C·B·H

a division of DBHIDS

PROGRAM INTEGRITY

Audit Codes

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Community Behavioral Health

TABLE OF CONTENTS

B = Billing Error 3
C = Case Rate Threshold Not Met 3
D = Discrepant Information 4
E = Services Provided by an Excluded Individual or Entity 4
G = Group Size Not Noted or Exceeds Allowable Number of Participants 5
H = Upcoding 6
IC = Insufficient: Content 7
ID = Insufficient: Documentation 8
M = Missing Documentation 12
N = Non-Billable Activity 13
P = Service Exceeds Allowable Contacts per Time Period 14
Q = Services provided by an unqualified individual 16
R = Re-Use of Content 16
S = Services Not Rendered 16
T = Treatment Plan Concerns 17
U = Unit Error 18
Y = Unbundling Codes 19
Z = Lack of Medical Necessity 20

The CBH Program Integrity Department utilizes a list of audit codes to categorize error types during clinical chart audits. The audit codes align the CBH error types/categories with those utilized by the Pennsylvania Department of Human Services (DHS), and to include additional billing errors such as group size exceeding allowable limits. The audit codes correspond with the items identified in audits as Overpayments and Non-Variance Items. The overpayment is the amount in dollars or units paid by CBH to a provider that is determined to be unallowed due to one or more violations of federal, commonwealth, or CBH requirements. Non-Variance Items are audit findings that do not result in a financial impact.

Please Note: *All examples provided are non-exhaustive.*

B = Billing Error

Description	The service type billed must match the type of service delivered (Differs from Upcoding in that there is no financial advantage to the billing. Also, differs from Unbundling). The Place of Service (POS) code listed on the claim must match the place where services were provided. Billing must reflect the correct *PROMISe* #, CBH Child #, CPT codes and modifiers, and service location.
Examples Include	➡ Billed to incorrect service location ➡ Service type error for less or no rate differential (e.g., billed collateral family therapy as family therapy) ➡ Billing one encounter as two service events/types *"The provider may not, either directly or indirectly, submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement"* ➡ Incorrect POS code on claim ➡ Use of an incorrect modifier on the claim
References	55 Pa. Code § 1101.75. Provider prohibited acts.

C = Case Rate Threshold Not Met

Description	The provider may not receive or retain a case rate payment without evidence (e.g., supporting claims, documentation) that the threshold of required services has been met.
Examples Include	➡ Lack of supporting claims ➡ Documentation concerns or errors with a qualifying service for the case rate payment ➡ Inappropriate payment made for more than one case rate for the same member
References	See CBH Provider Bulletins for case rate requirements

D = Discrepant Information

Description	Information contained within a clinical record must be consistent. Documentation is considered discrepant when it contradicts information within the same note, other notes, or other charts, either at the same or another provider. Documentation of services by individuals not on staff rosters covering the time period in question will be considered discrepant. This includes overlapping clock times for sessions, electronic medical record (EMR) entry times, information documented in encounter forms, and provider self-disclosures of falsified documentation and/or forged encounter forms.
Examples Include	➡ Incorrect client name and/or identifying information; Incongruent information in documentation by multiple staff members involved in the case and/or interaction (e.g., Two staff both document being present with a family at the same time, but their documentation gives different account of events or does not acknowledge the presence of the other) *In cases of two notes with discrepant content, both are coded as discrepant and included in overpayment.* ➡ Services with overlapping clock times (both notes will be included in overpayment) ➡ EMR entry times (overlaps with other service documentation will be included in overpayment) ➡ Encounter forms that contain different clock times when compared to the corresponding progress note for the service ➡ Encounter forms that contain a signature by an individual not noted as present in the progress note for the service ➡ Discrepancy between member report and chart documentation ➡ Consecutive sessions documented in two different geographical locations
References	55 Pa. Code § 1101.75. Provider prohibited acts.

E = Services Provided by an Excluded Individual or Entity

Description	Medicaid prohibits payments for services by entities or individuals who are barred from participating in federally funded healthcare programs (including Medicaid) as identified in the List of Excluded Individuals and Entities, System for Award Management, and State Medicheck lists
Examples Include	Services provided by or supervised by an excluded individual. Includes wages and benefits paid using Medicaid funds
References	➡ Medical Assistance Bulletin 99-11-05: Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs ➡ CBH Provider Manual

G = Group Size Not Noted or Exceeds Allowable Number of Participants

Description

The number of participants in a group must be documented on the progress note and cannot exceed the allowable number.

