Magellan Provider Compliance Forum- 2025

NOVEMBER 14, 2025

PRESENTED BY: MAGELLAN BEHAVIORAL HEALTH OF PENNSYLVANIA, INC.

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Introductions/ Housekeeping

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Welcome to our Guest Presenters:

The Office of Attorney General (OAG) Medicaid Fraud Control Section (MFCS)

Elizabeth Madigan, Attorney-in-Charge
Jennifer Snerr, Supervisory Special Agent

Meet Our Magellan Team

Tina Davis, M.Ed., CFE
SENIOR COMPLIANCE AND CLAIMS AUDITOR
BEDFORD CAMBRIA AND SOMERSET COUNTIES

Diane Devine, CFE
SIU TEAM LEAD, INVESTIGATIONS
ALL COUNTIES

Holly McQuiggan
SENIOR COMPLIANCE ANALYST
ALL COUNTIES

Patty Marth, CFE
SIU TEAM LEAD, AUDITS
LEHIGH AND NORTHAMPTON COUNTIES

Tanya Pennington, CFE, AHFI
SENIOR MANAGER, SIU INVESTIGATIONS
ALL COUNTIES

Karli Schilling, MA
COMPLIANCE OFFICER
ALL COUNTIES

Caitlin Vossberg, LSW
COMPLIANCE AND CLAIMS AUDITOR
BUCKS & MONTGOMERY COUNTIES

Housekeeping

- Magellan provides a focused Compliance Training for Providers annually
  - Prior trainings are posted on the Magellan of PA Compliance website page
- Today's training is being recorded
  - The Power Point and recording link will be sent to providers and will be posted on our website.
- All participants are muted. Please submit questions utilizing the Q&A feature in Zoom.
- **Brief Survey Questions will be shared at the end of today's training - please stay on the line to give us feedback!**

Agenda

- ✓ MFCS Presentation
- ✓ Outcomes and Trends
- ✓ Telehealth Services
- ✓ Regulation Updates
- ✓ Artificial Intelligence
- ✓ Billing Reminders
- ✓ Other Reminders
- ✓ Closing Remarks and Survey Questions

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MFCS Presentation

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Outcomes

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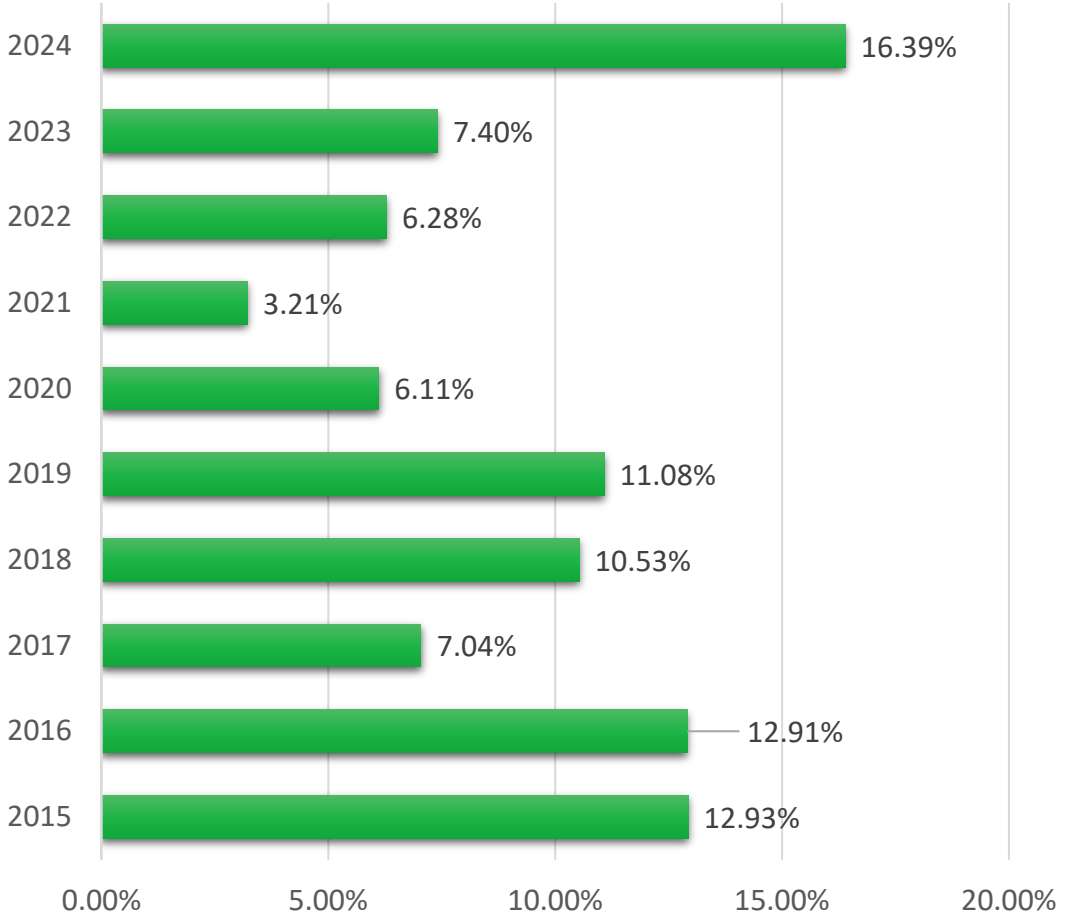
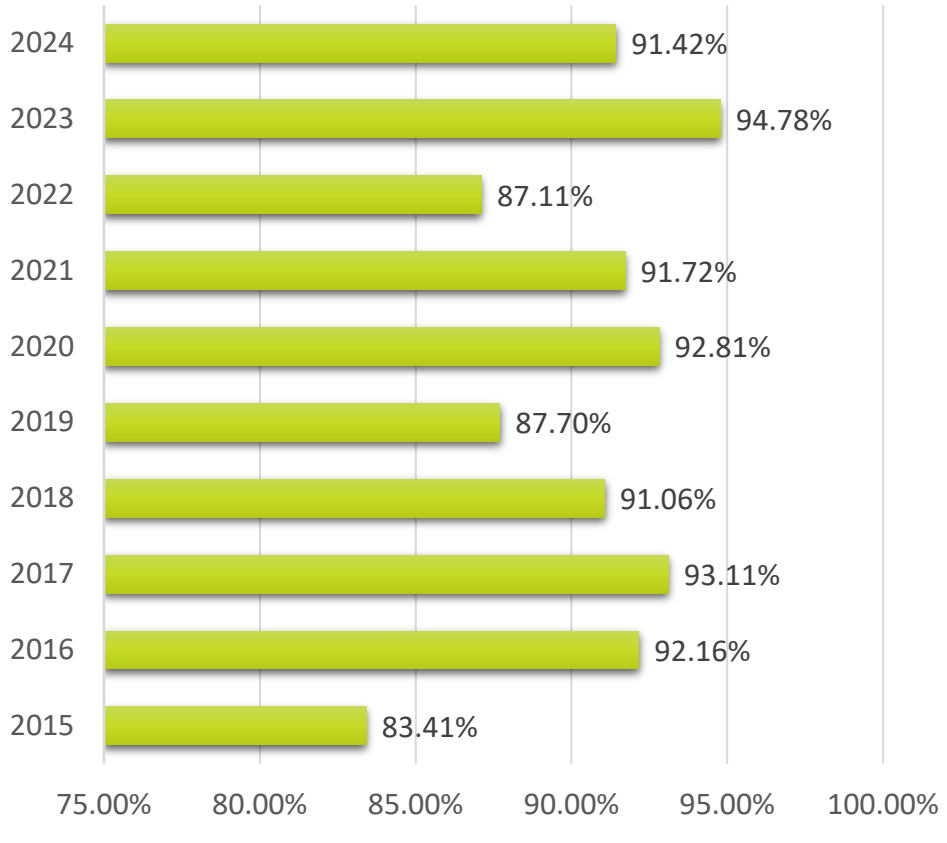
Year-to-Year Results from Audits

