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COMMUNITY BEHAVIORAL HEALTH

Provider Manual

Updated July 10, 2025

Community Behavioral Health

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1. INTRODUCTION

1.1. Document Purpose and Philosophy

This manual serves as a guide for providers within the Community Behavioral Health (CBH) network. As an extension of the Provider Agreement, this manual describes the policies, procedures, and practices developed by CBH and the Department of Intellectual disability Services (DBHIDS).

The content of this manual seeks to ensure that all Philadelphia recipients of mental health and substance use services receive the most appropriate treatment in the least restrictive environment possible. CBH is committed to helping people live successfully in the community. To that end, treatment should be based on principles of recovery, resilience, and self-determination.

Procedures and processes described herein, and the additional documents linked in the **Additional Documents and Links** section, are mandatory for all providers in the CBH network.

1.2. Organizational Overview

The City of Philadelphia contracts with the Commonwealth of Pennsylvania Department of Human Services (PA-DHS) for the provision of behavioral health services to Philadelphia's Medicaid recipients under Pennsylvania's HealthChoices behavioral health mandatory managed care program. Services are funded on a capitated basis through this contractual agreement. The City of Philadelphia, through (DBHIDS), contracts with CBH to administer the HealthChoices program.

DBHIDS is comprised the Office of Behavioral Health which includes Mental Health and Addictions Services and Intellectual disability Services (IDS). DBHIDS contracts with Community Behavioral Health (CBH) to administer behavioral health care services for the City's approximately 700,000 Medical Assistance recipients under Pennsylvania's HealthChoices behavioral health mandatory managed care program. CBH manages a full continuum of medically necessary and clinically appropriate behavioral health services. CBH employs more than 500 people and has an annual budget of approximately $1.8 million.

The Department has a long history of providing innovative and groundbreaking services in Philadelphia for people in recovery, family members, providers and communities and has become a national model for delivering behavioral health care services in the public sector. We envision a Philadelphia where every individual can achieve health, well-being, and self-determination. The mission of DBHIDS is to educate, strengthen and serve individuals and community so that all Philadelphians can thrive. This is accomplished using a population health approach with an emphasis on recovery and resilience-focused behavioral health services and on self-determination for individuals with intellectual disabilities. Working with an extensive network of providers, DBHIDS provides services to persons recovering from mental health and/or substance use, individuals with intellectual disabilities, and families to ensure that they receive high quality services which are accessible, effective, and appropriate.

This program will be administered by and receive oversight from CBH. CBH is committed to offering services to all Philadelphians. The mission of CBH is to meet the behavioral health needs of the Philadelphia community by assuring access, quality, and fiscal accountability through being a high performing, efficient, and nimble organization driven by quality, performance, and outcomes. We envision CBH as a diverse, innovative, and vibrant organization in which we are empowered to support wellness, resiliency, and recovery for all Philadelphians.

1.3. Philosophy

CBH values and cultivates a strength-based, culturally competent, and recovery-oriented system of care that promotes health, wellness, and achievement of individual goals. CBH grounds services in the principles of recovery, resiliency, and self-determination to facilitate the attainment of a meaningful life in the community for all members.

1.4. Nondiscrimination

CBH maintains a policy of nondiscrimination.

Our credentialing and recredentialing processes, which evaluate and select network providers, does not discriminate based on the applicant's race, ethnic/national identity, religion, gender, age, sexual orientation, or physical disability. CBH does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If CBH declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.

CBH is committed to developing and implementing recruitment and procurement activities to solicit providers reflective of the diverse membership we serve.

1.5. Contact Information

Important Contacts	Purpose	Phone Numbers/Emails	Hours of Operation
Behavioral Health Special Initiative (BHSI)	Providers seeking addictions treatment for uninsured Philadelphia residents should contact.	215-546-1200	Monday – Friday 8:00 a.m. – 5:00 p.m.
CBH	Call with general inquiries and transfers to specific CBH departments.	215-413-3100	Monday – Friday 8:00 a.m. – 5:00 p.m.
CBH Claims Hotline	Providers call with claims questions.	215-413-7125	Monday – Friday 8:00 a.m. – 5:00 p.m.
CBH Clinical Management	Providers call to request non-urgent authorizations.	215-413-3100	Monday – Friday 8:00 a.m. – 5:00 p.m.
CBH Program Integrity Hotline	Anyone can call to report a concern of fraud, waste, and/or abuse committed by CBH, a CBH provider, or a CBH member.	1-800-229-3050 CBH.ComplianceHotline@phila.gov	Staffed Monday – Friday 9:00 a.m. – 11:00 a.m., 2:00 p.m. – 4:00 p.m. Messages can be left at any time.
CBH Program Integrity Department	General contact for non-hotline issues	CBH.ComplianceContact@phila.gov	Messages can be left at any time.

Important Contacts	Purpose	Phone Numbers/Emails	Hours of Operation
CBH Member Services	Members can call for member needs; providers can call with member questions or to assist a member in inquiring about services and rights.	1-888-545-2600	24/7/365
CBH Operations Support Services	For all services requiring registration, providers call for authorization number for billing.	CBHauths@phila.gov	Monday – Friday 8:00 a.m. – 5:00 p.m.
CBH Provider Complaint Hotline	Providers call to make a complaint about CBH.	215-413-8581	Monday – Friday 8:00 a.m. – 5:00 p.m.
CBH Provider Relations Hotline	Providers call for provider needs.	215-413-7660	Monday – Friday 9:00 a.m. – 5:00 p.m.
CBH Psychiatric Emergency Services (PES)	Providers call for urgent services. If a provider wishes to request a service that requires prior authorization, they can also contact the PES line for treatment history before making that request.	215-413-7171	24/7/365
DBHIDS Case Management Unit	Providers call for authorizations for Adult Case Management Services (see section 9.4.)	(215) 599-2150	Monday – Friday 8:30 a.m. – 5:00 p.m.
Intellectual Disability Services (IDS)	Call with general inquiries.	215-685-5900	Monday – Friday 8:30 a.m. – 5:00 p.m.
Mental Health Delegates Hotline[1]	Call for help arranging crisis services for people with urgent behavioral health needs. After 5p.m., call to report missing persons with ID needs.	215-685-6440	24/7/365

[1] *Also known as the "Philadelphia Crisis Line" and "Acute Services."*

2. CREDENTIALING

2.1. Purpose

This chapter will assist you in navigating the credentialing process. As a contracted network provider, it is your responsibility to be familiar with and adhere to the policies and procedures contained herein.

Provider revalidation of enrollment is a federal Medicaid requirement. Providers must revalidate their Medicaid enrollment every five years. Failure to revalidate will result in termination of the provider's Medicaid enrollment and therefore CBH's ability to reimburse the provider for services rendered. We encourage providers to ensure they are aware of their revalidation dates and submit applications with as much lead time as possible to avoid disruptions in reimbursement.

We hope you find this a helpful tool in working with CBH to provide quality care to members. We welcome your feedback about how we can make this chapter better and more helpful to you. Please email comments to **CBH.CredentialingContact@phila.gov**.

2.2. Credentialing Decisions

2.2.1. Credentialing Committee

The Credentialing Committee provides oversight to the initial credentialing and recredentialing processes and all decisions made therein. The Committee is chaired by the CBH Chief Medical Officer (CMO). As Chair of the Credentialing Committee, the CMO may designate another senior level CBH physician to chair the committee. During periods where the CMO position is vacant, a CBH senior physician advisor may be designated to serve as committee chair by CBH officers. The committee chair can appoint a co-chair as needed to support the function of the committee. The Credentialing Committee Chair is responsible for ensuring that thoughtful consideration is given to all applications presented to the committee. In addition to responsibilities as Credentialing Committee Chair, the CBH CMO assists the credentialing process by:

➡ Providing guidance on proposed changes to both this Manual and the **Manual for Review of Provider Personnel Files (MRPPF)**.

➡ Ensuring that relevant actions and activities emanating from the Credentialing Committee are presented to other standing CBH meetings that include but are not limited to:

» Quality Council

» Program Integrity Committee

» Clinical Review Committee

» CBH Officers

➡ Communicating with the Board of Directors and Philadelphia County relating to the potential impact of unfavorable credentialing decisions

As Chair, the CBH CMO or designated physician reviews and approves all "clean" independent and group practitioner files, as well as FQHC BHC files (see **Definitions Appendix**).

The Credentialing Committee membership includes representatives from CBH's senior staff and physicians. CBH staff members serve on the Committee as a requirement of their position.

The Committee also includes at least one participating network practitioner who has no other role in CBH's management activities. The participating network practitioners must be reflective of the practitioners with whom CBH directly contracts. CBH aims to secure both clinicians and physicians from the provider network to ensure a variety of perspectives and experience.

The Credentialing Committee meets monthly, either in person or through video conference or web conference with audio.

No independent or group practitioner or facility can provide services for CBH reimbursement until they have been successfully credentialed.

The Committee also reviews any recommendation to terminate in-network status for any practitioner or facility based on adverse events or on-going significant concerns.

Examples of adverse events/concerns that may lead to a recommendation for termination include but are not limited to:

➡ Immediate member safety concerns

➡ Unresolved quality/compliance concerns

➡ Inability to effectively and appropriately staff program services

➡ Failure to meet minimum quality standards as defined by the CBH Provider Agreement

In addition to practitioner credentialing, the Committee reviews staffing waiver requests for organizational providers seeking a waiver of staffing requirements.

Finally, the Committee reviews proposed changes to the MRPPF. The MRPPF provides detailed requirements for specific clinical staff positions. CBH providers (see Definitions, **Definitions Appendix**) must meet all requirements in the MRPPF for the specific position.

2.2.2. Committee Minutes

The CBH Chief Medical Officer's staff is responsible for documenting discussions and decisions made in the Committee. Minutes are made available to Committee members for review and approval prior to the next regularly scheduled Committee meeting.

2.2.3. Provider Notification of Decisions

Providers are notified, in writing, of the Credentialing Committee decision within 60 days of the Committee meeting date. Notifications are sent for both initial and recredentialing reviews and specify the duration of the credentialing period.

Providers failing to meet standards for credentialing or recredentialing are provided with information related to the factors for which they were found to be deficient. When possible, information on steps needed to cure deficiencies will be provided in the notification letter. The letter will also contain a summary of the appeal rights and process to appeal negative decisions.

2.2.4. Confidentiality and Storage of Records

All members of the Credentialing Committee sign non-discrimination and confidentiality agreements annually (See the **Confidentiality and Nondiscrimination Agreement Appendix**).

CBH is committed to ensuring confidentiality of the information collected during the credentialing process. Original documents and copies obtained will be stored on network drives with restricted access. Information obtained will only be shared with outside entities as required by law.

All Committee members attest to respect and maintain the confidentiality of all discussions, records, and information generated in connection with Credentialing Committee activities and to make no disclosure of such information except to persons authorized to receive it.

Credentialing summaries for practitioners and facilities are de-identified during the Committee's review to facilitate objective discussion and to mitigate against potential conflicts. Additionally, participating network practitioners are required to immediately recuse themselves should the identity of a practitioner or facility become apparent during a discussion.

2.2.5. Nondiscrimination Processes

The Credentialing Committee is responsible for ensuring that the credentialing/recredentialing processes are conducted in a nondiscriminatory manner. All Committee members attest to ensuring that credentialing and recredentialing decisions are made in a non-discriminatory manner and will not be made based on an applicant's race, ethic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

On an annual basis, the CBH Program Integrity Department will conduct random reviews of procurements and credentialing files/decisions to ensure that discrimination of any kind was not involved in credentialing decisions.

2.2.6. Appeal/Cure Process

CBH affords providers opportunities to register appeals for negative credentialing decisions. Appeals may be made regarding the denial of entry of a prospective provider into the CBH network or the termination of an existing provider or program from the network. Providers are not able to appeal the length of an approved credentialing status.

Appeals must be submitted in writing within 30 days of communication of the decision.

Independent practitioners who cannot be credentialed due to missing elements of the Council for Affordable Quality Healthcare (CAQH) process or other matters leading to a negative credentialing decision can submit an appeal to the Credentialing Committee. Appeals must include resolution of any deficiencies identified during the credentialing process, as well as any relevant information related to the request for reconsideration of the credentialing decision. The appeal will be reviewed by the Credentialing Committee during the following meeting cycle, not to exceed 60 days from the appeal date and shall be communicated to the provider in writing within 5 business days of the decision. If a negative decision is made at this stage, a second-level appeal may be made to the City of Philadelphia Commissioner of the Department of Behavioral Health and disability Services (DBHIDS) as described below.