Examples Include

- Number of participants in group not listed
- Number of participants in a group exceeds allowable number

References

ASAM 1.0 / 2.1

- 55 Pa. Code § 1223.2. Definitions.

  Group psychotherapy—Psychotherapy provided to no less than two and no more than ten persons with diagnosed drug/alcohol abuse or dependence problems for a minimum of 1 hour. These sessions shall be conducted by drug/alcohol clinic psychotherapy personnel under the supervision of a physician.

- CBH Provider Manual Section 5.18.6. Clinical Documentation Requirements – Group Services

  Note: In addition, while mental health settings are not permitted to bill for groups that are psychoeducational in nature, they have historically been accepted in a limited manner in SUD care.

  Group psychotherapy services may not exceed 1-12 participants in most cases, depending on the license type of the program. When individualized psychoeducational groups are permitted, the maximum group size is 15.

ASAM 2.5 / 3.1 / 3.5 / 3.7 / 3.7WM / 4 / 4WM

- CBH Provider Manual Section 5.18.6. Clinical Documentation Requirements – Group Services

  For group psychotherapy, per CBH, the maximum group therapy size is 10 participants.

  Progress notes must clearly indicate the number of participants in the group, without listing names or identifiers of other group members.

- CBH Provider Manual Section 5.18.6.6. Other Reminders

  For LOCs for which psychoeducational groups are allowed, the maximum number of participants is 15.

CPS

- OMHSAS-22-08 Group services.

  PSS may be provided in group format when group services are specified in the individual's ISP. PSS agencies shall not allow individuals who are not currently receiving PSS from that agency to participate in group services.

IBHS

- CBH Clinical Performance Standards: IBHS, Group Services

  Group must include at least 2 and no more than 20 participants (Per OMHSAS-21-03).

IBHS-ABA

- CBH Clinical Performance Standards: ABA Group size

G = Group Size Not Noted or Exceeds Allowable Number of Participants

Group must include at least 2 and no more than 10 participants. For children under the age of 36 months, the group size is not to exceed six children as is consistent with PA Commonwealth regulations for center-based childcare centers.

For groups of mixed age children that include children under 36 months as well as older children, the maximum number of children is also six.

OP MH

- 55 Pa. Code § 1153.2. Definitions.

  Group psychotherapy—Psychotherapy provided to no less than 2 and no more than 12 persons with diagnosed mental illness or emotional disturbance.

PRS

- 55 Pa. Code § 5230.54. Group services.

  (a) A PRS agency shall provide group services in a PRS facility or in the community.

  (1) When a group service is provided in a PRS facility, group size may vary as long as the requirement under § 5230.52(c) (relating to general staffing requirements) is met.

  (2) When a group service is delivered in the community, one staff shall serve a group of no more than five individuals. Group size in the community may not exceed five individuals.

- 55 Pa. Code § 5230.52. General staffing requirements.

  (c) When a service is delivered in a PRS facility, a PRS facility shall have an overall complement of one staff for every ten individuals, a (1:10) ratio.

RTF

- 55 Pa. Code § 3800.283. Additional requirements.

  (2) No more than 12 children may be in a group at any one time.

H = Upcoding

Description	Services cannot be billed by using a CPT Code or Service Type for a more expensive service than was performed.
Examples Include	Billed as a service type at a higher rate than the documented service
References	55 Pa. Code § 1101.75. Provider prohibited acts.

IC = Insufficient: Content

Description

All billed dates of service must have adequate documentation that reflects the treatment rendered. The content of the note must contain clinician interventions, client response, plan for future session(s), and support the duration of time billed.

