Retrospective Reviews

If CBH does not reimburse for services that are not considered medically necessary and providers are prohibited from billing Medicaid members for services that should otherwise be covered, are there any exceptions for cases in which Medicaid denies payment for those services? Can you describe a clinical process (aside from just an assessment and diagnosis) that we can go through to ensure that we are following the medical necessity process?

There are no exceptions to either provision. That said, if medical necessity is determined to not have been met there are many avenues that can be used to challenge that finding. So, as with other findings, you can challenge the finding that medical necessity was not met.

Exclusions

Should vendors who are paid using MA dollars be checked as well?

MA Bulletin 99-11-05 states that all employees, vendors, contractors, service providers, and referral sources whose functions are a necessary component of providing items and services to MA recipients, and who are involved in generating a claim to bill for services, or are paid by Medicaid (including salaries that are included on a cost report submitted to the Department), should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search. The bulletin also provides examples.

Telehealth

1. **If we get overall telehealth consent for the participant at the time of admission to the program, you still want individual consent by session?**

   Getting consent at each appointment is inconsistent with guidance from OMHSAS. It's also inconsistent with the CBH Telehealth Best Practice Guidelines. Does the telehealth rule apply to case management surrounding documenting our client consent in the progress note before providing telehealth services?

   As confirmed with our partners at the Commonwealth, the current requirements are covered in OMHSAS Bulletin 22-02 and CBH Telehealth Best Practices. Both documents require informed consent prior to initiating service via telehealth with a provision that the member be offered the opportunity to switch to in-person services at any time. You are not required to obtain new consent prior to each service/session but must ensure that telehealth continues to be appropriate and acceptable to the individual.

2. **How do we get the signature for a telehealth session?**

   Providers need to follow OMHSAS Interim Telehealth Guidance 3.30.3023, which states that: "Effective on January 1, 2024, providers are expected to capture consent to treatment, service verifications, and approval of treatment plans in a manner that creates an auditable file and is in accordance with the timelines expected within regulation."

3. **When you are assessing the appropriateness of telehealth how often should this be done for the member? Does CBH have guidelines for documenting and process for determining the appropriateness?**

   The **CBH Telehealth Best Practices** has a section on determining appropriateness for telehealth but ultimately it states that a provider must have policies in place which would specify the factors considered and when reassessment of appropriateness would be needed. If CBH had a concern, our first step would be for us to request to review the policy you have in place.

4. **I have a provider-specific question, who is the best person to reach out to?**

   Providers should contact their Provider Relations Representative first. CBH Program Integrity can also answer questions at **cbh.compliancecontact@phila.gov**.

Artificial Intelligence (AI)

Does not using the AI bot include when making phone calls to members?

The prohibition on AI bots applies to meetings with CBH. Phone calls to members without CBH present are not covered by that edict. That said, you are responsible for ensuring that no PHI is being sent offshore and you are utilizing HIPAA-compliant technology.