Consistent with the (internal) CBH Network Termination Policy and Protocol, appeals regarding a network termination decision for cause by CBH pursuant to Article VIII.B. of the Provider Agreement must be made by submitting the request, in writing, to the City of Philadelphia Commissioner of the Department of Behavioral Health and disability Services (DBHIDS). Appeals may be made if the decision by CBH to terminate was for any of the following reasons:

➡ In the event of default or other noncompliance with the Provider Agreement;

➡ The refusal of health care provider to agree to amendments to the Provider Agreement;

➡ If the HealthChoices Behavioral Health Program is terminated or modified to such an extent that continuation of this Provider Agreement is no longer possible or feasible, in CBH's sole discretion, or the Contracts (as defined in the Provider Agreement) are terminated for any reason;

➡ If funding for this Provider Agreement from any source is not continued at a level sufficient (in CBH's reasonable judgment) to permit payment for Covered Services; or

➡ If health care provider fails to satisfy any or all of the credentialing requirements of CBH or fails to cooperate with or abide by the CBH Quality Management and/or Program Integrity programs.

The decision to terminate the Provider Agreement without cause in accordance with Article VIII.A. cannot be appealed.

Providers requesting a hearing as part of the appeal process must make this request in the appeal letter. Providers may choose, at their expense, to be represented by an attorney or another person of the provider's choice.

The decision of the appeals panel is considered final and will be provided via written notification. All appeal decisions shall be made within 10 business days and shall be communicated to the provider within one business day of the decision.

Existing in-network providers should reference the CBH Provider Agreement for additional remedies.

2.3. Provider Role in CBH Network Participation

2.3.1. CBH Policy

To be an in-network provider of mental health and substance use services with CBH, you must possess the requisite licensure for the service(s) you wish to provide, become credentialed with CBH, and enter into a Provider Agreement (contract) with CBH.

2.3.2. Provider Responsibility

As a network provider, you must provide medically necessary, covered services to members whose care is managed by CBH. Providers are expected to follow the policies and procedures outlined in the Provider Manual, relevant federal and state regulations, any applicable supplements, and the CBH Provider Agreement. Providers also agree to cooperate and participate with all access to care, care management, quality improvement, outcomes measurement, peer review, and complaint and grievance procedures.

The Provider Orientation is mandatory and available in LMS for all new providers coming into the network and also for existing providers with new staff who want to engage in the training opportunities.

Below are instructions on how to access the DBHIDS Learning Hub:

1. If you do not have an account with the DBHIDS Learning Hub:

   ➡ Go to the **DBHIDS Learning Hub**

   ➡ Click, "Create Your Account" and complete the form

      » Access Code: LHAccess20

> » **Guide for creating an account**

➡ Go to the My Courses section (on left panel) and find the course titled "CBH Provider Orientation Series."

2. If you have an account with the DBHIDS Learning Hub:

➡ Go to the **DBHIDS Learning Hub** and login

➡ Go to the Electives section (on left panel) and click "Enroll" next to the course.

If you have any trouble, please email us at **DBHIDS.LearningHub@phila.gov** and we can assist you.

2.3.3. Types of Providers

CBH's network of providers includes practitioners in private practice (also known as independent practitioners), practitioners in group practices, and provider organizations or facilities.

➡ **Independent/Individual Practitioner**: A clinician (psychiatrist, psychologist, licensed clinical social worker, licensed social worker, licensed professional counselor, licensed marriage and family therapist) who provides behavioral healthcare services and bills under their own Taxpayer Identification Number.

➡ **Group Practice**: A practice contracted with CBH as a group entity and as such bills as a group entity for the services performed by its CBH credentialed clinicians. A group practice is comprised of more than one clinician with the same license type (ex: LMFT group practice, LCSW group practice).

➡ **Facility**: An organization, or program within a parent organization, licensed by the state of Pennsylvania to provide behavioral health services. Examples of facilities include, but are not limited to, psychiatric hospitals, partial hospital programs, mental health clinics, residential treatment facilities, substance use disorder clinics, and rehabilitation providers.

➡ **Federally Qualified Health Center (FQHC)**: A community-based health care provider that receives funds from the Health Resources and Service Administration (HRSA). Behavioral health services are provided by a **Behavioral Health Consultant (BHC)** (psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapist).

Staff employed by a facility are not considered individual practitioners as previously defined. Provider organizations are solely responsible for ensuring that the staff they employ, or contract with, meet all educational and experiential requirements for the positions held as well as possess all the appropriate certifications and clearances. Provider organizations must utilize the CBH MRPPF to ensure that facility staff meets the requisite standards to provide treatment to CBH members. This provider organization responsibility is a component of the provider's contractual obligation as outlined in the CBH Provider Agreement.

2.3.4. Practitioner Directories

All information obtained during credentialing and recredentialing processes is utilized to accurately populate the **CBH Provider Directory**. If the information obtained during these processes varies from existing information in the Provider Directory, both the provider and their assigned CBH Provider Relations Representative will be made aware in order to resolve and correct the discrepancy.

2.4. Credentialing and Recredentialing Processes

2.4.1. Philosophy

CBH is committed to promoting quality care for its members. In support of this commitment, providers must meet and maintain a minimum set of credentials to provide services to CBH members.

CBH utilizes the services of a National Committee for Quality Assurance (NCQA) Certified Credentials Verification Organization (CVO) to collect and complete primary source verification on credentials for individual practitioners, group practice members and BHCs for both initial credentialing and recredentialing. Initial reviews and recredentialing reviews for facilities are conducted by CBH staff.

2.4.2. Types of Credentialing

2.4.2.1. Initial Credentialing

A practitioner or facility that is not an in-network, contracted provider at the time of application must undergo an initial credentialing review. Practitioners and facilities that have previously participated in the network, but who do not currently have an active contract, will also require an initial credentialing review. New programs proposed by an existing in-network provider will undergo a modified initial credentialing process, with some of the requirements having already been met through the credentialing of the parent organization.

The chart below illustrates the provider type and CBH department responsible for initial credentialing activities.

Provider Type	Responsible Department	Review & Approval
Individual Practitioner	CBH Program Integrity	➡ Clean Files: CBH CMO ➡ Files not meeting full threshold criteria: Credentialing Committee
Group Practice	CBH Program Integrity	➡ Clean Files: CBH CMO ➡ Files not meeting full threshold criteria: Credentialing Committee
Facility	CBH Provider Operations	Credentialing Committee
FQHC	CBH Provider Operations	Credentialing Committee

2.4.2.2. Recredentialing

Existing in-network, contracted practitioners and facilities must be recredentialed at intervals not to exceed three years.

Provider Type	Responsible Department	Review & Approval
Individual Practitioner	CBH Program Integrity	➡ Clean Files: CBH CMO ➡ Files not meeting full threshold criteria: Credentialing Committee

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Provider Type	Responsible Department	Review & Approval
Group Practice	CBH Program Integrity	➡ Clean Files: CBH CMO ➡ Files not meeting full threshold criteria: Credentialing Committee
Facility	CBH Contracting	Files not meeting full threshold criteria: Credentialing Committee
FQHC	CBH Program Integrity	➡ Clean Files: CBH CMO ➡ Files not meeting full threshold criteria: Credentialing Committee

A facility can be subject to an announced, routine recredentialing review, at any time, within the recredentialing calendar year as determined by the Network Inclusion Status awarded at Credentialing Committee and at more frequent intervals as determined by emergent issues related to member quality of care.

The recredentialing of FQHCs involves the review of documentation including the PROMISe enrollment for each FQHC service location, appropriate and active licensure for each FQHC, and presence of approved status as an FQHC via review of the Notice of Grant Award and/or listing on HRSA.gov. When these elements have been verified, CBH Program Integrity staff visits each site location to ensure that the location is still active and accurately listed on the contract. FQHCs must be recredentialed on a cycle of no more than three years.

2.5. Independent Practitioners and Group Practices Initial Credentialing and Recredentialing

This section of the Manual applies to independent practitioners and group practices for which the initial and recredentialing review process will be conducted by CBH's Program Integrity Department.

2.5.1. Provider Responsibilities

Each new independent and group practitioner and BHC will be required to complete an on-line application prior to entering the CBH network of providers. See the **Initial Credentialing Application for Independent and Group Practitioners**.

Individual practitioners and members of group practices are required to submit information to the Council for Affordable Quality Healthcare (CAQH), Inc., CBH's contracted CVO. Additional information may be required to complete contracting for individual practitioners and/or group practices.

CBH-contracted group practices must notify CBH within five business days if any credentialed practitioner leaves the practice.

2.5.2. Delegation of Credentialing

As previously stated, CBH has contracted with an NCQA-certified CVO (CAQH) to assist in the primary source verification required to complete the credentialing of independent practitioners and group practice members, and to complete primary source verification of the information obtained. Specific information that is required and the methods that may be used to verify the information are provided later in this guide.

2.5.3. Written Delegation Agreement

CBH has a signed agreement with the CVO specifying the services to be provided, costs, and terms. This agreement defines those areas for which the contracted CVO is responsible. Any functions not specifically identified in the agreement will be completed by CBH.

The written delegation agreement provides for renewal terms and the ability to terminate the agreement both for cause and for convenience. The written delegation agreement also provides for remedies and consequences for failure to meet required timeframes and performance standards. These remedies may include, but are not limited to, discounted fees for the period being reviewed and/or termination of the written delegation agreement.

The written delegation agreement requires that the contracted CVO maintain its NCQA certification.

2.5.4. Initial Credentialing Timeline: 180 Days

CBH is committed to ensuring that credentialing decisions are made in a timely manner consistent with NCQA standards and industry best practices. To that end, CBH has adopted a timeline of a maximum of 180 days for the course of the initial credentialing process.

Upon receipt of a provider request to enter the CBH Network, the Program Integrity Department will send an initial credentialing letter and CBH attestation form to the provider via email. Per the letter, the provider will have two weeks from the date of the email to do the following:

➡ Complete an application and attest or re-attest with CAQH

➡ Return the signed CBH attestation to CBH

The 180-day timeline for the initial credentialing process begins when a scan of the signed and completed CBH attestation is received at CBH (email to **CBH.CredentialingContact@phila.gov**) and is completed with the Committee decision. Upon receipt of the attestation, CBH will submit the provider's CAQH number to CAQH for primary source verification (PSV). A summary of CAQH's PSV process will be presented to the CBH Credentialing Committee for a decision regarding the provider's application for network entry.

2.5.5. Use of Protected Health Information (PHI)

CBH does not expect the contracted CVO to encounter PHI. In the rare event when the contracted CVO does review or encounter PHI, the written delegation agreement stipulates that the contracted CVO will abide by the protections provided under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

2.5.6. Reporting

The contracted CVO will report to CBH, on an ongoing basis, the results of initial credentialing and recredentialing requests. The written agreements detail the timeframes for the CVO to submit reports to CBH based on priority requests for credentialing and recredentialing.

Aggregate reporting is not completed per the written delegation agreement.

2.5.7. Monitoring of Contracted CVO Performance

CBH Program Integrity will monitor the performance of the CVO annually and report on overall performance to the CBH Credentialing Committee. Monitoring will be completed by utilizing the following methods:

➡ **CBH provider feedback**: CBH conducts an annual provider satisfaction survey. This survey contains questions specific to program integrity and provider credentialing. Feedback will be solicited regarding the experience of individual practitioners and group practice members in working with the contracted CVO.

➡ **Annual review of the delegated credentialing process** (see below)

➡ **Feedback from CBH Program Integrity staff**: CBH Program Integrity staff responsible for credentialing and recredentialing independent practitioners and group practice members will be surveyed to gauge their experience with the contracted CVO, including any concerns about the practices of the contracted CVO.

2.5.8. Review of Delegated Credentialing Process

CBH Program Integrity will annually, at least one month prior to the renewal term of the written delegation agreement with the CVO, audit a sample of credentialing and recredentialing files completed by the CVO. The audit will be completed to ensure that all CBH, State, and NCQA standards are met. The review will also include a review of the CVO's NCQA status. The written agreement with the CVO clearly states that the CVO must maintain NCQA certification as a CVO for the agreement to remain valid.

CBH Program Integrity staff will review a sample of 5 percent or 50 files (whichever is less) completed by the CVO. CBH Program Integrity will randomly select the files to be reviewed. CBH Program Integrity will continue to randomly select files, in excess of the minimum stated above, if necessary, to ensure that the sample contains at least 10 credentialing and 10 recredentialing files in the sample.

When fewer than 10 practitioners or group practice members were credentialed or recredentialed, the entire universe of that review type will be audited.

The audit will also include a review of any changes to the CVO's policies and practices to ensure that all required elements continue to be verified appropriately.

The audit will be summarized in a report to the CBH Credentialing Committee and benchmarked against the current NCQA standards.