Examples Include

- Clinical content does not support paid claim
- Evaluations lack required clinical content and/or domains
- Documentation includes general summaries of techniques used (e.g., "used CBT," "taught mindfulness exercise," "reviewed relaxation techniques")
- Documentation lacks evidence of Evidence-Based Practice (EBP) to substantiate enhanced rate

References

- 55 Pa. Code § 1101.51. Ongoing responsibilities of providers.
- CBH Provider Manual Section 5.18. Clinical Documentation Requirements
- CBH Clinical Practice Guidelines

ASAM 1.0 / 2.1

- 28 Pa. Code § 709.93. Client records.
  "Standards for Licensure of Freestanding Treatment Facilities Subchapter I. Standards For Outpatient Activities"
- 28 Pa. Code § 715.23. Patient records.
  "Standards for Approval of Narcotic Treatment Program"
- 55 Pa. Code § 1223. Outpatient Drug and Alcohol Clinic Services

ASAM 3.1 / 3.5 / 3.7 / 3.7WM / 4 / 4WM

- CBH Provider Manual Section 5.18.8. Per Diem Substance Use Disorder Services

CBE/R

- CBH Provider Manual Section 5.18.7. Comprehensive Biopsychosocial Evaluation and Re-Evaluation (CBE/R)
- CBH Provider Manual Appendix AC: Comprehensive Biopsychosocial Evaluation (CBE) Required Elements

FBS

- CBH Provider Manual Section 5.18.9. Family-Based Mental Health Services

Group Services

- CBH Provider Manual Section 5.18.6. Group Services

IBHS

- 55 Pa. Code § 5240. Intensive Behavioral Health Services
- 55 Pa. Code § 1155. Intensive Behavioral Health Services
- CBH Provider Manual 5.19. IBHS Billing Guide

IC = Insufficient: Content

Independent Practitioner

- CBH Provider Manual Section 5.18.10. Independent Practitioner

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OP MH

- CBH Provider Manual Section 5.18.5. Mental Health Outpatient Providers

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OP MH / PHP

- Medical Assistance Bulletin 29-02-03, 33-02-03 Documentation and Medical Record Keeping Requirements

  "The documentation of treatment or progress notes, at a minimum, must include: 1.The specific services rendered; 2. The date that the service was provided; 3. The name(s) of the individuals(s) who rendered the services; 4. The place where the services were rendered; 5. The relationship of the services to the treatment plan, specifically any goals, objectives and interventions; 6. Progress at each visit, any change in diagnosis, changes in treatment and response to treatment; 7. 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."

OP MH / PHP / MMHT

- 55 Pa. Code § 1153.2. Definitions.
  Outpatient Psychiatric Services definition of "Psychiatric evaluation."
- 55 Pa. Code § 1153.52. Payment conditions for various services.

PRS

- 55 Pa. Code § 5230. Psychiatric Rehabilitation Services

ID = Insufficient: Documentation

Description	Documentation must contain required elements.
Examples Include	Documentation is missing required elements: ➡ Lacks date of service ➡ Lacks start and/or end times including a.m./p.m. or military time designation for all LOCs with services measurable in units of time ➡ Document lacks required signature(s) ➡ Lacks original, non-photocopied or pre-printed signature(s) ➡ Lacks required co-signature(s) for interns ➡ Signatures, if not legible, must be accompanied by a printed name or name stamp ➡ Documentation is not original (photocopy) ➡ Client not identified on each page (including front and back of a 2-sided document)

ID = Insufficient: Documentation

- Note was not completed, signed, and/or entered into the clinical record within seven days or before the claim was submitted to CBH, whichever occurred first
- Improper corrections
- Lacks Encounter Form (for recipient verification of service) for required LOC
- Confirmed date error (Example: Provider reports that the service documentation contains the incorrect date)

- Refer to State and CBH Provider Bulletins for telehealth requirements
- CBH Provider Manual Section 5.18. Clinical Documentation Requirements
- CBH Clinical Practice Guidelines
- 55 Pa. Code § 1101.51. Ongoing responsibilities of providers

  (e)(1)(i) The record shall be legible throughout.

  (ii) The record shall identify the patient on each page.

  (iii) Entries shall be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record shall be signed and dated.
- 55 Pa. § 1243.52a. Clarification of the terms "written" and "signature" — statement of policy.

  (c) The term "signature" in § 1243.52(b)(5) includes a handwritten or electronic signature that is made in accordance with the Electronic Transaction Act (73 P.S. §§ 2260.101–2260.5101).