Claims Error Rates



Compliance Program Scores



Audit Trends

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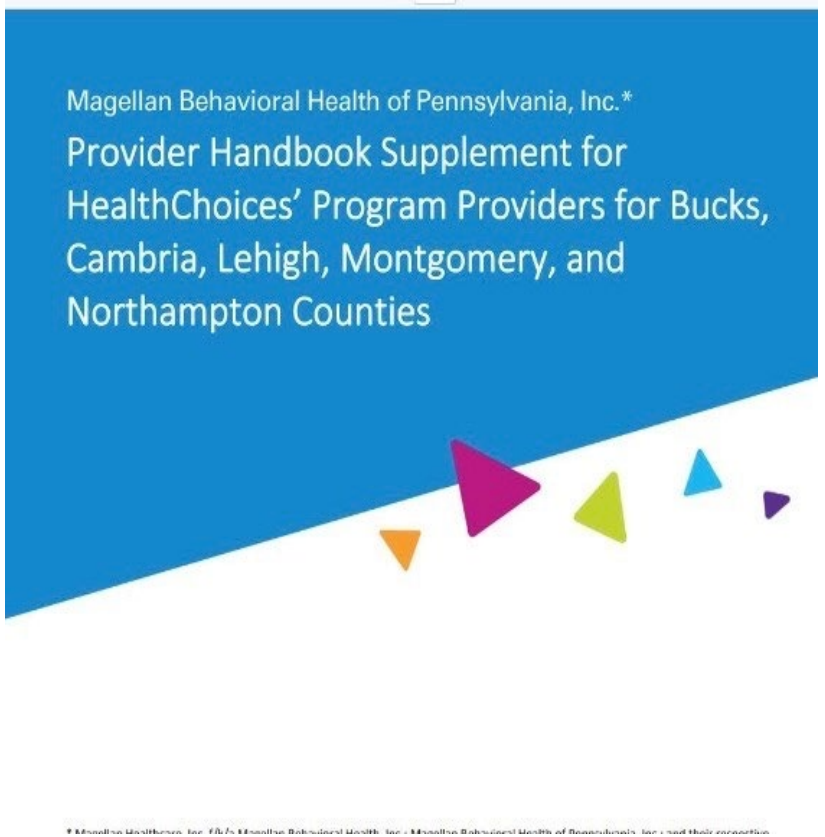
Overall Claims Audit Trends

- Missing documentation
- Non-compliance with the minimum documentation requirements (please reference Magellan's PAHC Provider Handbook Supplement). Specifically:
  - Including duration of session on progress notes instead of start and end time
  - Incorrect service date billed
  - Missing staff credentials
  - Limited documentation to support time period- 1-2 sentences
  - Portions of notes are copy & paste



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Overall Claims Audit Trends (continued)

- Services billed/ claims submitted to Magellan prior to having all documentation in place (completed and signed encounter forms & progress notes)
- Missing encounter forms/service verification (telehealth & community-based services have slightly different expectations)
- Rounding: billing the better part of a unit is an exception in only limited cases:
  - Targeted Case Management
  - Family-Based Services
  - Crisis Intervention Services
  - ACT
- Treatment/ Service Plan Trends
  - Missing Tx/ Service Plan
  - Tx/ Service Plan not updated in accordance with regulations
  - Services provided do not align with Tx/ Service Plan goals.
- Billing incorrect Place of Service (POS) codes
- Unbundling of units

Overall Claims Audit Trends (continued)

Telehealth:

- Pennsylvania Residents Temporarily Out-of-State: services may be provided using telehealth to meet the behavioral healthcare needs of Pennsylvania residents who are temporarily out of the state as long as the delivery of services out-of-state is consistent with the authorization for services and treatment plan, the individual continues to meet eligibility for the Pennsylvania MA Program, and the **Pennsylvania provider agency or licensed practitioner has received authorization to practice in the state or territory where the individual will be temporarily located.**
- Effective August 10, 2023, all providers must use a Health Insurance Portability and Accountability Act (HIPAA) compliant platform
- Missing signed encounters and consent for telehealth
- Missing rationale for audio only services – permitted only in 2 situations
- Billing the incorrect POS & modifier for audio-only telehealth
- Not meeting documentation standards
- Supporting documentation (e.g., encounter forms) must be obtained **prior** to billing
- Missing assessment for appropriateness for telehealth services
- Not meeting all signature requirements (encounter forms/ consent/ treatment plan)