2.5.9. Opportunities for Improvement

Annually, CBH will report to the CBH Credentialing Committee on any potential opportunities to improve the credentialing and recredentialing process for independent and group practitioners. Information will be reviewed that will include feedback from providers based on their experience, CBH Program Integrity staff, and results from the annual report of the review of the delegation process described earlier.

2.5.10. Provider Credentialing Checklist

A practitioner credentialing summary is prepared for presentation to Credentialing Committee. The second page of the summary includes a credentialing checklist of all required primary source verification elements (See the **Initial Credentialing and Recredentialing Site Visit Checklist – Facilities** Appendix). The CBH Program Integrity reviewer will ensure that all required elements have been verified by the contracted CVO.

When complete, the reviewer and Director of Credentialing sign off by affixing dates and a signature to the checklist. The document is then included with copies of relevant credentialing information and the report(s) from the contracted CVO.

2.5.11. Criteria Utilized for Credentialing and Recredentialing

An application will be considered clean and thus presented to the CBH Chief Medical Officer for signature if it meets the following threshold criteria:

➡ A completed CAQH application and attestation

➡ Valid and active license

➡ Educational and work history meet the minimum requirements for the position

➡ Not excluded from participating in federally funded healthcare programs

➡ No malpractice claims and/or settlements on NPDB (For initial credentialing only. For recredentialing, any claims since the previous credentialing will render the application unclean, and the entire history will be reviewed.)

➡ No adverse license actions

➡ A signed CBH and/or CAQH attestation reporting the applicant is/has:

  » Free of illegal drug use

  » Able to perform essential functions

  » Free of previous adverse licensure action

  » No previous felony convictions

  » No prior loss of admission privileges or any other disciplinary actions

  » Verified and attested to malpractice coverage

  » Attested to the completeness and correctness of the application

An application that fails to meet any of the above threshold criteria is not rejected automatically; it will be presented to the CBH Credentialing Committee for discussion and credentialing decision.

2.5.12. Verification of Credentials

2.5.12.1. Licensure

Practitioners must hold an active and valid license appropriate for their specialty. This verification will be completed by the contracted CVO. The license verification is valid for 180 days or until the license expiration date, whichever occurs first. (There is an exception to licensure for certain certified art and music therapists.)

2.5.12.2. Drug Enforcement Administration certification (Physicians and Nurse Practitioners Only)

Physicians and Nurse Practitioners must hold active and valid Drug Enforcement Administration (DEA) certification in each state where the physician or nurse practitioner provides care to CBH members. This will be verified by the contracted

CVO. The DEA review is valid until the expiration date noted on the certificate and must be completed prior to a successful credentialing decision. CBH verifies that all DEA eligible practitioners who do not have a valid DEA certificate, and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf.

2.5.12.3. Education

All staff must meet the minimum acceptable education requirements for their respective positions. CBH will review the highest of the following three levels of education, as appropriate:

➡ Board Certification

➡ Residency

➡ Diploma/Transcript (for physicians, this must be from a medical school)

The contracted CVO will verify the appropriate level of education or training. The contracted CVO may utilize the following sources in verifying educational requirements:

➡ American Medical Association (AMA) Physician Masterfile

➡ American Osteopathic Association (AOA) Physician Profile Report/Masterfile

➡ Educational Commission for Foreign Medical Graduates (ECFMG) for internationally trained physicians licensed after 1986

While the verification of appropriate training and education has no expiration date, the verification must occur prior to a successful credentialing decision.

2.5.12.4. Board Certification

CBH requires that all physicians be board certified or board eligible (i.e., residency has been completed). Verification of active board certification or residency will be done by the contracted CVO. The contracted CVO may complete the verification via direct confirmation with the applicable specialty board and/or the state licensing body. When this is not possible, the contracted CVO may also utilize one of the following options:

➡ American Board of Medical Specialties (ABMS) or its member boards

➡ AMA Physician Masterfile

➡ AOA Physician Profile Report/Masterfile

➡ The institution where the residency was completed

Board certification verifications are valid for 180 days.

2.5.12.5. Work History/Experience

Each practitioner must ensure that their CVO application shows the minimum work experience required for their position as defined in the MRPPF. This must reflect the most recent 5 years of relevant work experience. If the practitioner has fewer than 5 years of experience, the time frame starts at the initial licensure date.

CBH Program Integrity staff will review the application to ensure that minimum experience requirements have been met for the position. In addition, if the application shows a gap in employment of 6 months or greater, a clarification of the gap is required in writing, directly from the practitioner.

Clean applications must reflect a description of the gap or be free of gaps in employment of 6 months or longer.

Verification of work history and experience is valid for 180 days.

The contracted CVO, acting on CBH's behalf, will directly query the National Practitioner Data Bank (NPDB) for any history of malpractice claims and/or settlements made against the practitioner. Clean applications must be free of any malpractice claims and/or settlements. The NPDB query related to malpractice history is valid for 180 days.

2.5.12.6. Sanctions

2.5.12.6.1. Medicare/Medicaid Exclusions

CBH Program Integrity will query the sources identified below monthly for current sanctions against the practitioner that would preclude their participation in a federally funded health care program: Federal System for Award Management (SAM), List of Excluded Individuals and Entities (LEIE), Pennsylvania Medicheck List, Social Security Death Master File (SSDMF), and National Plan and Provider Enumeration System (NPPES).

2.5.12.6.2. Other State Sanctions

The contracted CVO will obtain verification directly from the National Practitioner Data Bank (NPDB) and/or the State licensing board that the practitioner has no current or past restrictions on their license or state-imposed sanctions. The NPDB State licensing board query is valid for 180 days.

2.5.13. Practitioner Rights

2.5.13.1. Report of Information Obtained from Outside Sources

Providers are entitled to be informed of any information obtained from the following sources as it relates to their application/credentialing decisions:

➡ Federal or State Exclusion lists

➡ Licensing bodies

➡ Drug Enforcement Agency status verification

➡ Education entities/sources (schools, residency sites, universities, etc.)

➡ Board certification verification

➡ NPDB queries

➡ Insurance carriers (related to required coverage)

Applicants are not entitled to information:

➡ That may be involved in an ongoing law enforcement referral/investigation

➡ From personal references/recommendations

➡ That is protected by peer-review stipulations

2.5.13.2. Ability to Correct Erroneous Information or Deficiencies

When able, CBH will notify practitioners of excluding information. The practitioner may correct any information believed to be erroneous, or deficient. The credentialing process timeline will not be extended to allow for correction of erroneous information.

If erroneous information or deficiencies are discovered in CAQH or other credentialing materials in advance of their presentation to the Credentialing Committee, providers will be notified by phone and/or email to address the discrepancies within 5 business days of the findings. Providers will then have 5 business days to correct the erroneous information or deficiency by providing the correct information to CAQH via CAQH ProView and/or by PDF scan via email to CBH (**CBH.CredentialingContact@phila.gov**), as indicated by CBH. Unresolved discrepancies will be presented to the Credentialing Committee for discussion and decision-making.

2.5.13.3. Application Status Updates

Practitioners may request, at any point in the credentialing process, an update on the status of their application. CBH will respond to the provider within 5 business days with an update of what stage the credentialing application is in. The stages are as follows: additional information needed from provider, awaiting rostering to CAQH, rostered to CAQH, or PSV returned from CAQH is awaiting review and Committee and/or CMO approval.

Clean applications (see **Definitions Appendix**) are reviewed and approved by the CBH CMO or designee. The Credentialing Committee is made aware of approvals, granted by the CMO, since the last Committee meeting.

2.5.13.4. Dates and Timeframes

A practitioner is considered to be credentialed as of the Credentialing Committee or CMO decision date. This date will be reflected on a decision signature sheet which will be retained by the CBH Program Integrity Department. The standard credentialing duration for independent practitioners and group practices is 2 years.

2.5.13.5. Monitoring and Quality Assurance Activities

CBH monitors in-network independent practitioners using the following criteria and time frames:

➡ Exclusion from Medicare/Medicaid programs (every 30 days)

➡ Request information from CBH Quality Management regarding complaints and significant incidents (semi-annually)

CBH Program Integrity staff will ensure that exclusion list reviews are completed on all contracted practitioners at least every 30 days to meet requirements related to screening for exclusions.

Practitioner complaints will be triaged through CBH Quality Management (QM). QM will notify CBH Program Integrity of any complaints made against a contracted practitioner or member(s) of a group practice. Any practitioner who receives 6 or more complaints in a 6-month timeframe will be subject to an internal Provider Teaming consistent with CBH's Oversight and Monitoring policy. The teaming group will decide on appropriate next steps that could include, but are not limited to, the following:

➡ Practitioner meeting with leadership team

➡ Closure to new admissions

➡ On-site monitoring or compliance audit

Adverse events will also be reported through CBH QM via the Procedures for Response, Reporting, and Monitoring of Significant Incident Policy. Adverse event checks will be limited to high-volume providers. A high-volume provider is defined as any practitioner or group practice providing services to 500 or more unique CBH members per calendar year. Any high-volume practitioner with a confirmed adverse event occurring with a CBH member is also subject to a provider teaming as described above.

In the absence of reported adverse events and/or complaints, CBH Program Integrity will request confirmation from CBH QM at least every 6 months.

Adverse events and complaints and confirmation requests will be tracked by CBH Quality Management as described in the CBH Procedures for Response, Reporting, and Monitoring of Significant Incident Policy.

When a teaming or recredentialing visit reveals evidence of substandard quality of care that could potentially impact the health and safety of our members, sanctions and interventions will be utilized to correct the behavior(s) and to ensure the safety of our members. These sanctions and interventions can range from provider meetings to the termination of the provider agreement.

2.5.13.6. Timely Access to Care Monitoring and Reporting

CBH is responsible for ensuring that members have adequate access to in-network providers who can meet their behavioral health needs. The provider network must provide face-to-face treatment intervention, including substance use disorder (SUD) treatment, for all members within one hour for emergencies, within 24 hours for urgent situations, and within seven days for routine appointments and specialty referrals (**HealthChoices Program Standards and Requirements**, II-5 (F)). CBH is also required to have a notification process in place for providers to report inability to offer an appointment within the timely access standards.

In order to monitor timely access of outpatient services, CBH requires all in-network mental health outpatient (MHOP) and SUD outpatient providers (SUD OP) report on appointment availability and timeframes on a monthly basis by completing the Outpatient Provider Access Survey through Quickbase. CBH monitors the accuracy of monthly Outpatient Provider Access Survey submissions by completing secret shopper calls on a regular basis. All in-network MHOP and SUD OP providers receive a phone call from an unidentified caller asking about appointment availability and providers' responses are compared to recent monthly survey submissions.

Providers who are identified as out of compliance with timely access standards and have reported meeting the timely access standards through the monthly survey are required to complete a root cause analysis (RCA) describing the misreporting of timely access and detailing any action steps to ensure accurate reporting occurs in the future. Questions about this initiative may be directed to the assigned CBH Provider Network Access Specialist.

All in-network providers must report any time they are unable to ensure timely access for new referrals or deliver care within the applicable timeframe, including when there are waitlists and when they are not accepting new CBH members. This applies to all levels of care. In-network providers are required to submit written notice to their assigned CBH Provider Relations Representative and Provider Network Access Specialist by completing the **Provider Operations Change Form**. The submission must include a corrective action plan (CAP) focused on meeting timely access standards. This form collects information about service locations affected, effective and target dates, persons responsible for monitoring plans, and allows for an upload of the required supporting documentation on official company letterhead which must include details around the barriers to access as well as the detailed plan for reconciling the barriers.

CBH utilizes this information as a monitoring process to ensure member access to needed behavioral health services. CBH monitors provider compliance with this requirement through member complaints and grievances, the annual

Member Satisfaction Survey, the monthly Outpatient Access Survey, secret shopper, provider reports, and overall utilization and referral trends. If a provider temporarily or permanently ceases providing services under the CBH Provider Agreement, it is considered an Event of Default under VI(B)(1) of the CBH Provider Agreement.

2.5.13.7. Notification to Authorities

CBH Program Integrity is responsible for notification of concerns related to overall quality of care and for potential instances of fraud, waste, and abuse (FWA) within our contracted providers. In addition to the notification of appropriate oversight and enforcement agencies, CBH has a range of actions available to assist providers in improving their performance.

2.5.13.8. Available Actions to Assist Practitioners

When a practitioner is identified as having problematic practices that could impact clinical services, many interventions may be utilized to improve the provider's performance and to ensure the health and safety of our members. These include, but are not limited to:

- Participation in trainings offered by CBH Provider Training and Development

- Participation in training offered by CBH Program Integrity (related to FWA)

- Corrective action or quality improvement plan

- Directed corrective action plan

- On-site monitoring by CBH staff

- Clinical chart audits

- Admission closures

2.5.13.9. Reporting to Oversight and Enforcement Agencies

CBH Program Integrity will report any potential instances of fraud, waste, and/or abuse to both the Pennsylvania Bureau of Program Integrity (BPI) and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section (OAG MFCS). Reporting is completed by the CBH Program Integrity Clinical Audit Team (CAT).