References

LOCs for which interns can provide services

- CBH Manual for the Review of Provider Personnel Files (MRPPF) Section 3.1.8 Intern (Student)

  The intern's designated supervisor (at the provider) is fully responsible for legal and clinical content of the services delivered and corresponding documentation by the intern. The supervisor must co-sign all documentation completed by an intern. The supervisor must be appropriately credentialed according to the requirements of the services required.

ASAM 1.0 / 2.1

- 28 Pa. Code § 709.93. Client records.
- 28 Pa. Code § 715.23. Patient records.
- 55 Pa. Code § 1223.42. Ongoing responsibilities of providers.

  (b) Record keeping requirements. In addition to the requirements listed in Chapter 1101, the following items shall be included in medical records of Medical Assistance patients receiving drug/alcohol outpatient clinic services:

  (2) As part of the progress notes, the frequency and duration of each service provided shall be included.

ASAM 3.1 / 3.5 / 3.7 / 3.7WM / 4 / 4WM

ID = Insufficient: Documentation

References (Con'd)

- CBH Provider Manual Section 5.18.8. Per Diem Substance Use Disorder Services

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CRR Adult Services

- 55 Pa. Code § 5310.51. Case record.

  (c) Client case records must be:

  (1) Legible and in ink or typewritten.

FBS

- CBH Provider Manual Section 5.18.9. Family-Based Mental Health Services

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Group Services

- CBH Provider Manual Section 5.18.6. Group Services

IBHS

- 55 Pa. Code § 5240. Intensive Behavioral Health Services
- 55 Pa. Code § 1155. Intensive Behavioral Health Services
- CBH Provider Manual 5.19. IBHS Billing Guide

Independent Practitioner

- CBH Provider Manual Section 5.18.10. Independent Practitioner

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MH ICM

- 55 Pa. Code § 5221.33. Intensive case management records — statement of policy.

  (4) Documentation of services.

  (i) Case notes. The case notes shall:

  (A) Be legible.
  (B) Verify the necessity for the contact and reflect the goals and objectives of the intensive case management service plan.
  (C) Include the date, time and circumstance of contacts, regardless of whether or not a billable service was provided.
  (D) Identify the consumer by name or case number on both sides of each page on which there is writing on both sides. The consumer's name and case number should appear together earlier in the file.
  (E) Be dated and signed by the individual providing the service.

OP MH

- 55 Pa. Code § 5200.41. Records.

  (a)(8) Treatment progress notes for each contact.

  (b)(1) Legible and permanent.

  (b)(4) Signed and dated by the staff member writing in the record.

- 55 Pa. Code § 1153.42. Ongoing responsibilities of providers.

ID = Insufficient: Documentation

(b) Recordkeeping requirements. In addition to the requirements listed in § 1101.51(e) (relating to ongoing responsibilities of providers), the following items must be included in the records of MA beneficiaries receiving psychiatric outpatient clinic, MMHT and psychiatric partial hospitalization outpatient services:

(2) As part of the progress notes, the frequency and duration of each service provided shall be included.

- CBH Provider Manual Section 5.18.5. Mental Health Outpatient Providers

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OP MH / PHP

- Medical Assistance Bulletin 29-02-03, 33-02-03 Documentation and Medical Record Keeping Requirements

Requirements: The documentation of treatment or progress notes, at a minimum, must include: 1. The specific services rendered 2. The date that the service was provided 3. The name(s) of the individuals(s) who rendered the services 4. The place where the services were rendered 5. The relationship of the services to the treatment plan, specifically any goals, objectives and interventions 6. Progress at each visit, any change in diagnosis, changes in treatment and response to treatment 7. 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.

References (Con'd)

PHP

- 55 Pa. Code § 5210.26. Records.

(a)(8) Treatment progress notes for each contact.

(b)(1) Legible and permanent.

(b)(4) Signed and dated by the staff member writing in the record.

PRS

- 55 Pa. Code § 5230.22. Documentation standards and record security, retention and disposal.

(1) The record must be legible throughout. (2) The record must identify the individual on each page. (3) Entries shall be signed and dated by the responsible staff. (4) The record must indicate progress at each day of service, changes in service and response to services. (5) Updates of the record shall be signed and dated.

