



Compliance Matters



!POP QUIZ!

Keeping with the last issue's theme: where was the world's first brick-paved street?

Find the answer in our next issue!

Previous issue's answer:

Front Street was the first street built in Philadelphia (and all of Pennsylvania!), built by Billy Penn. Well, he probably didn't do the digging or anything. Elfreth's Alley, which was left out of the original plans for Philadelphia, is now considered the oldest continuously inhabited *residential* street—in the whole country!

Donna's Desk

Welcome to the fall edition of Compliance Matters. Fall ushers in cooler temperatures, colorful foliage, and a sense of transformation—nature's last hoorah before the chill of winter. Here at CBH, fall is also a time to reflect on the past year and prepare for the next. Here are just a few notable changes on the horizon.

The new Mental Health Outpatient regulations are expected to become final in 2020. We encourage providers with MHOP programs to brush up on the new provisions. As a reminder, until the new regulations are effective, we are still operating under the existing regulations, which require a minimum of 16 hours per week of psychiatric supervision. We understand that clinics are challenged by the shortage of psychiatry in general; we anticipate that the new regulations will help address this for many of you.

The transition to Intensive Behavioral Health Services (IBHS) is underway. OMHSAS has published final-form regulations for IBHS; these will replace Behavioral Health Services as the modality to deliver child and adolescent services in the community. We expect that the regulations will be promulgated in September 2019. Our Community-Based team is actively working with OMHSAS and BHRS providers to unpack the changes and implications for agencies and members.

Lastly, we value our partnership with all our network agencies. If you have a concern about a CBH employee or CBH practice, an agency ED or CEO may utilize our provider complaint process by submitting your concern in writing or via the Provider Compliant hotline at 215-413-8581.

Happy Fall!

- Donna E.M. Bailey
COO & Compliance Officer

Junk Drawer



With the Great 2019 Per Diem tour in full swing, be on the lookout in coming months for a return visit to many of our IOP providers to check on group sizes! As a reminder, group sizes are limited to 10 for therapy groups and 15 for psycho-ed groups (when permitted). See our group size notice [on the web here](#).

We will also likely be polling our providers to get a sense of where records are stored. As we head out on more unannounced visits, there is a need to know in advance where clinical records are kept/most easily accessed. With the increase in electronic medical records, many times the access point is not the service location.

There is more information related to chart access in Lauren Green's article later in this issue.

**CONFIDENTIALLY REPORT FRAUD,
WASTE, and ABUSE.**

1-800-229-3050 or

CBH.ComplianceHotline@phila.gov

Also, in the coming months, look for your friendly neighborhood Compliance Analysts to be making the rounds to review CBE and CBRs, as updated guidance on those evaluations has been in place for some time. If you want to check out that bulletin again, [head over to this link](#).

Suggestions for future Compliance Matters features? Want to subscribe (it's free!)?

Contact Matthew Stoltz at:

Matthew.Stoltz@phila.gov

It's not Bigfoot, it's a CBE: Common CBE Myths Debunked

Oh, the things we see and hear. The stories Compliance Analysts could tell. Over the years, we have heard almost everything when it comes to CBE/Rs. Most are untrue, though most can be traced to a kernel of truth—but some just flat-out leave us scratching our heads. So, in conjunction with the recently published, new-and-improved guidance on CBE/Rs ([Bulletin 19-03](#)), and as a follow-up to our article last issue on CBE/Rs, we present to you our top 5 CBE/R myths—exposed!

1. *"I need to do a CBE to get John Q Public into outpatient treatment!"*

Nope. Fake news. There are a very limited number of services that require CBEs prior to initiating treatment. BHRS and RTF are the prime examples. Outpatient, though, does not require a CBE to initiate treatment. The provider must conduct an assessment to ensure that medical necessity is met and that the individual is appropriate for outpatient care. While CBEs are designed to give a complete picture of a member to guide care, they are not necessary, particularly to initiate outpatient services care.

2. *"Oh no, Joan Smith's annual CBR is due; we have to do it every year!"*

Yeah, I know, every year—annual, it's redundant. But it is there to drive home the point. There are no requirements for how often CBE/Rs need to be completed. In fact, they should be completed as clinically indicated. If Joan's clinical presentation changes, a CBR can and should be completed to ensure that

necessary shifts in treatment focus, modalities, and interventions are made.

An unfortunately common example is a member who initially presents for a mood disturbance but relays an unremarkable history in early assessments and sessions. Over time, though, the member reveals a significant trauma history. The provider can, and we would say should, complete a CBR to update the information and refocus care to the most relevant areas. Please also note, Compliance screens CBE/Rs for a "reason for evaluation." If your agency documents "Annual" or "CBE due" only, we will consider that an overpayment and move to recoup any payments made for that evaluation.