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Telehealth Services

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Telehealth Resources/ References

- Compliance E-mail Blast on Telehealth Documentation and Signature Requirements (January 2024): https://www.magellanofpa.com/documents/2024/01/013124_compliancenotebookforjan2024.pdf/
- Magellan's Telehealth FAQ (updated June 2023): https://www.magellanofpa.com/documents/2023/06/060123_updatedtelehealthfaq.pdf/
- Magellan's Telehealth Provider Performance Standards (updated July 2024): https://www.magellanofpa.com/documents/2022/05/telehealth-provider-performance-standards-may-2-2022.pdf/
- Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth Medical Assistance Bulletin OMHSAS-22-02 (July 1, 2022): https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/OMHSAS%20Telehealth/Bulletin%20OMHSAS-22-02%20-%20Revised%20Guidelines%20for%20Delivery%20of%20BH%20Services%20Through%20Telehealth%207.1.22.pdf
- OMHSAS Telehealth FAQs (updated August 2022): https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/OMHSAS%20Telehealth/Final%20-%20OMHSAS%20Telehealth%20FAQ%202%208.16.22.pdf

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Requirements before Telehealth Services can Commence: Member Consent and Assessment for Clinical Appropriateness

- Consent for services and service modality, such as in-person or telehealth, must be obtained and documented **prior to** rendering services.
- Consent to receive telehealth is required for **each service/ level of care** that is being provided via telehealth (remember, telehealth may not be clinically appropriate for all service modalities that an individual receives at an agency).
- Signatures for consent to telehealth treatment may be **physical or electronic**.
- 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.
- 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 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.

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Telehealth Signature Requirements

Enforced effective January 1, 2024

- **On January 1, 2024**, all telehealth signature flexibilities specific to consent to treat, service verifications and treatment plans **ended**.
- As outlined in Medical Assistance Bulletin OMHSAS-22-02, providers are 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 expected to be compliant 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.**
- As a reminder, Magellan sent a Compliance E-mail Blast to all providers in January 2024 outlining these reminders and all the signature requirements.

Telehealth and Treatment Plan Signatures

- Treatment plans are required to have an individual's or parent's signature attached to the record. Signatures may be obtained using a telehealth platform or by acquiring signatures via U.S. mail or email as *soon as possible and no later than 90 days after the service*.
- HIPAA-compliant telehealth platforms that utilize a check the 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.
- Signatures on treatment/ service plans may be physical or electronic signatures, unless prohibited by other laws.
- 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.

Telehealth and Encounter Forms

- Providers should follow all applicable Pennsylvania Medicaid Regulations/Bulletins and Magellan guidelines which outline encounter form requirements.

- MA Bulletin 99-89-05 outlines all the required components of an Encounter Form:
  - A Certification Statement which says the following: “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.”
  - The Provider’s Name and their MA ID
  - The Recipient’s Name and their MA ID
  - The Date of service
  - The Member or guardian’s signature

- **Magellan also considers the inclusion of start and end times on telehealth 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.

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Telehealth and Encounter Forms

- Per OMHSAS-22-02, signatures for service verification may include hand-written or electronic signatures, unless prohibited by other laws.
- As of January 1, 2024, providers must be able to capture service verifications in a manner that creates an auditable file and is in compliance with both MA Bulletin 99-89-05, as well as the agency's policies and procedures on encounter form signatures.
- 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 should be obtained as *soon as possible and no later than 90 days after the service*.
- Audio-only verification for service encounters must be obtained either by having another employee of the entity hear (meaning two people) and documenting that consent or by utilizing a mechanism such as a telehealth platform or U.S. mail or email to secure consent. Services cannot be provided audio-only if there is not the ability to document the verification of service as outlined above.
- Weekly/ Monthly Encounter Forms are okay.
- **Providers should not bill for services for which they do not have verification of service provision.**

Electronic Signatures

- 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.
- 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.

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Telehealth Documentation Requirements

- The documentation to support a telehealth transaction must include:
  - ✓ Member Consent to receive services via telehealth (at onset).
  - ✓ 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.
- 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 continue to adhere to the Unit Definition/Description on their Magellan Reimbursement Schedule in order to bill a unit of service (e.g., 15 minutes, 30 minutes).

Telehealth: Audio-only

- Technology used for telehealth, whether fixed or mobile, should be capable of presenting sound and image in real-time and without delay. Telehealth equipment should clearly display the practitioners' and participants' faces to facilitate clinical interactions. The 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).
- Audio-only refers to the delivery of behavioral health services at a distance using real-time, two-way interactive audio only transmission.
- Magellan has recently observed a trend of providers consistently providing audio-only telehealth services for all members and all sessions.
- Audio-only services can **only** be provided when clinically appropriate and the individual served does not have access to video capability; or for an urgent medical situation.
- Member/Provider preference is **not permissible** rationale for providing ongoing audio-only telehealth.

Telehealth Billing

- In accordance with Medical Assistance Bulletin OMHSAS-22-02, informational modifier FQ must be included on claims submissions when providing audio-only telehealth services.

- Providers must 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.

- A telehealth Place of Service (POS) code must be utilized on claims. The allowable POS codes for telehealth includes 02 and 10:
  - Telehealth provided in the identified member's home: POS = 10.
  - Telehealth provided in a location other than the home of the member: POS = 02.
  - This corresponds to the physical location of the member, not the provider.
  - Regardless of whether a provider adds modifier FQ to their claim for audio-only telehealth, the POS code must be represented with either 02 or 10.