RTF

- 55 Pa. Code § 3800.242. Child records.

(b) Entries in a child's record shall be legible, dated and signed by the person making the entry.

Unit-Based Services

- Medical Assistance Bulletin 99-97-06: Accurate Billing for Units of Service Based on Periods of Time

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ID = Insufficient: Documentation

"Providers who have units of service defined as time specific periods must document in the patient's record, the clock time spent providing the service (i.e., 7:15 a.m. – 8:15 a.m.)."

- CBH Provider Manual 5.18.4. Clock Times

M = Missing Documentation

Description

The clinical record must be complete and accurate. Treatment progress notes, signed and dated by the individual providing the service, shall be completed for each service provided. The medical record must speak for itself; if something is not documented, the presumption for review purposes will be that it did not happen.

Examples Include

- Progress notes and evaluation documents not filed in clinical record; Does not include missing treatment plans, which are listed under the code for "Treatment Plan concerns"
- Date Error (e.g., Provider billed for a date of service with no documentation present but a nearby date of service with no paid claim has documentation for the same service and number of units and provider does not report that the service documentation contains the incorrect date)

References

- 55 Pa. Code § 1101.51. Ongoing responsibilities of providers.
- CBH Provider Manual Section 5.18. Clinical Documentation Requirements
- CBH Clinical Practice Guidelines

ASAM 1.0 / 2.1

- 28 Pa. Code § 709.93. Client records.
- 28 Pa. Code § 715.23. Patient records.

ASAM 3.1 / 3.5 / 3.7 / 3.7WM / 4 / 4WM

- CBH Provider Manual Section 5.18.8. Per Diem Substance Use Disorder Services

Child/Adolescent Inpatient

- Clinical Performance Standards: Acute Inpatient Psychiatric

Section 4.1.5.1. Daily Assessment and Psychiatric Notes
The hospital psychiatrist should complete daily assessments for every child/adolescent and document these in the daily psychiatric progress note with a complete MSE. The MSE should describe the clinical presentation of the child. MSEs should reflect specificity for each child/ adolescent through elaboration of endorsed symptoms. A daily assessment with detailed MSE eases the approval process when CBH reviews level of care recommendations.
The attending physician must complete the daily face-to-face assessment and progress note. Notes should address treatment planning, progress, medication, and any changes in medication with a clear rationale in addition to the MSE.

M = Missing Documentation

FBS

- CBH Provider Manual Section 5.18.9. Family-Based Mental Health Services

Group Services

- CBH Provider Manual Section 5.18.6. Group Services

IBHS

- 55 Pa. Code § 5240. Intensive Behavioral Health Services
- 55 Pa. Code § 1155. Intensive Behavioral Health Services
- CBH Provider Manual 5.19. IBHS Billing Guide

Independent Practitioner

- CBH Provider Manual Section 5.18.10. Independent Practitioner

OP MH

- 55 Pa. Code § 5200.41. Records.

  (a)(8) Treatment progress notes for each contact.

- 55 Pa. Code § 1153.42. Ongoing responsibilities of providers.

  (b) Recordkeeping requirements. In addition to the requirements listed in § 1101.51(e) (relating to ongoing responsibilities of providers), the following items must be included in the records of MA beneficiaries receiving psychiatric outpatient clinic, MMHT and psychiatric partial hospitalization outpatient services:

  (2) As part of the progress notes, the frequency and duration of each service provided shall be included.

- CBH Provider Manual Section 5.18.5. Mental Health Outpatient Providers

PHP

- 55 Pa. Code § 5210.26. Records.

  (a)(8) Treatment progress notes for each contact.