In addition, should CBH Program Integrity become aware of any of the following actions, not previously reflected in the National Practitioner Data Bank (NPDB), CBH Program Integrity will make a direct report to the NPDB and/or other entities. Actions include:

- Medical malpractice payments

- Federal and state licensure and certification actions

- Adverse clinical privileges actions

- Adverse professional society membership actions

- Negative actions or findings by private accreditation organizations and peer review organizations

- Health care-related criminal convictions and civil judgments where CBH is a party

➡ Exclusions from participation in a federal or state health care program (including Medicare and Medicaid exclusions)

➡ Other adjudicated actions or decisions

In instances when a practitioner's provision of care raises immediate safety concerns for members and the provider is not willing or able to participate in remedial activities to improve the provision of care, the practitioner's licensing body will be notified. The CBH CMO will be responsible for designating staff to complete these referrals. Examples could include, but are not limited to:

➡ Engaging in dangerous prescribing practices

➡ Engaging in inappropriate relationships with members

➡ Practicing without appropriate training or education

➡ Practicing with an expired or suspended license

➡ Providing treatment outside of the appropriate scope of practice for the individual

2.6. Facilities: Initial Credentialing and Recredentialing

2.6.1. Facilities: Initial Credentialing

This section of the Manual applies to parent organization and facilities for which the review process is conducted by the CBH Provider Operations Department. See examples of facility types in the **Definitions Appendix**.

2.6.2. Network Entry

Parent organizations will be invited to join the CBH Provider Network consistent with the CBH Network Entry policy (link forthcoming). Parent organizations currently contracted with CBH may expand the scope of their services (to include the addition of new facilities) per the process outlined in the Network Adequacy and Service Expansion Policy. An organization or facility will be considered a network provider after the successful completion of the initial credentialing process, approval by the CBH Credentialing Committee, and contracting of the facility (i.e., signing of a Provider Agreement and/or issuance of a Schedule A).

2.6.3. Initiation of Initial Credentialing

The initial credentialing review process is initiated when a facility is licensed/approved and enrolled in the Pennsylvania Medicaid program. For new programs, CBH may provide technical assistance regarding the initial credentialing process prior to licensure. This may include a review of credentialing requirements with providers in advance of formal initiation of the credentialing process. The provision of technical assistance will typically occur for new programs that are entering the CBH Network via a procurement process.

CBH will convene a meeting with a facility to initiate the initial credentialing process. At a minimum, provider agency representatives and the CBH Provider Operations initial credentialing team will participate in the meeting. Other CBH departments (e.g., Clinical Management, Quality Management, Program Integrity) will be invited to participate as ad hoc members of the credentialing team. The facility meeting will be used to review the CBH credentialing and contracting process and will include a discussion of all required documentation necessary for facility credentialing.

Following the provider meeting, CBH Provider Contracting will send the facility written correspondence summarizing the initial credentialing process. Included in the correspondence will be a list of documents required for initial credentialing. The correspondence will also include a timeline for the initial credentialing process, identify the CBH initial credentialing team leader, and will explicitly state that the credentialing process must be completed within 180 days of the date of the letter.

2.6.4. Initial Credentialing Review Process

There are four components of the initial credentialing review process: review of business documents, review of staff files, review of policies and procedures, and a facility site visit.

2.6.5. Coordination of the Initial Credentialing Process

The CBH Provider Operations Department is responsible for the initial credentialing of facilities. Each initial credentialing request will be assigned to a team of Provider Operations staff to include representatives from the Provider Contracting, Provider Training and Development, and/or Provider Relations units. Provider Operations representation will vary depending on the avenue of network entry as defined by the Network Entry Policy and the Network Adequacy and Access Policy.

A CBH Provider Operations staff member will be identified as the team lead for both internal and external coordination related to initial credentialing of facilities. The team lead will be the primary point of contact for the agency/facility and will be responsible for coordinating internal review. The CBH team lead will be noted on the correspondence sent to the provider at the initiation of the initial credentialing process as noted above.

2.6.6. Business Documents

Required business documents are outlined in the Appendices of the Manual. For parent organizations new to the CBH Network, all documents on the list are required. For existing network parent organizations, only documents listed in the Facility-related Appendices are required. Submission of all documents is required to complete the initial credentialing process.

CBH Provider Contracting staff will complete the review of the business documents.

2.6.7. Staff Files

All facilities must complete and submit a completed staff roster and job descriptions for each position listed on the roster. For new facilities, all staff positions must be listed on the staff roster regardless of whether they are filled at the time of the initial credentialing review. Additionally, facilities must maintain staff files for each staff person on the roster with the documents outlined in the Appendices.

Individual staff files do not need to be submitted to CBH for the initial credentialing review. Facilities will be required to sign an attestation confirming that all staff files are complete and maintained consistent with the parameters outlined in the MRPPF. However, CBH reserves the right to request and review staff files as part of the initial credentialing review.

Facilities requesting waivers of any staff requirements must do so during the initial credentialing process. State and federal requirements cannot be waived by CBH.

CBH Provider Contracting staff will complete the review of the provider staff file submissions.

2.6.8. Policies and Procedures

Parent organizations and facilities are required to submit the policies and procedures outlined in the Appendices. Policies will be reviewed consistent with the standards specified in the Appendices. All policies must be reviewed and approved by CBH in order for a provider to complete the initial credentialing process.

Some policy requirements for facility credentialing may be waived if a required policy has been approved for the agency/parent organization or if the required policy is not applicable to the facility program type. For example, submission of medication management policies may not be required for programs that do not offer medication prescription and medication management.

Required policies and procedures will be reviewed with the provider agency representatives at the initial credentialing meeting. The correspondence sent to the provider following the meeting will document all required policies.

CBH Network Management staff will complete the review of the facility policies and procedures.

2.6.9. Site Visit

A site visit will be conducted at the facility as a component part of the initial credentialing process. Visits will occur for both accredited and non-accredited organizations. All CBH Provider Operations staff involved in the initial credentialing process will be invited to participate. Staff from other CBH departments will be invited to participate as indicated or requested.

The primary focus of the site visit will be to tour the facility to ensure there is an adequate treatment/service environment for CBH members (see Appendices for Site Visit Tool). Visits will not include an extensive physical plant inspection; however, site visits may coincide with the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) or the Pennsylvania Department of Drug and Alcohol Programs (DDAP) licensing visits for new programs or facilities. If the visit is not held in conjunction with the licensing visit, any observed physical plant issues that may impact member health and safety will be reported to the responsible licensing entity.

If providers have not submitted comprehensive initial credentialing documentation prior to the time of the site visit, CBH will request that any missing documentation be available for on-site review during the visits. Additionally, CBH may utilize the site visit as an exit meeting for the initial credentialing process, including discussion of any pending items related to the credentialing process.

The date and outcome of the site visit will be documented in the initial credentialing exit letter and the Credentialing Committee Summary.

2.6.10. Application Status Updates

The CBH Provider Contracting unit is responsible for tracking all initial credentialing requests. For each credentialing request, Provider Contracting will track the date of initiation of the initial credentialing process, the completion date of each phase of the process (i.e., business document, staff file and policy review, site visit), and the scheduled date of the Credentialing Committee presentation. Providers and DBH and CBH stakeholders may request a status update for any pending initial credentialing review.

2.6.11. Credentialing Committee Review

If a facility has not met initial credentialing threshold requirements 60 days in advance of the end of the 180-day review period, Provider Contracting will forward the agency a letter outlining the areas of deficiency. The letter will state that all missing documentation will need to be submitted by the 180-day deadline. If the initial credentialing process is still incomplete at the end of the 180-day review period, the facility application will be considered to not meet threshold

requirements and will be presented at the next scheduled Credentialing Committee for review. The provider will be notified of the decision of the Committee in writing within 60 days of the meeting date. For negative decisions, providers will have the right to register an appeal consistent with the Appeal/Cure process outlined in this chapter.

Once a facility has met the initial credentialing thresholds outlined in the Initial Credentialing Review section, Provider Contracting will forward the provider an initial credentialing exit letter. The letter will summarize the outcome of the initial credentialing process and will specify the date the facility will be reviewed by the Chief Medical Officer. At this juncture, the facility's request to enter the Network will be considered a clean application.

Provider Contracting will be responsible for preparing a Credentialing Committee Summary for each clean facility application which will be presented to the Chief Medical Officer for review and approval. Information outlined in the initial credentialing exit letter may be included in the Credentialing Committee Summary. All facilities presented to the Chief Medical Officer for initial credentialing will be recommended for a one-year credentialing status. Facilities that present unclean files will be presented to the Credentialing Committee for review.

2.6.12. Contracting

Following approval by the CBH Credentialing Committee, CBH Provider Contracting will be responsible for generating a contract for the credentialed facility. The contract will include a Provider Agreement (for new agencies/organizations entering the Network) and a CBH Schedule A (see **Definitions Appendix**), which will allow the provider to submit claims for the services provided at the newly credentialed facility.

For parent organizations new to the CBH Provider Network, A CBH Provider Agreement must be signed by both the organization and CBH prior to a contract being issued for the facility. Once the signed CBH Provider Agreement has been received, Provider Contracting will generate a Schedule A for the facility effective the date of the Credentialing Committee approval.

For existing parent organizations, CBH Provider Contracting will generate a Schedule A for the service(s) effective the date of the Credentialing Committee approval. The CBH Provider Relations Representative will email an original copy of the Schedule A to the agency/parent organization with a cover letter specifying the credentialing status.

Contracting correspondence will be sent to an agency within 30 days of the Credentialing Committee decisions.

2.6.13. Expansion of Services

In the event that providers are interested in expanding their services, they should submit the following:

➡ Letterhead formal request addressed to CBH CPO (including explanation of the need for services) (data should support the need)

➡ Budget

➡ Service Description

Request should be submitted to Provider Representative. If approved, provider will be notified and CBH will follow the credentialing process. If denied, provider will be notified.

2.6.14. Record Keeping

The initial credentialing file will consist of all documents reviewed during the initial credentialing review process (i.e., business documents, staff records, and policies and procedures) as well as the initial credentialing exit letter, the Credentialing Committee summary, and the letter notifying the provider of the Credentialing Committee status. If the

Credentialing Committee issues a negative decision, documentation of the Committee decision will also be included in the file. A tracking spreadsheet will be used to capture provider's license status, accreditation status, the date of CBH visit, and the date of approval from the Credentialing Committee.

Initial credentialing files will be maintained consistent with the parameters outlined in the Confidentiality and Storage of Records section of this chapter.

2.6.15. Recredentialing Process

The recredentialing of facilities is completed by CBH Provider Contracting in collaboration with CBH's Credentialing Committee. CBH seeks to reduce the cumulative number of site visits for providers. Recredentialing visits will occur for all IBHS-ABA providers and non-accredited facilities at intervals not to exceed three years. The criteria required for recredentialing include a site visit conducted by a CBH Provider Contracting Specialist and review of personnel files, business documents, policies, and procedures.

The length of review interval is determined by the recredentialing status a provider receives based on the CBH Credentialing Committee process. In the event a quality concern is identified by the CBH Contracting Specialist during the process, a quality improvement (QI) activity will be documented. After reviewing documentation, status recommendations are presented and approved by the Credentialing Committee, CBH Contracting will send a letter to the provider indicating the recredentialing status determination, by level of care, for the organization.

2.7. Applicable Documents

Please see the following linked documents:

➡ **Initial Credentialing Application for Independent and Group Practitioners**

➡ **Manual for Review of Provider Personnel Files (MRPPF) 2.8**

3. AUTHORIZATIONS

3.1. Overview

This chapter describes the procedures providers must follow to obtain authorizations for treatment of CBH members. Coordinating member care is at the core of the managed care concept. Authorizing services enables the managed care organization to have knowledge of the needs of its members, the capacities of its provider network, and the extent of its fiscal responsibilities.

The authorization process involves the following steps being completed by the provider:

➡ Verifying the individual is CBH-eligible and has no other forms of primary insurance

➡ Verifying the individual is eligible for the services requested

➡ Assessing the needs of members using medical necessity criteria (MNC) or guidelines (MNG)

➡ Submitting request for authorization based on MNC/MNG

➡ Obtaining the initial authorization to begin treatment

➡ Assessing progress or service utilization through concurrent reviews, as needed, for continued authorization

CBH follows Appendix AA (Department of Human Services Prior Authorization Requirements for Participating Behavioral Health Managed Care Organizations [BH-MCO] in the HealthChoices Program) of the **HealthChoices Program Standards and Requirements** (PSR) when determining services that require prior authorization. CBH reserves the right to require prior authorizations for levels of care not outlined in Appendix AA and will seek approval from the Pennsylvania Department of Human Services (PA-DHS).

