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, we would like to remind providers to follow all applicable regulations and requirements concerning the timeliness and completion of treatment/ service/recovery plans. Additional reminders about obtaining signatures on service plans when services are rendered via Telehealth are also provided.

Contracted Magellan providers must follow all applicable PA Medicaid requirements for which they are licensed, enrolled and/or contracted. Per Chapter 55 Chapter 1101 of the PA Code §1101.51, "a proper record shall be maintained for each patient. Treatments as well as the treatment plan should be entered into the record."

Magellan requires that treatment adhere to all applicable ethical standards. Per Magellan's Provider Handbook Supplement, all providers, regardless of provider type or service that is being delivered, must have a treatment plan in place for all members. Regulations and Medical Assistance Bulletins for each provider type include level of care specific requirements regarding when treatment/ service/ recovery plans must be initiated; how frequently they must be reviewed and updated; and who is required to sign the document* (please consult all applicable program requirements for specific details). In the absence of any direct regulation or bulletin outlining timeframes, all treatment/ service/ recovery plans must be reviewed and updated once every 180 days, at a minimum.

Furthermore, "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." As all services must be provided according to the individual treatment, service, recovery or rehabilitation plan, any Medicaid service that is provided in the absence of an active plan is non-billable.

Although non-compliance has been found during recent Magellan audits of all provider types, we would like to highlight some of the more common level of care requirements:

- Psychiatric Outpatient Clinics (reference § 5200.31 and § 1153.52) including individuals receiving Medication Management or Clozaril Services only:
  - An individual comprehensive treatment plan shall be developed within **30 days** of intake. The initial treatment plan shall be developed, reviewed, approved, dated and signed prior to the provision of any treatment services beyond the 30th day following intake.
  - For individuals voluntarily receiving treatment, the treatment plan shall be reviewed and updated at a minimum of every **180 days** by the mental health professional, mental health worker, certified registered nurse practitioner or physician assistant providing treatment services and the individual receiving services. The treatment plan update shall be signed and dated by the mental health professional, mental health worker under the supervision of a mental health professional, certified registered nurse practitioner or physician assistant providing treatment services.
  - The treatment plan shall be reviewed on an annual basis by the psychiatrist or advanced practice professional throughout the course of treatment from the psychiatric outpatient clinic and documented in the individual record.
  - If the individual is receiving psychotherapy and other clinic services, the psychiatrist or advanced practice professional shall review, approve, sign and date the initial treatment plan.
  - If the individual is receiving medication management services only, the psychiatrist, physician, certified registered nurse practitioner or physician assistant responsible for prescribing and monitoring the use of the medications shall sign and date the initial treatment plan.
  - Treatment shall be provided in accordance with the identified goals in the treatment plan and updates.

- Outpatient Drug and Alcohol Clinics (reference § 1223.52 and §709.92):
  - **Within 15 days following intake**, the clinic's supervisory physician shall review and verify each patient's level of care assessment, psychosocial evaluation and **initial treatment plan** prior to the provision of any treatment beyond the 15th day following intake. The clinic's supervisory physician shall sign and date the patient's level of care assessment, psychosocial evaluation, treatment plan and diagnosis in the patient's record.
  - **Sixty days** following the date of the initial treatment plan **and at the end of every 60-day period** during the duration of treatment, the clinic's supervisory physician shall review and update each patient's treatment plan. Each review and update shall be dated, documented and signed in the patient's record by the clinic's supervisory physician.
  - The treatment plan and updates shall be based upon the psychosocial evaluation and diagnoses. Treatment shall be provided in accordance with the treatment

plan and updates and under the supervision and direction of the clinic's supervisory physician. Clinic supervisory physician reviews and reevaluations of diagnoses, treatment plans and updates shall be done in the clinic.

- Family-Based Services (reference draft bulletin 5260.43):
  - The **initial plan** shall be prepared, reviewed and approved by the program director and clinical consultant, if required **within 5 calendar days of the initial service**.
  - The plan shall be **reviewed and updated at least once a month thereafter**.
  - Progress notes shall clearly record the delivery of services and how the services relate to the attainment of the goals in the treatment plan.
  - The parent of a consumer who is a child shall sign the treatment plan and updates. An adolescent who is a consumer shall sign the treatment plan and updates.

- Intensive Behavioral Health Services *except for Applied Behavior Analysis (ABA) or Group Services* (reference § 5240.22):
  - A written Individual Treatment Plan (ITP) shall be completed **within 30 days** after the initiation of a service and be based on the assessment.
  - The ITP must include the recommendations from the licensed professional who completed the written order for Intensive Behavioral Health Services (IBHS).
  - The ITP shall be reviewed and updated at least **every 6 months** or if one of the following occurs: The child, youth or young adult has made sufficient progress to require that the ITP be updated; The child, youth or young adult has not made significant progress towards the goals identified in the ITP within 90 days from the initiation of the services; The youth or young adult requests an update; A parent, legal guardian or caregiver of the child or youth requests an update; The child, youth or young adult experiences a crisis event; The ITP is no longer clinically appropriate for the child, youth or young adult; A staff person, primary care physician, other treating clinician, case manager or other professional involved in the child's, youth's or young adult's services provides a reason an update is needed; The child, youth or young adult experiences a change in living situation that results in a change of the child's, youth's or young adult's primary caregivers.
  - The ITP and all updates shall be reviewed, signed and dated by the youth, young adult or parent or legal guardian of the child or youth, and the staff person who completed the ITP. The ITP and all updates shall be reviewed, signed and dated by an individual who meets the qualifications of a clinical director.

- Intensive Behavioral Health Services *ABA Services* (reference § 5240.86):
  - A written ITP shall be completed by an individual qualified to provide behavior analytic services or behavior consultation—ABA services **within 45 days** after the initiation of ABA services and be based on the assessment.