N = Non-Billable Activity

Description	All billed activities must be appropriately reimbursable by Medicaid.
Examples Include	Billing for an activity/service not reimbursable by Medicaid. Examples include: ➡ Administrative activities such as recordkeeping and completion of consent forms and/or documentation ➡ Travel, homework assistance, recreational activities

N = Non-Billable Activity

	➡ Providing activities not appropriate to the level of care, such as case management billed as psychotherapy, psychoeducational groups billed as psychotherapy groups, and resume assistance billed as psychotherapy ➡ Services provided to a member without an appropriate diagnosis ➡ Billing for services beyond a member's date of death ➡ Services that do not meet minimum time requirements ➡ Specific to Per Diem LOCs: Billing for the date of discharge
References	➡ 55 Pa. Code § 1101. General Provisions. ASAM 1.0 / 2.1 ➡ 55 Pa. Code § 1223. Outpatient Drug and Alcohol Clinic Services OP MH ➡ 55 Pa. Code § 1153. Outpatient Psychiatric Services IBHS ➡ 55 Pa. Code § 5240. Intensive Behavioral Health Services ➡ 55 Pa. Code § 1155. Intensive Behavioral Health Services ➡ CBH Provider Manual Section 5.19. IBHS Billing Guide MH ICM ➡ 55 Pa. Code § 5221. Mental Health Intensive Case Management Services ➡ CBH Provider Bulletin 21-05: Elimination of BHCM Post-Death Claims Per Diem LOCs ➡ CBH Provider Manual Section 6.2. Claims All Other Service Types Not Specified Here ➡ Refer to the PA Code

P = Service Exceeds Allowable Contacts per Time Period

Description	Services cannot exceed allowable number of contacts, per regulations and/or CBH standards, or as prescribed.
Examples Include	Examples: ➡ Inpatient Consultations in Medical Facilities: PA Medicaid continues to allow for only one consultation and one follow-up per admission. ➡ SUD services must follow ASAM guidance on service limits.

P = Service Exceeds Allowable Contacts per Time Period

- IBHS services must be congruent with written orders.
- PRTF services must not exceed Medicaid-allowable therapeutic leave, hospitalization, elopement days per stay and/or per year.
- PRTF services must bill at 1/3 rate of the per diem when a member is hospitalized.

References

- 55 Pa. Code § 1101.66. Payment for rendered, prescribed, or ordered services.

  (a) The Department pays for compensable services or items rendered, prescribed or ordered by a practitioner or provider if the service or item is:

  (1) Within the practitioner's scope of practice. (2) Medically necessary. (3) Not in an amount that exceeds the recipient's needs. (4) Not ordered or prescribed solely for the recipient's convenience. (5) Ordered with the recipient's knowledge.

ASAM 1.0 / 2.1

- 55 Pa. Code § 1223. Outpatient Drug and Alcohol Clinic Services.

Consultations

- For Psychiatric Consultations in Medical Facilities, see CBH Provider Manual, Section 3.9.7., based on MA regulations found in 55 Pa. Code § 1150.56a. Payment policy for consultations — statement of policy.

  (a) The Department pays for five levels of inpatient and outpatient consultations. Payment for inpatient consultations is limited to two consultations per hospitalization.

IBHS

- 55 Pa. Code § 5240. Intensive Behavioral Health Services
- 55 Pa. Code § 1155. Intensive Behavioral Health Services
- CBH Provider Manual Section 5.19. IBHS Billing Guide

OP MH

- 55 Pa. Code § 1153. Outpatient Psychiatric Services

RTF

- Medical Assistance Bulletin 01-95-13 JCAHO Accredited RTF: 5. Therapeutic Leave; 6. Hospital Admissions; 7. Absence Without Leave (AWOL)
- Medical Assistance Bulletin 01-95-12 Non-JCAHO Accredited RTF: 3. Therapeutic Leave; 4. Hospital Leave; 5. Absent Without Leave (AWOL)

Q = Services provided by an unqualified individual

Description	Staff will meet the minimum requirements of the position/service description guidelines established by Federal, Commonwealth, and CBH standards.
Examples Include	➡ Failure to meet regulatory requirements ➡ Failure to meet waiver stipulations ➡ Failure to obtain required clearances ➡ Failure to complete foreign degree verification ➡ Evidence-Based Practice (EBP) services provided by staff not qualified to provide the EBP service ➡ Services requiring licensed staff being provided by unlicensed staff ➡ Functional Behavioral Assessments (FBA) being provided by non-FBA-certified staff
References	Refer to the CBH Manual for the Review of Provider Personnel Files (MRPPF)