PLACE OF SERVICE CODE LOOKUP

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Members Temporarily Out-of-State

- Per OMHSAS-22-02:

Pennsylvania Residents Temporarily Out-of-State

Behavioral Health Services may be provided using telehealth to meet the behavioral healthcare needs of Pennsylvania residents who are temporarily out of the state as long as the delivery of services out-of-state is consistent with the authorization for services and treatment plan, the individual continues to meet eligibility for the Pennsylvania MA Program, and the Pennsylvania provider agency or licensed practitioner has received authorization to practice in the state or territory where the individual will be temporarily located.

- *"… the Pennsylvania provider agency has received authorization to practice in the state or territory where the individual will be temporarily located"*.
- Is the provider licensed in the state that the member will be traveling to? If not, you will need to obtain permission from the appropriate state entity.

Regulations Updates

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Peer Support Services

- On December 20, 2024, OMHSAS issued an updated Peer Support Services (PSS) Bulletin titled **OMHSAS-24-05** and an updated Provider Handbook for Licensed Peer Support Services Provider Agencies.
- Resources:
  - *MA Bulletin:* https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omhsas/ohmsas-24-05-peer-services-bulletin-12-20-20.pdf
- Changes include:
  - Staff qualifications and requirements for Certified Peer Specialists (CPSs) and CPS Supervisors
    - ✓ The requirement for a CPS to have a high school diploma or GED has been removed.
    - ✓ The requirement for a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) has been replaced with a requirement to have a MH diagnosis and reach a point where they can positively support others.
    - ✓ Removed the requirement to have at least 12 months of successful full or part-time paid or voluntary work experience or at least 24 credit hours of postsecondary education.
    - ✓ The clause requiring CPSs "to attain certification through the PCB within six months of hire" has been removed.
    - ✓ Added a new qualification category for individuals that "have an associate's degree with three years of mental health direct service experience and have completed the CPS supervisory training curriculum approved by the Department within six months of hire" are now qualified to serve as CPS Supervisors.
    - ✓ A requirement was added that CPS Supervisors must complete a CPS Supervisory training course approved by the Department within 6 months of assuming the position.

Peer Support Services (continued)

- Changes include:
  - Supervision
    - ✓ Supervisory meetings held via telehealth are permissible, but a video component is required.
    - ✓ Supervisory meetings shall be provided at a minimum of one hour each week.
  - Telehealth
    - ✓ The prior requirement that only 25% of total services provided per beneficiary per calendar year can be delivered by telephone has been removed. PSS may be provided via telehealth technology, including audio-only service delivery, when it is clinically appropriate to do so.
    - ✓ PSS providers must ensure that the preference of individuals receiving services (or their legal guardian) is given a high priority when determining the appropriate service delivery modality.
    - ✓ PSS providers must has telehealth policies in place which include: services are only delivered through telehealth technology when clinically appropriate, in the best clinical judgment of the MHP employed by the licensed PSS provider agency; ensuring that the preference of the individual receiving services or their legal guardian(s), regarding the type of service modality (in-person or through telehealth technology), is given a high priority; and lastly informing, each individual receiving service in writing of their right to receive PSS in-person or via telehealth technology as requested and clinically appropriate (this notice must be given to individuals at intake and annually thereafter).

Psychiatric Rehabilitation Services (PRS)

- The Office of Mental Health and Substance Abuse Services (OMHSAS) recently promulgated updates to 55 PA Code § 5230 Psychiatric Rehabilitation Services (PRS) which were effective on January 18, 2025.
- Resources:
  - *PA Code:* https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter5230/chap5230toc.html&d=
  - *FAQ:* https://www.magellanofpa.com/documents/2025/04/042925_prsfaqfinal.pdf/
- The key changes to the regulations include:
  - Allow individuals who are 14 years of age or older but under 18 years of age who meet the admission requirements to access Psychiatric Rehabilitation Services (PRS), broadening access to younger populations.
  - The inclusion of individuals with posttraumatic stress disorder, bipolar disorder, major depressive disorder, and anxiety disorders without requiring an exception process.
  - Implementation of a weekly file note requirement to ensure comprehensive documentation of participant progress and engagement in PRS while reducing administrative burden.

PRS (continued)

Documentation Guidelines:

- Magellan strongly recommends and encourages providers to continue documenting daily notes which include specific times of attendance for each member. Daily progress notes help providers ensure accurate claims submission practices.
- If providers elect to complete weekly notes in accordance with the updated regulations, Magellan is requiring PRS providers to include on the weekly note, the member's daily attendance times including any breaks (this allows you, and us, to reconcile the daily units billed for each member). As a reminder, the OMHSAS FAQ clarified that a PRS agency must maintain daily attendance records which include attendance start and end times and activities/ sessions attended. Magellan is further requiring that this information be included in the weekly progress note.
- As outlined in the FAQ, whether using daily or weekly notes, the documentation must clearly identify the group sessions, individual sessions, and/or activities the individual participated in during each date of attendance.
- If using weekly notes, each PRS staff person who worked with an individual on any activity during the week must sign and date the weekly progress note.
- As a reminder and in accordance with MA Bulletin 99-89-05, signed encounter forms from the member are also required (this can be a daily/ weekly/ monthly encounter form in accordance with Magellan's prior guidance, but all unique dates of service must be included if using a weekly or monthly form). Additionally, start and end times are also required on encounter forms for all community-based services (mobile PRS) and their inclusion is a best practice for all other services.

Residential Treatment Facility (RTF) Reminders and pending Psychiatric RTF (PRTF) Regs

- Medical Assistance (MA) Bulletins 01-95-13 JCAHO-Accredited RTF Services and 01-95-12 Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children under 21 Years of Age outline the guidelines for reimbursement of time spent in **therapeutic leave** and **hospital reserve days** while in placement at a Residential Treatment Facility (RTF).

Bed Hold

- Payment for a hospital reserved bed day is one-third of the facility's per diem payment rate and is limited to 15 days per child per calendar year. Providers should bill the designated code on their contracts that reflects the Bed Hold rate.
- The 15-day per calendar year limit is cumulative and applies regardless of whether the child received continuous or intermittent treatment at one or more RTFs or was admitted to one or more hospitals or units during the calendar year.
- Overnight visits to the emergency room are considered “hospital reserved/ bed hold days”. An RTF may not bill the full rate when a member does not sleep in the RTF due to an overnight or multiple nights spent in an emergency room or crisis center.