CBH utilizes the Commonwealth of Pennsylvania's Medical Necessity Criteria (**Appendices S and T**), **American Society of Addiction Medicine** (ASAM), and State-approved MNC (for services not outlined in the PSR as noted above) in determining service authorizations. These criteria ensure that:

➡ Treatment services are based upon medical necessity and member need

➡ Care is provided in the most appropriate and least restrictive setting

➡ Authorizations are standardized, coordinated, and expedited

➡ Costs are controlled

All **CBH Medical Necessity Criteria** can be found on the CBH website.

3.2. Types of Services

3.2.1. Emergency Services

Services needed to evaluate or stabilize an Emergency psychiatric medical condition that are delivered by a provider qualified to furnish such services under the Medical Assistance Program. CBH does not require precertification or prior

authorization for emergency services, which include presentation to a Crisis Response Center, Drug and Alcohol Assessment Center, or Emergency Room.

3.2.2. Urgent Requests

Requests for acute services which due to the Member's psychological state could seriously jeopardize the life, health, or safety of the member or others. Under reasonable standards, a determination for care would be made within a 24-hour period and if left untreated, could rapidly become a crisis or emergency situation. An urgent request also includes when a Member's discharge from a hospital will be delayed until services are approved or a Member's ability to avoid hospitalization depends upon prompt approval of services.

3.2.3. Non-Urgent Requests

Request for non-acute services where the decision-making timeframe does not adversely affect the health of the member or the member's ability to regain maximum function and would not subject the member to severe distress or decompensation.

3.3. Eligibility

To ensure appropriate payment for services, providers should establish protocols for determining eligibility before providing services. Providers can determine an individual's eligibility for CBH-funded behavioral health services through the **PROMISe™ Eligibility Verification System (EVS)** by calling 1-800-766-5387 or visiting the linked portal. For uninsured members or members whose primary insurance is not CBH, please see the **related section** below.

3.4. Types of Authorizations and Related Processes

Authorization numbers are required for payment. There are three types of authorization categories and related processes as listed below (see also the **Utilization Review Care Coordination Grid**).

3.4.1. Blanket Authorization Number (BAN)

BAN services *can* begin without prior authorization and may be emergency or non-urgent services. Providers should refer to the Schedule A corresponding to the service when filing claims using the appropriate BAN.

3.4.2. Registration

Registration authorizations are provided for some non-urgent services. Registration services below can begin without prior authorization but require a member-specific authorization number for payment. Providers obtain this authorization number by faxing a Service Request Form (see **Service Request Form Appendix**) to the CBH Operational Support Services (OSS) unit at 215-413-7683 within 90 days of the start of service delivery. Please see the **Authorization Guidelines section** below for a list of services that can begin without prior approval and require a specific authorization number for payment.

3.4.3. Prior Authorizations

Prior authorizations are required for all urgent services (except Acute Inpatient (AIP), 23 Hour Bed, Crisis Stabilization Unit (CSU), and Withdrawal Management services) and some non-urgent services. They are services that cannot be rendered without being approved ahead of time and apply to requests for initial and continued treatment. Prior authorizations for urgent services are completed telephonically using the PES template (see **PES Prior Authorization Template Appendix**), and CBH issues prior authorizations in these cases within 24 hours. Authorization is time-limited, thus necessitating a concurrent review to continue treatment. Providers request prior authorizations through the PES line

(when no other service is in place, or the service is requested outside of normal business hours) or through the assigned clinical care manager (CCM) (for all concurrent reviews and/or when another service is already in place). Providers request prior authorizations telephonically using the PES template, via faxed or uploaded packets including comprehensive biopsychosocial evaluations/re-evaluations (see **CBE/R Appendix**), via faxed or uploaded Intensive Behavioral Health Services (IBHS) Written Order Forms, or through submission of a Service Request form to OSS (see authorization guidelines below). The requesting provider shall make good faith efforts to inform the member of the outcome of the prior authorization process. The provider shall document all attempts to inform the member, and documented failure by the provider to inform the member shall not be grounds for sanctions.

3.4.3.1. No Prior Authorization for Emergency Inpatient Admissions

To align with Appendix AA of the PSR, CBH no longer prior authorizes AIP, 23-Hour Bed, CSU, or Withdrawal Management services. When a physician has evaluated a member and determined that they meet Medical Necessity Criteria for AIP treatment, CSU, or a 23 Hour Bed, the requesting provider will contact the Psychiatric Emergency Services (PES) line at CBH and provide the following information:

➡ Living Situation

➡ Special Needs (significant medical issues, intellectual disability, etc.)

➡ Presenting Problem/302 Statement

➡ Mental Status Examination (MSE)

➡ Urine Drug Screen (UDS) results and substance use pattern as applicable

➡ Diagnosis

When a physician has evaluated a member and determined that they meet medical necessity criteria for withdrawal management services, the requesting provider will contact the PES line and provide the following information:

➡ Presenting Problem

➡ ASAM Dimensions 1-6

  » Dimension 1: Acute intoxication and/or withdrawal potential
  Exploring and assessing the current and past use of substances, as well as the history of withdrawal, including any withdrawal assessment scores and laboratory results

  » Dimension 2: Biomedical conditions and complications
  Exploring a person's medical needs and health history

  » Dimension 3: Emotional, behavioral, or cognitive conditions and complications
  Including any active psychiatric symptoms, psychiatric history, and trauma-related needs

  » Dimension 4: Readiness to change
  Determining a person's willingness and readiness to change their substance use

  » Dimension 5: Relapse, continued use, or continued problem potential
  Assessing a person's individual needs influencing their relapse potential, including relapse history

> » Dimension 6: Recovery environment
> *Assessing how a person's living situation can help or hinder recovery efforts*

➡ Documented conversation of medication-assisted treatment (MAT) with member

➡ Assessment completed (including credentials) with the level of care requested

The PES line will then approve five days of withdrawal management and the accepting provider can contact PES within 24 hours for the authorization number.

3.4.3.1.1. Adult

If the member is age 18 and over and has received treatment in an acute service within the past 30 days, the member will be approved for three days of initial AIP treatment.

If the member is age 18 and over and has not received treatment in an acute service within the past 30 days, the member will be approved for five days of initial AIP treatment.

➡ Services impacting the default length of initial authorization include AIP, Subacute Inpatient (SAIP), Extended Acute Care (EAC), Crisis Residence, 4WM, 4, 3.7WM, 3.5, 3.1

3.4.3.1.2. Child

If the member is age 17 and under, they will be approved for five days of initial AIP treatment.

3.4.3.2. Approvals

If the member meets MNC, CBH staff will authorize the level of care, amount and length of time (i.e., number of days/units). If the requesting provider is not the admitting provider, the admitting facility must contact CBH to obtain the authorization number. When a member is prior authorized for an urgent level of care, the admitting provider has 24 hours to notify CBH of a member's admission. If CBH is not contacted within 24 hours, the authorization will begin the date CBH is notified, and authorization will be generated to match the last covered day anticipated at the time of precertification. See service-specific exceptions below.

3.4.3.3. Denials

CBH authorization decisions are made based on eligibility criteria and Medical Necessity Criteria as approved by the Commonwealth of Pennsylvania. CBH does not reward or provide any form of incentive to physician advisers for issuing denial of services. CBH does not reward or provide any form of incentive to clinical management staff to make decisions that result in underutilization of benefits.

In alignment with the HealthChoices Behavioral Health Program's updated **Program Standards and Requirements (PSR) – Primary Contractor**, prior to issuing a denial based on medical necessity criteria for a member under 21 years of age, CBH must make a reasonable effort to consult with the prescriber. This effort must include a request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact CBH. CBH uses its **insufficient information process** to satisfy this requirement.

3.4.3.3.1. Peer-to-Peer Review

When CBH makes the decision to deny a request for any service requiring prior authorization, the CCM will verbally or electronically notify providers of the denial and offer an opportunity for a peer-to-peer review (between attending or licensed evaluating psychologist and the attending CBH physician or licensed psychologist reviewer). A provider may

designate another licensed member of the provider's affiliated or employed clinical staff with knowledge of the member's condition and the requested service as a qualified proxy for purposes of completing a peer-to-peer discussion.

If the member files a grievance, a peer-to-peer review discussion is available until the grievance hearing occurs. If the member does not file a grievance, providers have the opportunity for a peer-to-peer review within 24 hours of the notification for levels of care requested telephonically or by 2 p.m. the next business day for levels of care requested via written documentation (e.g., IBHS, RTF). See service-specific exceptions below.

3.4.3.3.2. Insufficient Information

3.4.3.3.2.1. Bed-Based Services

If the CCM does not have all of the components necessary to make a medical necessity decision (approval or denial), the CCM will notify the provider verbally, detailing which components are missing and allow the provider 24 hours to respond with missing information. The request is marked insufficient until the end of the 24-hour decision-making period from the time of the request or the missing information is received, whichever comes first.

If the provider submits the missing documents within the requested time frame, the CCM will review the request for medical necessity. If the provider fails to submit the missing documents, CBH will deny the request.

3.4.3.3.2.2. Community-Based Services

If the CCM does not have all components necessary to make a medical necessity decision (approval or denial), the CCM must notify the provider within 48 hours of the request for service(s) and relay which components are missing or deficient. The CCM will also generate an Insufficient Notice for member and provider detailing which components are missing and allow the provider 14 calendar days to send missing documents.

If the provider submits the missing documents within the requested time frame, the CCM will review the request for medical necessity. If the provider fails to submit the missing documents, CBH will deny the request.

3.4.3.4. Authorization Errors

For authorization errors, the provider must follow the Authorization Correction Protocol for the respective service line. For some services, the provider must submit a **CBH Authorization Correction Form** to the Operations Support Services Coordinator within 30 days of the date of service. Providers will receive the corrected authorization number via an Authorization Letter or Report within four weeks of the date of submission. In the event that an authorization number cannot be corrected as requested, the provider will receive a CBH Outpatient Feedback Form notifying the provider of such.

For community-based levels of care (e.g., IBHS) providers should notify their assigned Clinical Care Manager of any authorization errors or questions. This can be done via telephone or email and providers are encouraged to carefully examine every Outcome Notification Grid for accuracy and alignment with requested services upon receipt. All requests for authorization corrections should be submitted within 30 days of the date of service at the latest. CCMs have the authority to review and correct any true authorization errors made by CBH Staff. It is not considered an Authorization Correction if the error was made by the provider, licensed prescriber, or administrative staff of the provider. CBH will not issue corrections in these cases.

Requests for authorizations that are submitted more than 30 days after the date of service will be referred to the Claims department and are not guaranteed for payment. The request must contain the CBH Authorization Correction Form and a cover letter that details the nature of the authorization error, the attempts made to get the authorization corrected and the reason the request is being submitted past 30 days. The provider will receive a written decision within four weeks of the date of submission of request. Any Authorization Correction Forms that are incorrectly completed or illegible will be sent back to the provider without review.

3.4.3.5. Retrospective Review

All services for which prior authorization have been suspended will be subject to retrospective review for medical necessity by CBH and the Bureau of Program Integrity in the Department of Human Services. In alignment with **HealthChoices Program Standards and Requirements** (PSR), the process below describes a procedure for CBH Clinical Management staff to complete a retrospective review of the Medical Necessity Criteria (MNC) for a clinical service that did not require prior authorization:

➡ A CCM identifies a case that does not appear to meet MNC for admission and warrants a retrospective review.

➡ The CCM reviews the case with a Physician Advisor (PA). If the PA is in agreement, the CCM submits a chart request letter to the provider via secure email.

➡ When the CCM receives the requested information, they will review the MNC for the level of care, complete a MNC chart review, and discuss with a PA.

➡ After the chart reviews are completed, the CCM will forward a response letter to the Provider with feedback about the outcome of the review (See **Provider Bulletin 22-19: Retrospective Review**).

3.5. Authorizations for Philadelphia Residents Who are Uninsured or Have CBH Secondary

Philadelphia County/OMH/BHSI are responsible for ensuring that individuals in Philadelphia County who are uninsured receive mental health and substance use services. CBH assists providers in obtaining prior authorization for acute psychiatric services. Providers should contact BHSI and OMH for authorization requests for other levels of care.

3.5.1. Uninsured Philadelphia Residents – Acute Psychiatric Services

Providers seeking acute psychiatric services for uninsured individuals should follow the process below:

1. Verify Philadelphia residency through review of one or more of the following: utility bill, social security card, photo identification, etc. in anticipation of CBH requesting this information.

   ➡ If an individual is not a Philadelphia resident and is presenting for voluntary admission, refer to the respective office of mental health for funding.