R = Re-Use of Content

Description	Documentation must be original and accurately describe the individual's treatment experience for the billed service. This applies to re-used content found in documentation within one member's chart and/or across different members' charts.
Examples Include	➡ Identical content ➡ Content is taken from a textbook or website ➡ For treatment plans, use treatment plan code instead.
References	➡ 55 Pa. Code § 1101.51. Ongoing responsibilities of providers. *(e)(1)(vi) The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment.*

S = Services Not Rendered

Description	Services must be provided to be billed.
Examples Include	➡ Billing for services not provided ➡ Member documented as absent, no show, present but no services provided ➡ Includes Provider self-disclosures of falsified documentation and forged encounter forms
References	➡ 55 Pa. Code § 1101.75. Provider prohibited acts. *(a)(5) Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.*

S = Services Not Rendered

➡ Medical Assistance Bulletin 99-10-14: Missed Appointments

The Centers for Medicare and Medicaid Services (CMS) which is responsible for administering the Medicaid Program, has an existing policy that prohibits MA providers from billing recipients or the Medicaid agency for missed appointments. According to CMS, a missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider's overall cost of doing business.

ASAM 1.0 / 2.1

➡ 55 Pa. Code §1223.14. Noncovered services.

(3) Cancelled appointments.

ASAM 3.1 / 3.5 / 3.7 / 3.7WM / 4 / 4WM

➡ CBH Provider Manual Section 5.18.8.

Services (minimum amount each day varies by the level of care) must be provided every day, including weekends and holidays.

OP MH

➡ 55 Pa. Code § 1153.14. Noncovered services.

(2) Cancelled appointments. (3) Covered services that have not been rendered.

T = Treatment Plan Concerns

Description	Treatment plans must be developed, updated, and signed by all appropriate persons as required for each level of care. Refer to the Treatment Planning Guide within the CBH Provider Manual for detailed information. Services provided shall be consistent with goals and interventions identified in the current treatment plan.
Examples Include	Missing plan to cover date of service, provided service is not prescribed on the treatment plan as a modality, plan is not signed by required parties by the due date, lack of or re-use of content in updated sections, repeated goals without any clinical explanation of their continuation

➡ Refer to the Program Integrity Treatment Planning Guide in the CBH Provider Manual for detailed information on each LOC.

References

ASAM 1.0 / 2.1

➡ 55 Pa. Code § 1223.52. Payment conditions for various services.

(a)(6)(i) Within 15 days following intake, the clinic's supervisory physician shall review and verify initial treatment plan prior to the provision of any treatment beyond the 15th day following intake. The clinic's supervisory physician shall sign and date the patient's treatment plan in the patient's record.

(ii) Sixty days following the date of the initial treatment plan and at the end of every 60-day period during the duration of treatment, the clinic's supervisory physician shall review, update, and sign each patient's treatment plan.

T = Treatment Plan Concerns

ASAM 3.1 / 3.5 / 3.7 / 3.7WM / 4 / 4WM

- 28 Pa. Code § 709.92. Treatment and rehabilitation services.

  (c) The project shall assure that counseling services are provided according to the individual treatment and rehabilitation plan.

IBHS

- 55 Pa. Code § 5240.22. Individual treatment plan.

  (a) A written ITP shall be completed within 30 days after the initiation of a service and be based on the assessment completed in accordance with § 5240.21.

  (f) The ITP shall be reviewed and updated at least every 6 months or as clinically indicated.

OP MH

- 55 Pa. Code § 1153.52. Payment conditions for various services.

OP MH / PHP

- 55 Pa. Code § 1153.42. Ongoing responsibilities of providers.

  (b)(1)(ii) Services to be provided to the individual by the psychiatric outpatient clinic or partial hospitalization outpatient facility or through referral.

PHP

- 55 Pa. Code § 5210.35. Contents and review of a comprehensive treatment plan.

  (a)(4) Be maintained and updated with signed daily notes and kept in the patient's medical record on a form developed by the facility.

U = Unit Error

Description	The units of service billed must equal the units of service documented in the clinical record.
Examples Include	➡ Providers who have units of service defined as time specific periods must provide the full time period in order to bill for a unit of service. ➡ Providers are not permitted to round the unit of service to the next higher unit when providing a partial unit of time. ➡ Providers are not permitted to combine partial time units to equal a full unit of service. ➡ Providers who have units of service defined as time-specific periods must document in the patient's record the clock time spent providing the service (i.e., 7:15 a.m. to 8:15 a.m.). This applies to all providers enrolled in the Medical Assistance (MA) Program under the Fee-For-Service payment system EXCEPT Intensive Case Management, Resource Coordination Programs, Family Based Mental Health Rehabilitation services, and Mental Health Crisis Intervention.
References	➡ 55 Pa. Code § 1101.75. Provider prohibited acts.