Residential Treatment Facility Reminders (cont'd)

Therapeutic Leave

In order to receive reimbursement from Magellan for therapeutic leave, the following documentation must be in the record:

- ✓The physician's order for the therapeutic leave.
- ✓A description of the desired outcome.
- ✓The date and time the child went on therapeutic leave and when the child returned.
- ✓A written evaluation resulting from interviews with both the child and family or legal guardian after the leave.
- ✓The evaluation shall describe the treatment objectives of the leave and the outcomes.
- ✓The facility must report therapeutic leave usage when requesting prior approval for continued stay.

Residential Treatment Facility Reminders (cont'd)

Other important reminders and guidelines regarding reimbursement of therapeutic leave:

- Therapeutic leave in excess of 48 days per calendar year is not billable.
- The facility is responsible for maintaining documentation of all usage of therapeutic leave (including from other facilities).
- Therapeutic leave cannot exceed 4 nights/ 5 days per episode.
- Leave is subject to concurrent review and will be evaluated along with other elements of treatment.
- If the member does not return back to the RTF from a therapeutic leave, the date of discharge will be the date of the last night the member spent in the RTF and reimbursement will not be provided for that episode of leave.

PRTF Draft Regulations: Chapters 1130 and 5330

- *Background*: DHS currently licenses residential treatment facilities (RTFs) that serve children, youth or young adults. A subset of the RTFs that provide medically necessary psychiatric treatment in a residential setting to children, youth or young adults under 21 years of age with a behavioral health diagnosis are also certified by DHS.
- *Purpose*: The **proposed Psychiatric Residential Treatment Facilities (PRTF) regulations** codify the minimum licensing standards and Medical Assistance (MA) participation requirements and payment conditions for PRTFs that provide medically necessary behavioral health treatment to children, youth or young adults under 21 years of age with a behavioral health diagnosis who cannot be effectively treated in their home and community. **When the proposed rulemaking is promulgated, RTFs that are currently licensed and certified by the Department to provide behavioral health treatment to children, youth or young adults will need to be regulated under the new licensing and payment chapters as PRTFs**.
- OMHSAS has completed review of public, Independent Regulatory Review Commission (IRRC), and legislative Standing Committee comments. DHS hosted a Stakeholders webinar in May to discuss some of the highly commented areas. Any suggested changes to the proposed regulations may be considered as long as they do not expand the regulation's coverage to a new subject matter or if it is federal regulation. Final-form regulations must be submitted to IRRC within 2 years of the end of the public comment period. IRRC addresses the final form regulations at a public meeting a minimum of 30 days from the date the final-form regulations are submitted.
- **Magellan strongly recommends that all DHS-licensed RTF providers familiarize themselves with the proposed new regulations as soon as possible.**

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Crisis Intervention Draft Regulations – Chapter 5250

- OMHSAS recently announced the publication of the proposed Licensure of Crisis Intervention Services regulations in the Pennsylvania Bulletin on October 18, 2025.
- OMHSAS' proposed regulation seeks to codify minimum standards for the issuance of licenses to provide emergency behavioral health crisis intervention services (crisis intervention services) in this Commonwealth in alignment with national best practices for crisis services.
- The package is also posted on the Independent Regulatory Review Commission (IRRC) web site and can be found here: https://irrc.state.pa.us/regulations/RegSrchRslts.cfm?ID=3475
- Comments are open between 10/18/25 and 11/17/25 (via email at: RA-PWCRISISSRVSREGS@pa.gov). all public comments must be published verbatim on the IRRC website with the name of the commenter included.

Depression Screening G Codes

- The Center for Medicare and Medicaid Services (CMS) established various Core Data Set Measures that states must report to CMS. OMHSAS is requiring BH-MCOs to collect depression screening data and documented follow-up as a result of the depression screening from providers in scope for this requirement via claims submission using various G codes.
- All five PA BH-MCOs collaborated to develop a single set of specifications for this depression screening reporting. Providers should not report depression screening G codes for persons already diagnosed with depression or bipolar disorder. When a depression screen is conducted as part of diagnostic evaluation or other qualifying service, only one of the G codes for depression screening should be submitted on the claim with the qualifying service.
- G Codes for depression screening cannot be submitted as a standalone claim.
- Magellan requested that providers (MH OP clinics, Psychologists, Psychiatrists and SUD OP clinics) begin submitting G codes for depression screening per the specification effective June 1, 2025.
- Resources:
  - *Provider Notice*: https://www.magellanofpa.com/documents/2025/03/030625_screeningrequirements.pdf/
  - *FAQ*: https://www.magellanofpa.com/documents/2025/06/060925_provideremail_faqfordepression-screeninggcodes.pdf/