   ➡ If an individual is not a Philadelphia resident and is presenting for involuntary admission, contact PES and use the Preadmission form during the phone call.

   ➡ If an individual is a Philadelphia resident, the provider physician must assess for MNC for the acute inpatient psychiatric services.

   » If the assessing psychiatrist believes MNC is met, contact PES and use the Preadmission form during the phone call.

2. The Office of Behavioral Health (OBH) expects the provider to take primary responsibility for assisting the member with the Medical Assistance application process and retaining the following documentation:

   ➡ Member liability determination standards as outlined by DBHIDS

➡ Medical Assistance application

➡ Documentation of approval or rejection.

　　» To be approved for county funding, the individual must be rejected for reasons other than excessive income, insufficient information, or other non-medical reasons.

If an individual is determined to be financially liable, the hospital must make collection arrangements with the individual. Collected funds must be deducted from any request for county reimbursement. Verification of an exhaustive collection effort must include proof that the delinquent payment was submitted to a collector and credit bureau for credit reference. Please note that county funding will not be available to reimburse inpatient stays for individuals who have used their annual or lifetime benefits from other third parties.

3.5.2. Authorizations When CBH is Not Primary

For services requiring prior authorization, the following procedure applies:

➡ If a member presents with primary insurance and an approval for services, CBH will request a copy of the approval letter.

➡ CBH will match any authorized services at the same frequency and duration as the primary insurer, for which CBH is secondary payor.

➡ CBH will not render a separate decision of medical necessity, nor is an authorization packet necessary when services are authorized through TPL. Please refer to 96-195 Third Party Liability for Clinical Management Policy.

➡ CBH will only review cases as primary payor for medical necessity if:

　　» The member has exhausted their straight Medicare days.

　　» The member's primary insurer denies services.

　　　• Provider must complete denial process prior to contacting CBH for a medical necessity determination.

　　» The service being requested is not a covered benefit under the member's primary insurance coverage as evidenced by the Explanation of Benefits (EOB).

　　» The member has exhausted their annual benefit limit and the provider has received a denial or non-authorization due to meeting the "cap."

　　» As soon as the provider is aware that an annual benefit limit has been exhausted and the provider wishes for CBH to become primary payor, the provider should follow standard prior authorization procedures.

➡ If none of the three scenarios described are applicable, CBH will not review for medical necessity.

　　» The treating provider will contact CBH only to inform that the member has been admitted and how many straight Medicare days the member has remaining.

» If the number of straight Medicare days cannot be confirmed by a provider due to it being a weekend or holiday, the provider will verify the number of days remaining on the next business day and contact CBH with this information.

» Clinical management will document this in CBH's clinical information system, but no authorization will be generated, no clinical information is required, and no concurrent reviews are completed.

» Discharge information is provided to Clinical management and the information will be entered within one business day.

- Clinical management will then generate an authorization to cover the member's stay in treatment as long as the member's primary insurance coverage remains active.

- If any dates are not covered by the member's primary insurer, Clinical management will ask the provider to submit the member's chart for a retroactive appeal.

➡ If a member's primary insurance coverage is active and a provider wishes to request a service that is not a part of the primary benefit plan, the provider may contact CBH to review for medical necessity.

➡ When a provider requests that CBH become the primary funder for a member's treatment, CBH makes a medical necessity determination on the date the request is made.

Also see the CBH Provider Notice dated December 6, 2018 (amended December 20, 2018), "CBH as Primary Insurance for Select Drug and Alcohol Services."

3.6. Out-of-Network and Out-of-Area Services

CBH works to maintain a robust provider network. If an in-network provider cannot meet the clinical needs of a member, an out-of-network (OON) provider may be considered. Criteria for a member to receive services from an OON provider:

1. Temporary for continuity of care for members who are relocating outside of the Philadelphia area (where there is no in-network availability) to allow for change to Medicaid enrollment in the county of new residence.

2. A newly enrolled member who is receiving services at the time of enrollment from an OON provider.

3. CBH member has Medicare as primary insurance and is receiving services from an out-of-network provider who is billing CBH as secondary.

4. Children and adolescents under the care and supervision of the Philadelphia Department of Human Services (DHS), who are living in substitute care placements in Pennsylvania where no in-network provider is available.

5. If an in-network provider is unable to provide a medically necessary service within the timely access standards.

6. There is no in-network provider who has the unique clinical specialty needed to deliver the identified service.

7. The member has an emergent clinical need for services outside of Philadelphia County.

8. The member's health would be threatened by requiring the member to transfer to an in-network provider.

CBH will approve and reimburse out-of-network medically necessary behavioral health services provided to members when there is a demonstrated need for the service. Providers should review and complete the **Out-of-Network Provider Application**, which includes an attestation that all information submitted is accurate and the organization agrees to comply with all stipulations outlined in the attestation. This application should be submitted to Provider Contracting. Providers should also complete the Out of Network (OON) Request Form (see the **OON Form Appendix**) and submit it to the CBH Clinical Management team of the requested service type (e.g., IBHS, IBHS-ABA).

3.7. Request for Continued Service/Extended Authorization

Requests for continued services for all other levels of care should be made no later than the last covered day in the current authorization period. If a request for continued authorization is received after the last covered day in the current authorization period and services are approved as requested, a new authorization number is generated on the date the approval is made.

For continued authorization in SUD Clinically Managed High-Intensity Residential Services (ASAM 3.5), the admitting provider will use the **CBH Provider Portal** to submit an ASAM assessment to the PES team. See **Provider Bulletin 25-06** for further details.

3.8. Reporting Discharges/Leaves

3.8.1. Planned Discharges

For services reviewed telephonically, discharge reviews are completed with the CCM within one business day of discharge. For services reviewed by packet or Written Order, discharge summaries are submitted to CBH via the secure file server within five business days of discharge. See respective Clinical Management team for directions of how and where to submit.

3.8.2. Against Medical Advice, Administrative Discharge, and AWOL

If the member is not in a facility overnight for any reason, planned discharge, or leave, for all services providing 24-hour monitoring and treatment, the facility must:

➡ Verbally inform CBH within 24 hours, providing any known contacts for the members (family, significant other, etc.).

➡ Fax a completed copy of the Significant Incident Report (SIR) Form within 24 hours to CBH Quality Management at (215) 413-7132. **See this webpage for details on SIR.**

3.9. Service-Specific Guidelines

3.9.1. Children's Community-Based Services

3.9.1.1. Family Based Services

Family Based Services (FBS) is an 8-month (up to 32 weeks), comprehensive family therapy treatment designed for youth and adolescents under 21 years of age. FBS is based on the treatment model Eco-Systemic Structural Family Therapy (ESFT). ESFT is a treatment for youth and families experiencing behavioral or relational challenges and is based on the theory that change in family structure contributes to change in the behavior of individual members. ESFT begins

with the fundamental assumption that both the youth and caregivers functioning are linked to their relational environments at home and in the community. Treating a child within this model means working simultaneously with the child and family, the home setting, and the family's community network.

FBS is requested via a Comprehensive Biopsychosocial Evaluation (CBE) or psychiatric evaluation. The evaluation must be a face-to-face assessment of the youth, by a physician, psychiatrist, or licensed psychologist, written within 60 days of the request, and should include the following:

➡ A behavioral health disorder diagnosis listed in the most recent edition of the DSM

➡ At least one adult family member/caregiver must agree to actively participate in the service along with the child or adolescent

➡ Demonstrate that behaviors must be treated in the context of the family in order to offer expectation of improvement

➡ Identify parenting and attachment styles, current challenges as prioritized by the family, child behavioral needs, any factors creating risk to the child's placement, and interaction patterns.

➡ Identify social determinants contributing to family stress

➡ Family-centered and strengths-based, prioritizing resources already accessible to the family that can be utilized throughout the treatment process, both to bolster the family's sense of competence and hope and to enhance treatment efficacy

CBH manages and distributes referrals to the provider of family choice and/or specialty based on youth and family need. Providers are expected to maintain timely communication with CBH concerning the status of referrals and the actions they have taken upon receipt of referral.

Once CBH has made a FBMHS referral to a provider with accompanying documentation, providers are expected to contact families within one business day of receipt of referrals to offer available appointments convenient for youths and families, meeting families' needs to initiate services. This consideration supports family engagement. Providers are to notify referral sources and CBH if they believe the referral is incomplete and it is expected that the referral source provide whatever additional information is needed. FBMHS providers must make efforts to secure updated contact information from the referral source, CBH, DHS/CUA, and/or any other system that is involved before (when appropriate) when there are barriers establishing contact for an FBMHS intake.

3.9.1.2. Written Orders (WOs) for Intensive Behavioral Health Services (IBHS)

IBHS refers to the array of therapeutic interventions and supports provided to a child, youth, or young adult in the home, school, or community setting. IBHS may be requested for any CBH-eligible member when the services are medically necessary to address the need associated with a behavioral health diagnosis, up through the day before the individual's 21st birthday. IBHS may be delivered via one or a combination of Individual, Group, and/or ABA Services.

IBHS is requested via a **Written Order (WO)**. A WO must be written within the 12 months prior to the initiation of IBHS and written by a licensed physician, licensed psychologist, certified registered nurse practitioner or other licensed professional whose scope of practice includes the diagnosis and treatment of behavioral health disorders, and the prescribing of behavioral health services, including IBHS. Centers for Medicare and Medicaid Services (CMS) also requires that physicians and other practitioners who order or refer IBH Services for Medicaid Members must be Medicaid-enrolled.

The WO must include the following:

➡ A behavioral health disorder diagnosis listed in the most recent edition of the DSM or ICD

➡ Orders for one of more IBHS for the child, youth, or young adult, including the following:

» The clinical information to support the medical necessity of the services ordered

» The maximum number of hours of each service per month

» The settings where services may be provided

» The measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed, or terminated

3.9.1.2.1. Requesting Changes to Services During a Current Authorization Period

This section clarifies the use of WO Forms, CBRs, service authorization grids, and updated mental status examination (MSE) requirements to request service changes within an already determined authorization period for children and adolescents.

3.9.1.2.1.1. *Comprehensive Biopsychosocial Re-evaluations (CBRs)*

Within an established authorization period for FBS, PRTF, and CRR-HH, the CBR is the preferred means to request changes to services for youth receiving prior authorized treatment. A CBR is preferable to integrate changes in the member's presentation or situation into a comprehensive formulation that best supports the diagnosis and resulting request for services. A CBR can be used at any time to continue or revise the above services for a child, as long as the clinical reason(s) for the CBR are clearly documented in the Reason for Re-Evaluation section. Reasons for a CBR may include:

➡ Significant changes in clinical presentation and/or psychosocial context that warrant a comprehensive and updated evaluation

➡ Lack of progress or worsening of symptoms despite treatment

➡ A need for further information to contribute to comprehensive treatment planning

FBS extension requests require the completion of an extension review with a CBH Clinical Care Manager (CCM). FBS extension requests for more than 30 days require a subsequent CBR completed by a psychiatrist, psychologist, or licensed psychologist.

CBRs may be billed. See the **Program Integrity section on CBE/R** for details.

3.9.1.2.1.2. *Written Orders (WOs)*

IBHS WO letters are required to initiate any IBHS service. WOs are not a standalone billable service. WOs may result from any number of therapeutic encounters with a qualified professional. WOs include "up to" prescriptions. If the number of hours requested is within the range specified on the WO, changes in clinical need can be reflected through the update of the individualized treatment plan (ITP), which should specify how many hours of each service are needed in which setting. If the clinical needs change to exceed the maximum of what is reflected on the WO, an updated WO is needed and should be submitted to CBH to review the request for the increase in services. See **CBH Provider Bulletin 20-11** for guidance. Providers are advised to reference the **CBH Provider Bulletins** for the latest guidance regarding concurrent requests for IBHS.

3.9.2. Psychiatric Residential Treatment Facilities (PRTF)

At the time of PRTF referral, CBH may request that an interview be performed before a facility issues a denial for admission. CBH will not request interviews with every referral, but CBH will request interviews when the youth clearly fits the program outlined in the facility's service description and stated inclusionary and exclusionary criteria. In these instances, CBH requests that an in-person, pre-admission interview be performed prior to determining that the youth is not a clinical fit for the program. For providers that are located more than 50 miles from the youth's current location, HIPAA-compliant video conferencing is permissible. Upon completion of the pre-admission interview, the PRTF should notify CBH of the outcome. Please note that children referred to PRTF have already been determined to meet medical necessity for this LOC, and any denials following the interview should reflect that any contributing areas of clinical concern were fully explored and assessed. To support these pre-admission assessments, providers may seek reimbursement for LOC 500- 24, "RTF Accredited – Pre-Admission Assessment." LOC 500-24 will be reimbursed at a rate of $115 per event. This rate includes costs related to travel and videoconference. The interview must be completed by a clinician credentialed as a Mental Health Professional, psychologist, or psychiatrist. Providers continue to be able to accept referred youth based on the written referral alone; in these cases, no interview is required. In instances where CBH has requested an interview and the provider is not able to accept—based on the written referral—the provider will reach out to the CBH RTF Referral Behavioral Health Liaison with the time and date of the interview; an authorization will then be issued for LOC 500-24. Please note that requested interviews are mandatory and must take place whether the provider seeks payment or not.