3. *"Yeah, Skippy, we know, we can't bill for the CBE until it is complete. It's simple—we just add up all the time spent on it and combine it to bill on the last day!"*

In this case, Skippy's friend is partially right. The CBE/R, in fact, cannot be billed until it is completed. However, the billing must then accurately reflect when the work was done. As an example, Cookie Moore is seen on June 1st for 30 minutes for information gathering (AKA Part 1) and then the psychiatrist sees Cookie for an hour on June 28th and fills in gaps and completes the CBE that day. The billing would be: 1 unit on 6/1 and 2 units on 6/28. If we see that three units are billed on 6/28, it is a unit error or discrepancy and the payment would be recouped.

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4. *“Don’t sweat it, we meet all the State rules about CBEs!”*

The State provides guidance on a ton of things. From psychiatric supervision in outpatient clinics to therapeutic leave requirements for RTFs to fishing regulations to—my personal favorite—auto inspection requirements (for the record, fog lights are not required, and neither are original equipment tailgates—just saying). One thing you will not find are CBE requirements. The CBE/R is a Philly original. Gritty, cheesesteaks, wooder, Mummers, and CBEs. There are rules and requirements, in some places, around assessments and evaluations—but nothing about CBH’s own CBE/R.

5. *“It’s a CBE Non-MD, anyone can complete it!”*

Be careful of the words you use. We chose Non-MD to describe CBEs/CBRs completed by licensed psychologists. Why? Who knows? My guess is that psychologists was too long for our system and PsyD/PhD leaves out the licensed psychologists who do not have a doctorate. Non-MD though, for us, is a licensed psychologist. And, because of State rules, a CBE/R non-MD must be completed in its entirety by the psychologist. CBE/R MDs can use other staff to complete the information-gathering portion of the evaluation. Requirements for staff credentials for those completing all or portions of the CBE/R can be found linked in [the previously mentioned bulletin](#).

BONUS ROUND!

Runner-Up #1. *“No, No, it’s totally okay to bill for medication management and the CBE at the same time. I mean seriously, Dr. Baltar did talk about medications with Starbuck”.*

Nope, not how it works. You are not permitted to bill the same encounter as two different types of service. In this example, Dr. Baltar documents the CBE, including a discussion about previous medications and plans for future medication orders, from 1:00 p.m. to 2:00 p.m. That gets billed as 2 units of CBE. It is not possible to also bill for any units of medication management for that same timeframe.

Should you have any questions about completing and/or billing CBE/Rs, please ask! It’s always better to ask before setting off down the Whisper Down Lane!

We will take two charts and a side of EMR, please

In our last issue, we again alerted our readers to the need to be prepared for audits that may come with little-to-no advance notice. In that article (Junk Drawer), we also noted that this topic has been covered many times in different venues. It never hurts to hear things again, though!

The CBH Provider Bulletin 18-02: Updates to CBH Compliance Audit Policies and Procedures ([March 15, 2018](#)) requires CBH Providers to ensure access to paper-based and electronic clinical charts beginning at 9:30 a.m. for Announced CBH Compliance Chart Audits and by 10:00 a.m. for Unannounced CBH Compliance Chart Audits. This means that CBH Providers typically have 30 minutes for scheduled audits and 1 hour for unscheduled audits to begin making charts accessible to CBH Compliance Analysts.

Over the course of the audit day, clinical charts are to be produced on a continuous basis for CBH Compliance Analysts until all the requested charts are provided. Depending on the factors of the audit (reason for the audit, audit type, etc.), CBH Providers are to be aware that the CBH Compliance Analysts may request a high number of charts to view.

CBH Compliance Analysts may also ask CBH Providers for policies and procedures about their medical record system that should contain (but not be limited to) the following details (when applicable):

- The type of medical record system (e. g. paper-based, electronic medical record system, hybrid system using both paper-based and electronic medical record systems, or multiple electronic medical record systems)
- Name of electronic medical record system(s)
- Inception date of electronic medical record system(s)
- Access to electronic medical record system(s) (e. g. web-based)
- Process of filing of paper-based documents into electronic medical record system(s) (including timeframe of when paper-based documents will be uploaded)
- Process of archiving paper-based clinical charts (including timeframe for retrieval)
- Physical location of archived paper-based clinical charts

In the presence of CBH Compliance Analysts, provider-designated representatives will be asked to review clinical charts for documentation that cannot be located by CBH Compliance Analysts throughout the course of the audit day. Chart documentation that is not located within paper-based clinical charts or electronic medical record systems by provider-designated representatives will be considered absent and payment for services will be recouped.

