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 communication is directed to **all** providers regarding their documentation of services rendered within the medical records, especially those that use an Electronic Health Record (EHR).

Per your licensure and enrollment with the state, providers are expected to be compliant with all regulatory requirements within the Pennsylvania Code and applicable Medical Assistance (MA) Bulletins, many of which outline documentation requirements. Adherence to federal and state regulations is also outlined in Magellan's provider contracts.

In an effort to align all the documentation requirements for various services/ programs and provide a consistent guideline, Magellan has published "*Documentation Standards*" which is outlined in the Pennsylvania HealthChoices (PAHC) Provider Handbook Supplement (page 57-58):

> ***In addition to serving as a legal record of services rendered, the documentation within each member's health record serves many purposes. It allows health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time; facilitates communication and continuity of care among the physicians and other health care professionals involved in the patient's care; ensures accurate and timely claims review and payment; promotes appropriate utilization review and quality of care evaluations; can be used for research and education; and finally, serves as evidence that the services were provided as billed to a payer.***
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> ***Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations. Specifically:***
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> - ***The record must be legible throughout.***
> - ***The record must identify the individual on each page.***

- ***Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be counter-signed by the responsible licensed provider.***
- ***Alterations of the record must be signed and dated.***
- ***The record must contain a preliminary working diagnosis, as well as a final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.***
- ***Treatments, as well as the treatment plan, must be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages, must be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's records require a notation to this effect.***
- ***The record must indicate the progress at each visit, change in diagnosis, change in treatment, and response to treatment.***
- ***The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.***
- ***The disposition of the case must be entered in the record.***
- ***The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.***

The 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.***

In addition to the above requirements, providers must follow the applicable MA regulations and bulletins for the services for which they are licensed and enrolled. Retractions may be pursued if documentation does not meet Magellan or the state's minimum expectations.

Magellan has observed a trend of non-adherence which results in retractions for services rendered. The most common errors are the lack of inclusion of both a start and end time of the session on the progress note/assessment/med note, as well as a time stamp on an electronic signature conflicting with session times. The emergence of Electronic Health Records has yielded a long list of advantages; however, it has also incited some unintended downfalls,

especially from a compliance and auditing perspective. We want to ensure that providers are aware of these nuances so they can address them internally and avoid compliance deficiencies and/ or claims retractions. Providers need to ensure that the EHR system they employ supports all applicable regulatory and documentation requirements. Your agency's designated Compliance Officer should be fully involved with any new system roll-out or enhancement to identify potential limitations and risks.

Some important reminders for progress note documentation:

- The start and end times should represent the actual billable/ face-to-face time with the member. Some providers utilize an EHR system in which the session times default to the appointment time. This does not account for late arrival or other variables during the session that may affect timing. The rendering clinician must ensure that they update the start and end times to reflect the actual billable time.
- Documentation time (writing a progress note) is not billable time unless a provider is fully adhering to the OMHSAS *Collaborative Documentation* requirements.
- The session time must be represented by the start and end time in actual clock hours. Documenting the duration of the session (i.e. "30 minutes") is not sufficient.
- Electronic time stamps on signatures should not precede the end time of the session. This includes both the rendering clinician's signature on the progress note and any member signatures that are collected to validate the session. Please ensure that staff and the individuals receiving services sign documentation **following** completion of the activity.
- All progress notes and treatment plans should be individualized. Most EHR systems have the capability to disable "pull through" or "cut-and-paste" functionality. We strongly recommend that providers do not allow their EHR systems to employ this tool as it lends itself to duplicate documentation.
- Rounding up session times is not permitted. The number of minutes (i.e., 15 minutes, 30 minutes etc.) that equates to a billable unit is dictated by The Department of Human Services Office of Mental Health and Substance Abuse Services' (OMHSAS) Covered Services Classification Chart, we as well as your Magellan contract. [Please note that OMHSAS, through level of care specific regulations and MA Bulletins, has permitted exceptions for 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 Assertive Community Treatment (ACT)/ Community Treatment Teams (CTT) to round up to the next billable unit). The exception states that if the better part of a unit is provided (i.e., at least 8 minutes), the provider may round up and bill 1 full unit. This is only applicable to the last unit of service in a given time period. For example, if 38 minutes of Crisis Intervention Service is provided on 7/20/23, you would bill 3 units; or if 8 minutes of Family-Based Service is provided on 7/21/23, you would bill 1 unit.] Rounding up is not otherwise permitted in any other service/ program.

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