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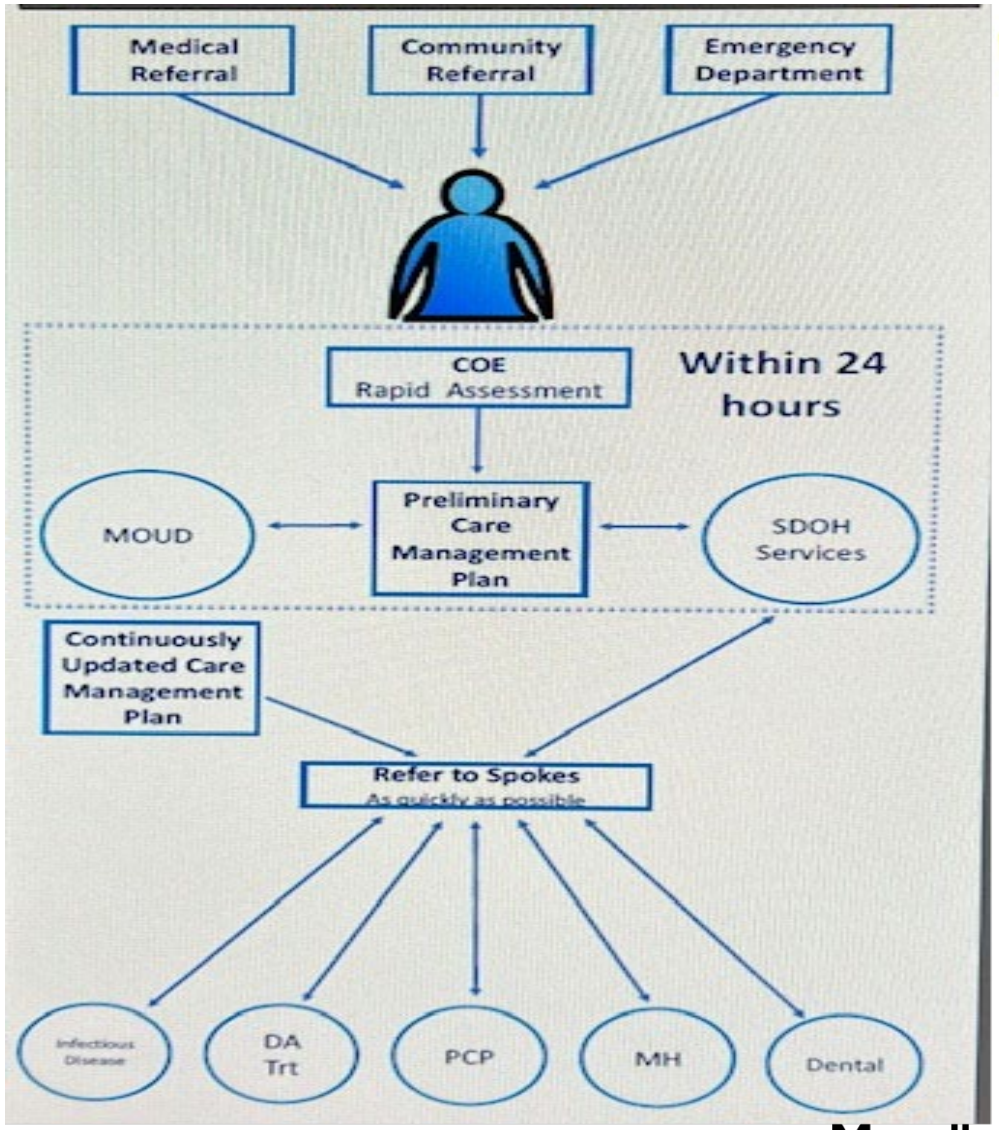
COE Fidelity Guidelines

- The primary goal of the COE is to provide comprehensive care and support to clients with specific Opioid addiction needs, particularly related to Medications for Opioid Use Disorder (MOUD) and Social Determinants of Health (HRSN/SDOH).
- This image illustrates a structured and systematic approach taken by the COE to cater to the complex needs of clients, ensuring they receive comprehensive care through a network of specialized providers and social support services.
- COE Fidelity Guidelines were issued August 2024.
- **<u>Required Compliance Date: January 1, 2026.</u>**



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COE Fidelity Guidelines (continued)

Standard guidelines ensure that all Pennsylvania Centers of Excellence (COEs) provide consistent, evidence-based care to individuals seeking treatment for opioid use disorder.

Following established guidelines helps ensure that individuals receive the most effective and up-to-date treatments, increasing the likelihood of successful recovery.

Standard guidelines facilitate better coordination among healthcare providers within the COE, this coordinated approach ensures that individuals receive comprehensive and integrated care, addressing both their medical and psychosocial needs.

Guidelines help streamline workflows and procedures within the COE, leading to more efficient and effective care delivery. Consistent procedures promote staff efficiency and reduce variability in care.

Establishing standard guidelines promotes client safety, care coordination, regulatory compliance, and data-driven improvement efforts, ultimately leading to better outcomes for individuals and strengthening the overall response to the opioid crisis.

Providers should consider an approach to the implementation of the Fidelity Guidelines that shows commitment to high-quality enhanced care management and supports the delivery of evidence-based practices that facilitate each member's ability to achieve optimal health, well-being, recovery, and choice.

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COE Fidelity Guidelines (continued)

Mandated Requirements:

- Opioid Use Diagnosis
- Formal interactive, **non-automatic** enrollment process
- Completion of COE-specific enrollment paperwork
- Development of rapid care management plan
- Assessment of social determinants of health/health related social needs using a validated tool within 7 days of enrollment in COE services
- Individualizing duration and frequency of engagement to individual client's needs
- Offering mobile engagement services
- Discharging from enhanced care management when care plan is complete, no new needs are identified, and client can navigate community resources independently

Best Practices:

- Records of potential referral partner outreach
- Identification of the COE as the client's provider of choice
- Rapid access to MOUD prior to formal enrollment in COE services
- Reviewing ASAM Level of Care Assessment results during enrollment
- Frequency of repeated assessments of social determinants of health/health related social needs
- Risk screening
- Continuous assessment of appropriateness of enhanced care management services
- Engaging family members in care management
- Conducting interdisciplinary care team meetings that include all providers rendering services to the client within the facility

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Artificial Intelligence

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Artificial Intelligence (AI)

- Artificial Intelligence refers to any machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations or decisions in an automated way influencing real or virtual environments.
- Artificial Intelligence (AI) including Generative Artificial Intelligence (GenAI), is a technology that companies are increasingly using to gain or maintain competitive advantage.
- While the use of AI by providers in behavioral healthcare (BH) has the potential to increase efficiency and support clinical workflows, it comes with potential risks, including data protection, copyright/intellectual property issues, bias, ethical considerations, consent, risks to member safety, lack of human connection, environmental impacts, and compliance with wider legal risk and obligations.
- Support for the use of AI by BH providers is evolving and currently, there are limited guidelines and best practices available. Technology is advancing faster than regulatory frameworks for safety and efficacy.

