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/ encounter forms)
- Missing signatures and/or credentials on progress notes, and/or encounter forms
- Use of abbreviations on progress notes, treatment plans, etc.
- Error correction protocol not utilized (if using paper documentation and a correction needs to be made, the appropriate protocol is to use a single line to cross out the error, make the necessary corrections and then initial and date the change)
- Progress notes read similarly from session-to-session or are copied & pasted from previous notes
- Claims billed prior to documentation completed (progress notes/encounter forms)
- 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., 4:03 PM - 4:48 PM).
- Treatment/ service/ care plan deficiencies:
    - Missing plans

- Services do not relate back to the treatment/ service/ care plan (all services must be provided in accordance with the identified member's current plan goals)
- Expired plans (the treatment/ service/ care plan has not been developed or updated in accordance with the allowable timeframes per Pennsylvania Medicaid requirements)
- Plan goals remain the same throughout care
- Plans are missing required signatures

- 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 definitions (e.g., 15 minutes, 30 minutes)
  - Using appropriate procedure code(s)/ modifier(s) based on qualifications/credentials of the staff rendering the service (e.g. medication management/ evaluation and management codes can be provided by a MD, CRNP and/or RN- providers must bill with the correct code combination)

- 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 (OMHSAS), 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. Magellan also permits Community Treatment Teams (CTT)/ Assertive Community Treatment (ACT) providers to bill the better part of a unit.

- Every phone contact is exactly 8 minutes, 15 minutes or 30 minutes (whichever is necessary to justify a unit)

- Back-to-back services over the course of the day without any transition time between sessions (i.e., individual therapy sessions for different members are documented as occurring at: 9:00 AM - 10:00 AM, 10:00 AM - 11:00 AM, 11:00 AM - 12:00 PM, 12:00 PM - 1:00 PM, 1:00 PM - 2:00 PM, 2:00 PM - 3:00 PM, 3:00 PM - 4:00 PM; and 4:00 PM - 5:00 PM)

- Documentation Standards not being met - 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 (e.g., the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:03 AM to 11:03 AM)
    - 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 do not match the progress note.
    - Blank encounter forms should never be signed by members or a parent/ guardian.
    - Missing encounter forms
    - Missing times on encounter forms (for community-based 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 or the signed encounter form)

- Billing incorrect units

- Group therapy services exceeding the maximum allowable participants (reference Magellan's October Compliance E-mail Blast)

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

- 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 signature requirements for telehealth. Member signatures are required on the following documents:
        - Encounter forms
        - Consent to treat via telehealth
        - Approval of treatment/ service/ care plans
        - Consent to be recorded, if applicable

    - 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.

    - Billing the incorrect telehealth place of service (POS) code (e.g., 02 or 10)

    - Not billing the informational modifier for audio-only telehealth services (FQ)

    - Providers must clearly document a telehealth session and include the following documentation standards:
        - Documenting the mechanism for how services were delivered (e.g., telehealth, video, phone).
        - Documenting the telehealth platform that was utilized, if applicable (e.g., zoom)
        - Documenting the member's phone number that was utilized, if applicable.
        - Rationale for audio-only telehealth services must be documented
        - Assessment for appropriateness

- For providers who are reimbursed under an Alternative Payment Arrangement (APA), zero pay encounters were missing or not submitted prior to the monthly rate. According to the *Pennsylvania HealthChoices Provider Handbook Supplement*, providers who are on an APA must submit encounter data to Magellan to process all invoices/ payment codes. In most cases, zero pay encounters should be submitted throughout the service month. The claim that includes the bundled payment for the service month should be submitted the first week following the service month.

- Billing for non-billable services including:
    - Travel/ transportation
    - Social/ leisure activities
    - Administrative duties such as record-keeping and documentation
    - Supervision
    - Training

- Electronic Health Record issues 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)