- The ITP must include the recommendations from the licensed professional who completed the written order for ABA services.
- The ITP shall be reviewed and updated at least **every 6 months** or if one of the following occurs: The child, youth or young adult has made sufficient progress to require that the ITP be updated; The child, youth or young adult has not made significant progress towards the goals identified in the ITP within 90 days from the initiation of ABA services; The youth or young adult requests an update; A parent, legal guardian or caregiver of the child or youth requests an update; The child, youth or young adult experiences a crisis event; The ITP is no longer clinically appropriate for the child, youth or young adult; A staff person, primary care physician, other treating clinician, case manager or other professional involved in the child's, youth's or young adult's services provides a reason an update is needed; The child, youth or young adult experiences a change in living situation that results in a change of the child's, youth's or young adult's primary caregivers.
- The ITP and all updates shall be reviewed, signed and dated by the youth, young adult or parent or legal guardian of the child or youth, and the staff person who completed the ITP. The ITP and all updates shall be reviewed, signed and dated by an individual who meets the qualifications of a clinical director.

- Intensive Behavioral Health Services *Group Services* (reference § 5240.96):
  - A written ITP shall be completed by a graduate-level professional **within 30 days** after the initiation of group services and be based on the assessment.
  - The ITP must include the recommendations from the licensed professional who completed the written order for group services.
  - The ITP shall be reviewed and updated at least **every 6 months** or if one of the following occurs: The child, youth or young adult has made sufficient progress to require that the ITP be updated; The child, youth or young adult has not made significant progress towards the goals identified in the ITP within 90 days from the initiation of the services; The youth or young adult requests an update; A parent, legal guardian or caregiver of the child or youth requests an update; The child, youth or young adult experiences a crisis event; The ITP is no longer clinically appropriate for the child, youth or young adult; A staff person, primary care physician, other treating clinician, case manager or other professional involved in the child's, youth's or young adult's services provides a reason an update is needed; The child, youth or young adult experiences a change in living situation that results in a change of the child's, youth's or young adult's primary caregivers.
  - The ITP and all updates shall be reviewed, signed and dated by the youth, young adult or parent or legal guardian of the child or youth, and the staff person who completed the ITP. The ITP and all updates shall be reviewed, signed and dated by an individual who meets the qualifications of a clinical director.

- Mental Health Case Management (reference § 5221.33 and OMHSAS-10-03 Blended Case Management):
  - Written service plan. The initial written service plan shall be **developed within 1 month of registration** and **reviewed at least every 6 months**.
  - The service plan shall be signed by the member, the family if the member is a child, the intensive case manager, the intensive case management supervisor and others as determined appropriate by the member and the intensive case manager.
  - Documentation of services shall verify the necessity for the contact and reflect the goals and objectives of the intensive case management service plan.

- Peer Support Services (reference OMHSAS-19-05 and Provider Handbook for Peer Support Services):
  - Peer Support Service (PSS) agencies shall ensure that an Individual Service Plan (ISP) is developed by the individual, the certified peer specialist (CPS), and the mental health professional **within one month of enrollment and every six months thereafter**.
  - A certified peer specialist and an individual shall update the ISP at least **every six months** and when: the individual requests an update; the individual completes a goal; or the individual is not progressing towards stated goals.
  - The ISP must include dated signatures of the individual, the CPS working with the individual and the mental health professional.
  - To be compensable, services provided shall be identified in the individual service plan and must correspond to specific service goals.
  - A PSS agency shall complete an assessment of an individual prior to the development of the ISP.

- Certified Recovery Services (reference Magellan's Certified Recovery Services Minimum Program Requirements):
  - An Individual Recovery Plan will be developed by the individual and the Recovery Specialist **within 60 days** from first contact/ consent and will be reviewed at a **minimum of every 6 months** thereafter; or, upon any major changes in goals or events in the individual's life.
  - The Recovery Plan will be signed by the individual and the Recovery Specialist; and will specify individualized goals and objectives pertinent to the individual's recovery and community integration in language that is self-directed, outcome oriented and measurable.
  - The progress notes must include how the service encounter related to the individual's goals, objectives and/or resources identified in the Individual Recovery Plan and will summarize the purpose and content of the session, along with the specific resources utilized as related to the goals in the Individual Recovery Plan.

- Opioid Centers of Excellence (reference Magellan's Provider Performance Standards, Appendix G of the Program Standards and Requirements and COE Fidelity Guidelines):
    - A rapid care management plan is developed on the **day of intake** to decrease risk of overdose and substance using behaviors and to address immediate needs that could create barriers to consistent attendance within the first month after COE enrollment. An extended care management plan around HRSN/ SDOH gaps should be implemented **by the second month** and updated throughout an individual's enrollment in COE via monthly monitoring.
    - Care plans should be **updated every six months** or sooner if there is a new need identified.
    - The member's plan of care should clearly outline how the COE is supporting the member in connecting to treatment, community, and health services.
    - The development of integrated, individualized care plans should include, at a 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 Primary Care Physician (PCP), mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician or gynecologist, and Behavioral Health Managed Care Organization (BH-MCO), as applicable.
    - 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.

Specific to any services that are rendered via telehealth, the following guidance has been shared previously for obtaining signatures on treatment/ service plans:

- 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 <u>but no later than 90 days after the service date</u>.

- 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.

These requirements are assessed during routine and targeted audits by Magellan's SIU Department. Retractions and/or Corrective Action Plans may be applied as indicated. If you need any assistance in locating the requirements for a particular service or level of care, please outreach Magellan's Compliance Department for technical assistance.

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!

Magellan of Pennsylvania's Compliance Team
O 215-504-3967 | **F** 866-667-7744