Artificial Intelligence (continued)

All contracted providers and provider organizations who choose to use AI tools should adopt and maintain policies and procedures which includes:

1. Transparency and Disclosure
   - Providers must clearly disclose to members how AI is being used and the associated risks
2. Human Oversight and Accountability
   - AI tools may assist with drafting documentation, but final clinical notes must be reviewed, validated, and signed by a licensed provider. AI does not replace professional judgment or clinical responsibility.
3. Privacy and Data Security
   - AI tools used for documentation must comply with HIPAA and all applicable federal and state privacy laws.
4. Accuracy and Clinical Integrity
   - AI-generated notes must not include fabricated information. Providers must ensure that all documentation—AI-generated or not—accurately reflects the individual's clinical condition, services provided, and the provider's assessment.

Artificial Intelligence (continued)

All contracted providers and provider organizations who choose to use AI tools should adopt and maintain policies and procedures which includes:

5. Documentation Standards
   - All medical documentation must continue to meet the standards set by Magellan, OMHSAS, and applicable accrediting organizations.
   - Notes must be individualized to the patient, clinically relevant, and support medical necessity for services rendered.
6. Training and Competency
   - Organizations using AI for documentation must ensure that staff are trained in the appropriate use of such tools, including how to detect and mitigate errors
7. Auditing and Compliance
   - As with all documentation, Magellan reserves the right to audit documentation that includes AI-generated content.
   - Improper use of AI resulting in inaccurate or non-compliant documentation may result in corrective actions, recoupment, or referral to regulatory agencies.

Billing Reminders

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Billing Reminder- Magellan Contract/Fee Schedule

- Different payors have different expectations.
- All documentation (e.g., progress notes, encounter forms) must be completed prior to billing.
- Remember to review your Magellan contract and fee schedule and bill claims accordingly. Pay specific attention to:
  - ✓ Unit definitions
  - ✓ Appropriate procedure code/modifier combination used
  - ✓ Correct place of service (POS)
  - ✓ All inclusive services

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Billing Reminder- Documentation in 24-hour SUD Programs

- Staffing patterns must align with all Medical Assistance Regulations and Bulletins as well as Department of Drug and Alcohol Programs (DDAP) Licensing Requirements to allow for meaningful treatment to be provided every day that the member is physically in the facility.
- In compliance with the daily per diem rate that encompasses both Treatment plus Room and Board costs, it is Magellan's expectation that Substance Abuse Facility Providers implement and document behavioral health interventions for each date of service billed, including all weekends and holidays.
  - Progress Notes/ Daily Entries must document the interventions used, the individual's response, and relate to the treatment plan goals.
  - Interventions should be individualized and specific; use of vague language such as "listened and provided positive feedback" or "watched a video on substance abuse" would not be considered sufficient.
  - Must include any and all interventions, both formal and direct treatment (i.e., structured individual and group sessions) as well as those interventions that are less traditional.
  - Interventions may be delivered by any inpatient/ residential staff member and there is no minimum time requirement for the intervention as long as it is documented.
  - Documenting medication dosing only for detoxification or rehabilitation is NOT considered sufficient substantiation of payment for a day of service.
  - Group therapy notes should include a brief description of the group. They must also include individualized information for each participant including their behavior during the group session, level of participation and response to interventions/ information discussed.

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Billing Reminders- Group Psychotherapy/ Psychoeducational Group Size

- Reference Magellan's October Compliance E-mail Blast
- *What's in Scope*: Medicaid-funded Outpatient Mental Health and Substance Use Disorder (SUD) Clinics as well as Partial Hospital Programs, Intensive Outpatient Programs (IOP), Residential SUD programs, and Halfway Houses.
- *Level of Care Specifics:* Pennsylvania Medicaid regulations and ASAM requirements include requirements around the maximum number of individuals who can participate in a Medicaid-funded Group Psychotherapy session at any time in order to promote optimal therapeutic value. Likewise, Magellan has implemented some additional guidelines regarding the maximum size of Psychoeducational Groups within day programs as well as 24/7 programs.
- *Caveat*: Please note that adding an additional group facilitator does not allow a provider to double or otherwise expand the maximum size of the group. Regardless of the number of provider staff co-facilitating or leading the group, the maximum allowable size cannot be increased.

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Billing Reminders- Group Psychotherapy Size (cont'd)

- *Group Therapy* focuses on behavioral change through interpersonal processes and shared experiences. Prioritizes deeper emotional exploration and relationship dynamics for personal growth.

- *Group Therapy Level of Care Specifics*:
  - **MH OP Clinics**: Per PA Code 55 § 1153.2, Group Psychotherapy is Psychotherapy provided to no less than two (2) and no more than twelve (12) persons.
  - **SUD OP Clinics**: Per PA Code 55 §1223.2, Group Psychotherapy is Psychotherapy provided to no less than two (2) and no more than ten (10) persons with diagnosed drug/alcohol abuse or dependence problems. ASAM also outlines requirements for 1.0 Levels of Care, which caps the maximum psychotherapy group size at ten (10) individuals. SUD OP Clinics may submit a waiver to OMHSAS for consideration to expand the maximum psychotherapy group size to 12 individuals.
  - **SUD IOP programs:** Considered an in-lieu-of service in the HealthChoices continuum; however, the ASAM requirements for 2.0 Levels of Care, outline a maximum psychotherapy group size of 10 individuals (the waiver process can also be utilized for Level 2.1).
  - **MH Partial Hospital Programs:** Per PA Code 55 § 1153.2, Group Psychotherapy is Psychotherapy provided to no less than two (2) and no more than twelve (12) persons with diagnosed mental illness or emotional disturbance. MH PHP providers may not unbundle and bill separately for group psychotherapy. All treatment is included as part of the PHP unit rate.
  - **SUD Partial Hospital Programs:** Considered an in-lieu-of service in the HealthChoices continuum; however, the ASAM requirements for 2.0 Levels of Care, outline a maximum group size of 10 individuals (the waiver process can also be utilized for Level 2.5). SUD PHP providers may not unbundle and bill separately for group psychotherapy. All treatment is included as part of the PHP unit rate.