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(Charts - Continued from previous page)

CBH Providers should consider their current infrastructure and their ability to meet these requirements, especially for unannounced audits. Providers should have adequate staff who are familiar with policies and procedures about the medical record system and can inform CBH Compliance Analysts about the medical record system at the start of an audit. Failure to provide access to the medical record system within the specified time frames may result in the cancellation of the audit and a recommendation to the CBH Compliance Committee to consider all claim lines as an overpayment.

Please email questions/concerns to CBH.ComplianceContact@phila.gov with the Subject Line "Documentation for On-Site Audits." Thank you for your continued cooperation!

– Lauren Green, Compliance Supervisor

Oh, come on! Another Compliance Audit?

I love Sheetz! When I am in Allentown or Harrisburg or Morgantown or Fairmont—any real civilization (defined by the presence of a Sheetz)—I go to Sheetz. I pore through their computer screen of heaven (AKA their ordering screen) and make requests for them to deliver goods to me (always to include Mac and Cheese Bites). I do this because, again, I love Sheetz!

So, if we keep coming back to your agency, poring through your medical records, asking you to bring us charts, we must love your agency, right? I know it doesn't feel like love sometimes, but we do appreciate and value all our providers. And, it can certainly seem like sometimes you are being singled out. So why are you blessed with our presence so seemingly often?

Let's discuss.

There are providers who receive more audits than others. Why? Some common reasons include:

- Providing a wide variety of services
- Providing services outside of an office/hospital setting
- Having unresolved internal complaints
- Having licensing issues

If you are at an agency that sees many of our members and/or offers a varied array of services, your agency likely has an increased chance of a compliance visit.

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It is simple math, really; the more services you provide, the higher the chance that one will be flagged, either by data mining or by a complaint/tip.

Services provided outside of the office setting, both in behavioral and physical health, have long been viewed as having an increased risk for fraud, waste, or abuse (FWA). Services such as BHRS, Home Health, etc. do not have the check and balance of peers or supervisors being in-house to observe things like “hey, Elsa wasn't here on Monday, why are there claims for that day from her?”

As we have mentioned in these pages before, empowering and listening to staff is a particularly effective way of avoiding our visits. I hold that individuals who feel that their concerns have not been heard and acted on are more likely to reach out to us or other payors/regulators to provide “tips” on FWA. While we often hear from providers, “oh that was just a disgruntled former employee, it's just sour grapes” as a response to our initial outreach, that disgruntled former employee often provides accurate information that identifies FWA. Dealing with the issue in-house and completing a self-audit is often preferable to having audit teams show up unannounced to investigate. We have an obligation to follow-up on all calls and emails to our hotlines.

Finally, if your agency is given a provisional license and the issues leading to the provisional status include those that could be tied to FWA, chances are we will be calling. In many instances, this offers you, as the provider, an opportunity to showcase changes made since the licensing visit, as our visit will happen after the State visit. Stop me if you've heard this before, but a good compliance program can help head off problems with licensing. If you are completing regular self-audits to ensure that relevant state requirements are met, you should be in good shape when your licensing visit rolls around.

We have started to include, in most cases, a more detailed “reason for audit” section on our Audit reports. This section gives as much detail as possible about why we feel the audit and methodology used (extrapolation, unannounced, SSRS, etc.) was necessary. This is used, particularly in larger audits, to establish the predication for the audit. This is our version of probable cause, that is, why this audit is needed at this time. These steps have been added as another layer of checks and balances by which we operate both for review by our providers and by our Compliance Committee.

I realize that, for most, a compliance visit is a stressful occurrence. I do understand that what is, for us, a rather routine audit day, may be the most stressful day of your month. When we arrive or request records, I can assure you it has been vetted as being necessary. And, we will provide all possible information to your agency as to why it is necessary to the extent possible, based on the open investigation.

PUZZLING!

A	Q	M	O	J	A	B	V	A	H	A	N	I	Q	C	P	U
M	P	V	K	D	J	B	G	B	M	B	I	S	Y	I	S	K
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I	B	T	I	C	A	R	R	U	L	E	T	A	A	M	T	O
S	Q	K	H	C	M	O	O	R	B	D	N	N	Q	R	D	I
S	D	G	J	M	S	O	L	D	Y	O	U	A	N	L	M	L
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A	H	J	B	W	R	T	G	I	K	N	D	R	H	O	E	I
B	Z	S	H	W	S	I	I	E	U	I	S	O	Y	V	O	G
X	Q	E	O	R	V	K	L	H	K	R	C	H	R	M	C	T

WORDS:

Ambrosia

Anansi

Bigfoot

Chupacabra

Dorado

Excalibur

Fountain

Mothman

Nessie

Odin

Yeti

Youth