3.9.2.1. Initial Authorization Requests

For initial authorization requests, packet submission will remain a requirement. An inter-agency meeting is required with the participation of CBH Clinical Care Management and all other involved parties/agencies prior to the submission of the formal recommendation to CBH for PRTF level of care. Comprehensive Biopsychosocial Evaluations/Re-evaluations (CBE/CBR) must be completed by a psychiatrist within 30 days of submission to CBH and include all required elements of CBE/CBR. Initial authorization will be for up to 30 days.

3.9.2.2. Continued Authorization Requests

For continued authorization requests, packet submission to CBH will no longer be necessary. CBH will make medical necessity determinations based on the information presented during monthly interagency meetings, for up to 30 days. CBH will participate in these meetings along with all involved parties. Providers must keep documentation in the member's health record of the monthly interagency meetings. The psychiatrist must sign off on the monthly interagency meeting documentation, indicating if PRTF level of care continues to be medically necessary. Continued authorization will be for up to 30 days. During treatment, CBH will require a CBE/CBR to be completed every six months. Evaluations must be completed within 30 days of submission to CBH and include all required elements.

3.9.2.3. Discharge and Re-entry

If the residential treatment services continue to be clinically appropriate for the child upon discharge from the hospital, the residential treatment program must accept the child back into treatment immediately upon discharge from the hospital.

The discharging facility's treating physician or psychiatrist must provide the residential treatment program with a comprehensive evaluation that includes a recommendation that the child return to the residential treatment program for the balance of the originally approved period.

CBH will review the clinical information during the hospital stay. If it is determined that the child's return to the residential treatment program is unlikely, the residential treatment program will be notified, and an end date will be determined.

3.9.2.4. Medical/Psychiatric Leave

In order to reserve a child's place in a residential treatment program when the child leaves for either a general inpatient hospital or a psychiatric facility, CBH will reimburse at one-third of the facility's negotiated per diem rate for up to 15 days per calendar year. For this period, the residential treatment program may not accept reimbursement from any other source on behalf of the child. The days during a hospital leave can be billed electronically or on paper and separately from the residential treatment billing. The residential treatment program should calculate the units to be one-third of the unit (not one-third of the rate) for each day in the hospital. The residential treatment program will be reimbursed for less than 15 days if, during the hospital leave, CBH determines that it would not be clinically beneficial for the child to return to the residential treatment program.

3.9.2.5. Therapeutic Leave

Members in PRTFs often receive therapeutic leave passes which provide opportunities for them to return briefly to their home/community while continuing treatment at the PRTF. Therapeutic leave passes allow members to practice skills acquired in PRTF outside of the residential setting.

Providers must follow all MA regulations regarding leave in **MA Bulletin 01-95-12** and **MA Bulletin 01-95-13** for JCAHO and Non-JCAHO facilities.

3.9.3. Residential Addictions Treatment

3.9.3.1. Discharge and Re-entry

If the residential treatment services continue to be clinically appropriate for the member upon discharge from a medical or psychiatric hospital, the residential treatment program must accept the member back into treatment immediately upon discharge.

CBH will review the clinical information during the psychiatric hospital stay. If it is determined that the member's return to the residential treatment program is unlikely, the residential treatment program will be notified, and an end date will be determined.

When the member is readmitted to the residential rehabilitation facility, the facility must revise the treatment plan to reflect the hospitalization and to identify any changes in goals and objectives. The CCM will record this as part of the continued stay review with the respective addiction treatment program. The Medical to Treatment form needs to be completed over the phone with the assigned CCM or the PES line when a member is readmitted from a medical hospital.

3.9.3.2. Reduction of Prior Authorization Criteria Requirements

3.9.3.2.1. UDS

CBH no longer requires urine drug screens (UDS) and vital signs for prior authorization for a member for residential and inpatient substance use treatment. This change was made to further increase access to treatment. While UDS and vital signs are not required for prior authorization for substance use treatment, CBH will continue to ask providers with capability to collect UDS and vital signs to provide this information to inform clinically optimal treatment authorizations.

This change means assessment sites (for example CRCs) currently capable of collecting UDS and vital signs should continue to do so. Assessment sites without this capability will now be able to request prior authorizations and make referrals for substance use treatment without UDS and vital signs. Therefore, substance use treatment providers will need to accept the minority of members who will receive prior authorization and be referred for treatment without UDS and vital signs. Providers will need to factor this into acceptance criteria, admission protocols, and treatment decisions and should continue to follow clinical best practices and state regulatory standards related to obtaining vitals and UDS results as part of their assessment and treatment planning process.

3.9.3.2.2. ASAM Partial Hospitalization (Level 2.5) and ASAM Clinically Managed High Intensity Residential Services (Level 3.5)

Providers admitting CBH members to 2.5 or 3.5 should notify the CBH Psychiatric Emergency Services (PES) line (215-413-7171) at the time the member is admitted, and an initial authorization for 30 days for 3.5/45 days for 2.5 will be provided. Concurrent reviews will begin on the last covered day for 2.5 and 3.5, and subsequent reviews will occur as necessary (See **Request/Concurrent Review Template for SUD Bed-Based LOCs Appendix**).

As historically required, providers admitting members to 2.5 or 3.5 units must complete an assessment within 72 hours of admission, including American Society of Addiction Medicine (ASAM) criteria, documenting that the member meets medical necessity for this level of care. Discharge planning must begin upon intake; if it is determined upon the initial concurrent review that the individual does not meet medical necessity criteria for 2.5 or 3.5, the member must be sufficiently ready for discharge. Additionally, when questions regarding medical necessity arise during concurrent review, retrospective chart reviews may occur through the CBH Program Integrity Department.

3.9.3.2.3. Mobile Psychiatric Rehabilitation and Peer Specialist Services Testing Out the Margin Settings of These Headers

Effective October 13, 2019, CBH no longer requires prior authorization for Mobile Psychiatric Rehabilitation (level of care 900-5) and Peer Specialist Services (level of care 800-17). This change only impacts providers who do not already use blanket authorization numbers for Mobile Psychiatric Rehabilitation and Peer Specialist Service Providers. These providers will notify CBH's Community Support Services via secure email (**cbhcss@phila.gov**) upon admitting CBH members to Mobile Psychiatric Rehabilitation and Peer Specialist Services. Once this information is received, a CBH Clinical Care Manager will generate an authorization number for six months. If additional Mobile Psychiatric Rehabilitation or Peer Specialist Services are required after this period, additional requests should be made to the assigned CBH Clinical Care Manager. As historically required, providers admitting members to Mobile Psychiatric Rehabilitation and/or Peer Specialist Services must have appropriate documentation supporting medical necessity for this level of care, including a completed Licensed Practitioner of the Healing Arts (LPHA) form.

3.9.4. Psychological and Neuropsychological Testing

Psychological and neuropsychological testing is a prior authorized service and can be requested via a **Neuropsychological/Psychological Testing Prior Authorization Request Form**.

*Please Note: A copy of the most recent evaluation (e.g., CBE, psychological, evaluation, psychiatric evaluation) needs to be included and can be **uploaded directly** via this form. Upon receipt by CBH, the request will be date-stamped.*

Requests will be considered for authorization:

➡ When the request meets MNC and clearly indicates how testing will inform the behavioral health treatment plan.

➡ When the request indicates why the psychiatric evaluation, psychological evaluation, or clinical assessment was insufficient to determine an initial case formulation and treatment plan.

➡ The member or appropriate representative has provided informed consent for psychological testing.

➡ The request is for behavioral health services other than establishing risk for fire setting.

➡ The request is not primarily for medical/physical treatment/rehabilitation or educational/vocational services in the absence of a specific anticipated impact on the behavioral health treatment plan.

➡ The request indicates, by name, what tests will be administered, the questions that each test will address, and estimated administration time for each test. Note that estimated testing times that differ significantly from test publisher recommendations should be accompanied by a rationale.

➡ The request is signed by a licensed psychologist and the PA license number is indicated.

Testing authorization is provided in one-hour units including administration, scoring, interpretation, and report preparation time. Testing typically includes a battery of instruments administered during a concentrated time period. Thus, testing is typically authorized in 30-day increments. A longer duration can be considered for medical necessity provided there is documentation of a rationale regarding the purpose. Verbal requests for extensions can be made to the CBH Director of Psychology.

Determination of testing authorization or denial will be made within two business days from receipt of the request. A CBH-designated Administrative Assistant will provide notification of approval or denial via fax to the provider and will issue an authorization number. A notification letter regarding testing denial and grievance process will be mailed to the CBH member within 2 business days of receipt of the request. This letter is completed by a designated CBH Clinical Care Manager using the electronic record Denial Module.

The psychological testing must be completed within one month of authorization. Upon completion of the psychological testing report, the provider agency should fax a copy of that report to the CBH Director of Psychology.

Psychological testing is inclusive of services provided in the following bed-based levels of care and no prior authorization is needed: AIP, EAC, PRTF, RTFA. A Psychological Testing Pre-Authorization Request Form does not need to be completed on behalf of members receiving treatment in such settings. Neuropsychological testing may be requested in these bed-based levels of care.

If a provider identifies an individual member who requires psychological or neuropsychological testing, but that provider does not have a contract with CBH to provide psychological testing services, it is preferable for that provider to obtain a release of information from the member and collaborate directly with a provider who is under contract with CBH to provide psychological testing services. A CBH Provider Relations or Member Services Representative can assist with a list of agencies that provide psychological testing. The identified agency that will be completing the testing can submit the Testing Preauthorization Request Form to CBH for review. A CBH Provider Relations Representative or Member Services Representative can provide testing referral support when needed.

Psychological or neuropsychological testing may also be indicated to address questions that are not primarily related to behavioral health services. Such requests should be directed to the appropriate payer. For example:

➡ Requests for neuropsychological testing to determine organic contributions to behavior should be directed to the member's Physical Health Managed Care Organization.

➡ Requests for testing for educational services should be directed to the member's School District.

➡ Requests for testing for vocational services should be directed to the PA Office of Vocational Rehabilitation at 215-560-1900.

➡ Requests for testing for intellectual disability case management or services should be directed to Intellectual disability Services at 215-685-5900.

3.9.5. Behavioral Health Case Management Continuum

The behavioral health case management services listed below are authorized and coordinated by the CBH Behavioral Health Case Management Unit using MNC found in Appendix T of the **HealthChoices Behavioral Health Program Standards and Requirements (PSR)**. To obtain information on prior authorization, contact Targeted Case Management and Assertive Treatment Team Providers directly. Each referral must be accompanied by a completed **DBHIDS integrated intake form**. Referral sources are encouraged to utilize the TCM Provider Directory List and Case Management Continuum Guide to determine most appropriate provider and level of case management for the member.

Based on the PA DHS Office of Mental Health and Substance Abuse (OMHSAS) definition, Targeted Case Management is a primary, non-clinical, direct service provided to individuals with serious and persistent mental illness who live in the community. It is designed to ensure individual access to community agencies, services, and people whose functions are to provide the support, training, and assistance required for a stable, safe, and healthy community life. It is a time-limited, voluntary service.

Behavioral Health Case Management includes:

➡ **Resource Coordination:** A short-term service for individuals with a serious and persistent mental illness who may also have minor substance use issues and mild to moderate difficulty in accessing mental health treatment, social, job-related, or daily living skills. Resource Coordinators will meet with individuals on a regular basis as dictated by their Personal Goal Plan. Frequency of contact may range from daily to every 30 days. Services are available Monday-Friday, 9-5.

➡ **Intensive Case Management (ICM):** ICM is for persons with a severe and persistent mental illness who may also have significant substance use problems. ICM is recommended for persons who experience chronic homelessness and frequent times of crisis. These individuals may be unable to obtain or maintain a safe place to live, or to identify, reach, and maintain personal goals. The service is accessible 24/7 and supported with active street outreach efforts. Frequency of contact can range from multiple times in a day to once every 14 days.

➡ **Blended Case Management (BCM):** BCM is for persons with a severe and persistent mental illness who may also have significant substance use problems. BCM is recommended for persons who experience frequent hospitalizations or times of crisis. These individuals may be unable to obtain or maintain community-based MH treatment or to identify, reach, and maintain personal goals. The service is accessible 24/7. Frequency of contact can range from daily to once every 30 days based on individual need and their Personal Goal Plan.

