians to use a variety of different templates and it has been observed that this often leads to an increase in documentation errors.

- Records should contain documentation of **all** activity regarding a member's treatment, regardless of whether it was billable or not.

- There should be a field on progress note templates for all required elements that align with Magellan and Pennsylvania Medicaid requirements including:
    - Type of service
    - Date of service
    - Place of service
    - Start and end time of the service in actual clock hours (e.g. 4:00 PM to 4:45 PM)
    - Printed name and credentials of the individual(s) who rendered the service
    - The relationship of the services to the treatment/ service plan—specifically, any goals, objectives and interventions
    - Progress, any change in diagnosis, changes in treatment and response to treatment

- EHR systems/ electronic progress notes offer a lot of benefits, most notably legibility; however, they can also lead to "cutting and pasting" from session to session. Providers that utilize an EHR should deactivate short-cuts such as cutting-and-pasting from a prior note. Employees and staff should be trained not to employ this practice and it should be routinely audited by supervisors and during internal claims audits. Each progress note should be unique and individualized.

- For services that require Encounter Verification Form signatures (e.g. IBHS, Case Management, Peer Support, Family Based Services, etc.), incorporate the clinical documentation and encounter signature on the same form/ template.

- For services that allow some non-direct billable contact (e.g. IBHS, Family-Based Services): when conducting research or outside work for the family, there should be evidence that this information is shared with the family in future sessions. Furthermore, the researched material could be printed out and included in the record as evidence (attached to the applicable progress note).

Telehealth Best Practices:

- Providers should have the following Policies and Procedures in place around telehealth services:
    - Policy on the operation and use of telehealth equipment
    - Policy around staff training to ensure telehealth is provided in accordance with the guidance Medical Assistance Bulletin OMHSAS-22-02, MCO specific requirements, as well as the provider's established patient care standards.
    - 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.
    - 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.
    - Policy for how appropriateness for telehealth will be determined.
    - Policy that describes how interpretation services, including sign language interpretation, will be delivered for individuals being served through telehealth.
- 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).