U = Unit Error

(a)(1) Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA.

- Medical Assistance Bulletin 99-98-12: Accurate Billing for Units of Service Based on Periods of Time

  Providers who have units of service defined as time specific periods must provide the full time period in order to bill for a unit of service. Providers are not permitted to round the unit of service to the next higher unit when providing a partial unit of time. Providers are not permitted to combine partial time units to equal a full unit of service. Providers who have units of service defined as time specific periods must document in the patient's record, the clock time spent providing the service (i.e., 7:15 a.m. to 8:15 a.m.).

  This bulletin exempts additional providers from this billing procedure.

ASAM 1.0 / 2.1

- 55 Pa. Code §1223.2. Definitions.

  Family psychotherapy — Psychotherapy provided to members of a family who regularly live and interact together. At least one family member must have a diagnosed drug/alcohol abuse or dependence problem. Sessions shall be at least 1/2 hour in duration and shall be conducted by drug/alcohol clinic psychotherapy personnel under the supervision of a physician.

  Group psychotherapy — Psychotherapy provided to no less than two and no more than ten persons with diagnosed drug/alcohol abuse or dependence problems for a minimum of 1 hour. These sessions shall be conducted by drug/alcohol clinic psychotherapy personnel under the supervision of a physician.

- 55 Pa. Code §1223.52. Payment conditions for various services.

  (b) Payment will only be made for drug/alcohol clinic visits provided to eligible drug/alcohol patients in approved drug/alcohol outpatient clinics under the following conditions: (1) The visit shall be a minimum duration of 15 minutes.

Y = Unbundling Codes

Description	Billing bundled services separately. Breaking out and billing individually for services normally covered by a single, comprehensive service, or CPT code.
Examples Include	➡ Billing parts of a single, whole procedure separately ➡ Billing separately for UDS during a Methadone Clinic Dosing visit which already includes payment for UDS
References	➡ 55 Pa. Code § 1101.75. Provider prohibited acts. *(a) An enrolled provider may not, either directly or indirectly, do any of the following: (4) Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.*

Y = Unbundling Codes

ASAM 1.0 / 2.1

- 55 Pa. Code § 1223.52.

  (a)(2) A comprehensive medical examination shall be provided only by a licensed physician. Additional interviews with other staff may be included as part of the comprehensive medical examination but shall be included in the comprehensive medical examination fee. Separate billings for these interviews are not compensable.

OP MH

- 55 Pa. Code § 1153.14. Noncovered services.

  (5) Psychiatric outpatient clinic, MMHT or partial hospitalization outpatient services to residents of treatment institutions, such as individuals who are also being provided with room or board, or both, and services, on a 24-hour-a-day basis by the same facility or distinct part of a facility or program.

  (9) Psychiatric outpatient clinic services, MMHT services and psychiatric partial hospitalization outpatient services provided on the same day to the same individual, with the exception of clinical services not offered by the facility providing services to the individual.

- 55 Pa. Code § 1153.53. Limitations on payment.

  (5) Family psychotherapy and collateral family psychotherapy are compensable for only one person per session, regardless of the number of family members who participate in the session or the number of participants who are eligible for psychotherapy.

Z = Lack of Medical Necessity

Description	All services billed to CBH must meet the medical necessity criteria (MNC) for the service.
Examples Include	➡ Services deemed not meeting MNC by a CBH psychiatrist/psychologist via Retrospective Review ➡ Reviews can be initiated by CBH Program Integrity, Quality Management, or Clinical Management.
References	➡ 55 Pa. Code § 1101.51. Ongoing responsibilities of providers. *(e)(1)(x) The record shall contain documentation of the medical necessity of a rendered, ordered, or prescribed service.* ➡ PA HealthChoices/CBH MNC ➡ CBH Provider Bulletin 22-19: Retrospective Review