Billing Reminders- Psychoeducational Groups Size (cont'd)

- *Psychoeducational Groups emphasize learning specific skills and information about a condition or topic. These groups integrate educational materials to teach coping skills and understanding.*
- *Psychoeducational groups that best address the needs of the milieu at the time should also be offered in day/ residential programs. At a minimum, these psychoeducational groups should include topics such as coping skills development, life skills, nutrition, occupational training, self-help groups, social support development, substance use disorder management skills, relapse prevention, harm reduction, parenting/ family relationships, confrontation skills and sexuality. In addition, the provider should aim to help individuals return to productive daily activity and family living. Programs are to create a therapeutic environment and milieu by providing the necessary structure and opportunity for interventions in real time to foster recovery.*
- *Psychoeducational Groups Level of Care Specifics*:
  - **MH and SUD Outpatient Programs:** Psychoeducational groups are not billable.
  - **MH and SUD Partial Programs:** Psychoeducational groups that best address the needs of the milieu at the time should be offered. Therapeutic group size for psychoeducational programs should include **no more than 15 individuals**. PHP providers may not unbundle and bill separately for psychoeducational group services. All treatment is included as part of the PHP unit rate.
  - **SUD Residential Programs (3.1, 3.5, 3.5E and 3.7 programs):** Psychoeducational groups that best address the needs of the milieu at the time should be offered in all SUD Residential programs. Programs are to create a therapeutic environment and milieu by providing the necessary structure and opportunity for interventions in real time to foster recovery. Therapeutic group size for psychoeducational programs should include **no more than 15 individuals**. All treatment is included as part of the per diem rate.

Other Guidance/ Reminders

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Magellan Staffing Verification Assessment Tool

A few years ago, Magellan added a Staffing Verification Assessment Tool which we utilize during Routine and Targeted Compliance Audits.

- The self-assessment focuses on staffing requirements outlined in the applicable regulations including:
  - Staff Certifications
  - Staff Credentials
  - Required Trainings
  - Staffing Patterns
- The expectation is for providers to complete the tool and return to the designated SIU auditor at least one week prior to the audit date.

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Magellan Compliance Audit Tool Updates

Magellan utilizes a CMS supported Compliance Program Audit Tool during Routine and Targeted Compliance Audits. Recent enhancements include:

- Policy regarding documentation completion which includes a timeframe of completion following service delivery
- Policy to ensure telehealth encounters/ service verification are obtained in accordance with the guidelines in MA Bulletin 99-89-05, OMHSAS-22-02 and MCO specific requirements.
- Documentation of procedure/workflow for obtaining member consent to telehealth in accordance with the guidelines in MA Bulletin OMHSAS-22-02 and MCO specific requirements.
- Policy for how appropriateness for telehealth will be determined

Member Service Verification Process

- Required by the Pennsylvania HealthChoices Program Standards and Requirements (PS&R).
- On a quarterly basis, Magellan sends Member Service Verification surveys to members.
- The surveys request that members verify the provision of various elements of paid claims (e.g., date of service, provider name, type of service).
- Magellan may outreach to providers requesting documentation to support services billed.
- If no documentation is submitted for review by the due date to support the paid claims, it will be referred to Magellan's Cost Containment Department (CCD), for possible recovery action.
- Providers should also implement their own service verification process, especially for community-based and telehealth services in order to verify various provisions of service.

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Authorization to Use and Disclose PHI Form

- On February 8, 2024, the U.S. Department of Health & Human Services (HHS) announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2 ("Part 2").
- Effective 7/1/25, Magellan updated its Authorization to Use & Disclose Protected Health Information Form (Release Form). Provider e-mail blast was sent on June 30: https://www.magellanofpa.com/documents/2025/06/june2025compliancenotebook.pdf/
- The new regulations allow a single consent for all future uses and disclosures of substance use disorder (SUD) information for treatment, payment, and health care operations. It also allows Health Insurance Portability and Accountability Act (HIPAA) covered entities and business associates that receive SUD records under this consent to redisclose the records in accordance with the HIPAA regulations.
- **Providers must discard all previous versions of Magellan's Authorization to Use and Disclose (AUD)/ Release Forms**. In the future, we will no longer be able to accept old versions when compliance with the 42 CFR Part 2 Final Rule becomes a requirement on February 16, 2026.
- Forms/ Submission Options:
  - Online version: https://www.magellanofpa.com/consent-to-release-phi-online/
  - Fillable form: https://www.magellanofpa.com/documents/2022/07/070122_pahcaudform.pdf/
  - Online submission is preferred. Signed and completed AUD/ Release Forms may also be faxed to Magellan at 1-866-667-7744; or sent via e-mail to PAHC_AUD@MagellanHealth.com.

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Compliance Resources on PAHC Website

- **FWA Compliance Page**: includes FWA Resources, Compliance Best Practices, Audit Tools, Trainings/ Education, and How to Prepare for an Audit.
- **Compliance E-mail Blasts**: issued monthly via e-mail and also posted under “Compliance Alerts” section on the Provider Page of Magellan’s website. Address important regulatory and PAHC guidelines including recent audit trends and policy changes.
- **Provider Trainings**: ongoing training materials are available for both new and existing providers. All new PAHC providers are required to complete the “PA HealthChoices New Providing Training” prior to contract execution. Providers will be sent a link to this pre-recorded webinar when they receive their contract; ALL provider staff must complete the training.
- **Provider Handbook Supplement**: important requirements and guidelines for all providers.

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Magellan Compliance/ SIU Contacts

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Next Steps

- Participants should remain on the webinar for a few minutes to provide instant feedback and input for future training opportunities.
- In the near future, Magellan will send a copy of the Power Point Presentation and Zoom Recording to all participants.
- Providers should submit any additional questions to Magellan utilizing the contact information on the previous slide.

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SURVEY QUESTIONS

Leading humanity to healthy, vibrant lives

OWN IT

If it is to be done, it's up to us to do it

DELIVER

We are relentless in the pursuit of value and results for our customers

WIN TOGETHER

We believe in the collective genius of our people and the magic of teamwork

CARE

We care deeply about each other, our customers and the communities we serve

STAND TALL

We always do the right thing

EVOLVE

We embrace learning as a means to reinvention – in all that we do

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THANK YOU!

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