➡ **Non-Fidelity Assertive Community Treatment Non-Fidelity ACT:** Non-fidelity ACT is for individuals with a severe and persistent mental illness who may also have serious substance use problems and/or additional issues. Non-fidelity ACT is recommended for individuals who experience frequent hospitalizations, CRC visits, and mobile emergency service use. These programs are enhanced with a full-time psychiatrist, nurse, and Alcohol and Other Drugs (AOD) specialist to support the needs of certain individuals on the caseload. These teams have extended office hours during the week and limited active work hours over the weekends. The service is accessible 24/7. Frequency of contact can range from multiple times a day to every 14 days depending on the individual's Personal Goal Plan.

➡ **Assertive Community Treatment (ACT):** ACT is a service delivery model for providing comprehensive community-based treatment to persons with serious mental illness who may also have serious substance use and/or other co-morbid issues. It is a level of care that is used when other types of community-based treatment have been tried but not been effective and there have been several inpatient admissions. It is a self-contained mental health program comprised of a multidisciplinary mental health staff, including a peer

specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services individuals need to achieve their goals.

3.9.5.1. ACT Referral/Authorizations and Transfer Requests

1. ACT referrals will be directly sent to ACT providers by the bed-based, community referral source and other case management agencies via the ACT referral form. Providers can submit referrals to ACT providers:

   » **Community Treatment Teams (CTT)**

   » **Horizon House**

   » **PATH**

2. When an ACT/NFA/BCM provider receives an ACT referral from a referral source, the ACT provider has five business days to respond to the referral source indicating need for additional information, status of approval or disapproval, or provider capacity on hold. If providers need additional information to determine MNC, they will be able to contact CBH for treatment history if they can verify that member signed consent/ROI to obtain treatment history from CBH.

3. If application meets MNC, ACT, and specialized NFA, the provider will submit an authorization request with the following information to **CBHCMReferrals@phila.gov** indicating the start date of services:

   » Referral Source

   » Referral Contact, Phone, and Email

   » Current Address, Phone, and Living Situation

   » Reason for Request

   » MH Dx/Physical Health Dx

   » D/A Use (drug choice, duration, amount)

   » Specified ACT TEAM Assigned

   » Clinical Summary/Rationale for ACT Services

4. BHCMU CCM will respond to the referral review within 48 hours of receipt of referrals from the ACT provider. CCM will generate provisional ACT authorization for 10 days, 1 unit.

   NOTE: Any referrals can be submitted for retrospective review.

5. ACT provider only has up to 10 days from the CBH provisional authorization date to get the participant's consent to ACT services.

6. If the participant signs the consent to services by day 10, they will be officially admitted to ACT and services will continue. The CCM manager will adjust the date of authorization to 365 days from initial authorization date; units remain the same and the referral process is complete. The ACT provider will enter ACT referral intake information into Web Focus.

7. If the participant does not sign the consent to ACT services, the ACT provider will send an update regarding the reason why ACT services are being withdrawn. The Member will be removed from the ACT provider's active roster. CBH will discontinue the authorization.

8. If the ACT/NFA provider defers from providing services or member does not meet MNC, an outcome assessment form should be submitted to **CBHCMreferrals@phila.gov**, cc: BHCMU Supervisor **Elisabeth.Caba@phila.gov**.

   NOTE: A provider should only defer a member from services if the member does not meet MNC, the provider has no capacity or staff shortage to accept the member, or there are extenuating circumstances (e.g., former assaultive member). For instance, the provider should indicate that a member meets MNC and provide rationale as to why they are not accepting the member.

3.9.5.2. Referral Concurrent Reviews

ACT providers submit request for all currently authorized ACT members on designated month yearly. ACT providers submit updated FACE sheet, environmental matrix and justification for continued medical necessity for ACT.

3.9.6. Extended Acute Care

Requests for the Extended Acute Level of Care (EAC) should be made directly to CBH Clinical Care Managers during concurrent Acute Inpatient (AIP) reviews. The request will be reviewed for Medical Necessity Criteria (MNC) and the provider will be informed of the outcome of the review. Requests will continue to be evaluated based on MNC. The Admissions, Discharges, and Planning Team (ADAPT) assessment should be completed to help inform ongoing treatment needs. **The EAC MNC can be accessed via the CBH website**.

3.9.7. Authorization Guidelines for Psychiatric Consultations in Medical Facilities

Providers are reimbursed for one initial and one follow-up consultation. CBH reserves the right to retroactively deny payment if a consultation is not deemed medically necessary. The following constitutes MNC:

➡ Suicidal ideation, intent, or plan

➡ Homicidal ideation or plan

➡ Acute agitation

➡ Chronic and persistent mental illness with concomitant medical illness

➡ Substance use and dependence, including withdrawal management

➡ Constant observation needed

➡ Differential diagnosis and treatment recommendations are requested

➡ Competency assessment

➡ Any psychiatric disorder or disturbance that interferes with a patient's care in a medical setting

CBH provides payment for one initial consultation and one follow-up visit.

If a service recipient has been in a Nursing Facility for 30 consecutive days or longer, they are no longer CBH eligible.

Psychiatric consultations are to be performed ONLY by licensed psychiatrists or groups of psychiatrists who are independently credentialed by CBH.

Each type of consultation has a distinct BAN which must be used in billing. CPT codes are time specific and therefore must contain a start and end time for the consultation.

3.10. Authorization Guidelines

These guidelines concern the **CBH Continua of Services**.

3.10.1. Child Services Authorization Requirements

Finalized authorization information about Intensive Behavioral Health Services (IBHS) is forthcoming. For updates, please see the **CBH Provider Bulletins and Notices page**.

3.10.1.1. Emergency Level of Urgency (No Prior Authorization)

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Children's Mobile Crisis Team (CMCT)	Philadelphia Crisis Line, 215-685-6440	BAN	N/A	N/A	N/A
Crisis Walk-In (Crisis Response Center/CRC)	Walk-in/ Philadelphia Crisis Line, 215-685-6440 for help with 302	BAN	N/A – Schedule A	N/A	N/A

3.10.1.2. Urgent Level of Urgency (Prior Authorization usually provided in 24 hours)

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Acute Inpatient Psychiatric Hospitalization [100-1, 100-4]	Physician at a children's crisis provider recommends	Clinical call to CBH for referral	PES line[2] Assigned CCM	PSR: Appendix T	Use Preadmission form during phone call.

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[2] When an authorization is being requested by the inpatient provider for members who are already on the inpatient unit (in cases when CBH coverage is initiated during inpatient stay, i.e., county or Medicare coverage exhausts and individual becomes CBH eligible), the care manager assigned to the provider provides the prior authorization.

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Children's Mobile Intervention Services (CMIS) [800-30]	Children's crisis providers recommend; cannot have other prior authorized services in place	Clinical call to CBH for referral	PES line	State-Approved **MNC**	Provide current clinical presentation including current MSE and behaviors.
Crisis Stabilization Unit (CSU) [800-5]	Physician at a children's crisis provider recommends	Clinical call to CBH for referral	PES line	State-Approved **MNC**	Use Preadmission form during phone call.
Enhanced Staffing [100-10, 100-22, 100-28]	Evaluating physician recommends	Prior Auth	Assigned CCM	State-Approved **MNC**	Provide current clinical presentation including current MSE and behaviors
Private Room Exception [100-32]	Evaluating physician recommends	Prior Auth	Assigned CCM	State-Approved **MNC**	Provide current clinical presentation including current MSE and behaviors

3.10.1.3. Non-Urgent Level of Urgency

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Acute Partial Hospitalization Program [325-6]	Contact Member Services or the provider.	Registration	OSS	**PSR**: Appendix T	Submit **Service Request Form**.
Acute Partial Hospitalization Program [325-21]	Physician recommends	Prior Auth.	PES line or CCM	**PSR**: Appendix T	Use **PES Prior Authorization Template** during phone call.
Blended Case Management	Contact the provider.	Prior Registration	OSS	**PSR**: Appendix T *(use MNC for TCM)*	Submit **Case Management Referral Form** to the provider of choice. Submit the Service Authorization Form to OSS.
Clinical Transition and Stabilization Services (CTSS)	Contact Member Services or the provider.	Prior Auth.	CCM	State-Approved **MNC**	Submit **IBHS Written Order (WO) Letter Form**.

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Community Residential Rehabilitation (CRR) Host Home	Contact Member Services or the provider.	Prior Auth.	CCM	State-Approved MNC	Submit CBE/R no older than 60 days; Treatment Plan; ISPT Meeting Form and Signature Page
Family-Based Services (FBS)	Contact Member Services or the provider.	Prior Auth.	CCM	PSR: Appendix T	Submit CBE/R no older than 60 days and FBS Referral Form
Functional Family Therapy (FFT)	Contact Member Services or the provider.	Prior Auth.	CCM	PSR: Appendix T	Submit IBHS WO and FFT Referral Form.
Intensive Behavioral Health Services (IBHS) *Initial Assessment and Treatment, Behavioral Consultant (BC), Mobile Therapist (MT), or Behavioral Health Technician (BHT)*	Contact the provider. For assistance locating a Regionalized IBHS provider by ZIP code, contact Member Services.	Prior Auth.	Clinical Management Staff	PSR: Appendix S	Submit IBHS WO via the secure file server, email, or fax. For assessment and inital treatment, only a WO is required. If requesting BHT, include a Functional Behavior Assessment. All concurrent requests require WO, IBHS Assessment and Individual Treatment Plan (ITP).
IBHS – Group Services *Group Mobile Therapy*	Contact the provider. For assistance locating a Regionalized IBHS provider by ZIP code, contact Member Services.	Prior Auth.	Clinical Management Staff	PSR: Appendix S	Submit IBHS WO via the secure file server, email, or fax.
IBHS – Applied Behavior Analysis (ABA) Services *ABA-Initial Assessment and Treatment, ABA-BCBA, ABA-BC, or ABA-BHT*	Contact an ABA-designated provider.	Prior Auth.	Clinical Management Staff	PSR: Appendix S	Submit IBHS WO via the secure file server, email, or fax. For ABA-Initial Assessment and Treatment, only WO is required. All concurrent requests require WO, IBHS Assessment including FBA and/or Skills Assessment, and Individual Treatment Plan (ITP).
IBHS – ABA Early Childhood Intensive Treatment (ABA-ECIT)	Contact an ABA-ECIT Provider.	Prior Auth.	Clinical Management Staff	PSR: Appendix S	Submit an IBHS WO or for ABA-Initial Assessment to an ABA-ECIT Provider. Only contracted providers can determine appropriateness for this program.

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Mental Health Outpatient Services (MHOP)	Contact Member Services or the provider.	BAN	N/A	N/A	N/A
Multi-Systemic Therapy: Problem Sexual Behaviors (MST-PSB), Risky Sexual Behavior (MST-RSB), and Traditional (MST)	Contact Member Services or the provider.	Prior Auth.	CCM	PSR: Appendix T	Submit IBHS WO, CBE/R, and MST Referral Form. IPST with the CBH CCM, family, and MST provider also required.
Psychiatric Consult in a Medical Facility	Administered at medical facility	BAN	N/A	N/A	N/A
Psychiatric Residential Treatment Facility (PRTF) (JCAHO and Non-JCAHO accredited) [500-2, 500-7, 550-1, 550-2, 550-7]	Contact Member Services or the provider.	Prior Auth.	CCM	PSR: Appendix T	CBE/CBR completed within the last 30 days of receipt; Treatment plan; ISPT meeting form and signature page
Psychological Testing (Outpatient) [300-7]	Contact Member Services or the provider.	Prior Auth.	CBH Director of Psychology	State-Approved MNC	Submit CBH Psychological Testing Preauthorization Form along with most recent CBE/R, including a description of what other psychological testing has been conducted or requested (e.g., neuropsychological, psychoeducational, or vocational).
Psychosexual Evaluation	Contact Member Services or the provider.	Registration	OSS	N/A	Submit Service Request Form.
Substance Use Disorder (SUD) Clinically Managed High-Intensity	Substance use assessment	Prior Auth.	PES line[3] or Assigned CCM	ASAM[4]	Use PES Prior Authorization Template during phone call.

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[3] When an authorization is being requested by the inpatient provider for members who are already on the inpatient unit (in cases when CBH coverage is initiated during inpatient stay, i.e., county or Medicare coverage exhausts and individual becomes CBH eligible), the care manager assigned to the provider provides the prior authorization.

[4] D Mee-Lee, GD Shulman, MJ Fishman, DR Gastfriend, MM Miller, eds. The American Society of Addition Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions (3rd ed. Carson City, NV: The Change Companies, 2013)

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Residential Services (ASAM 3.5) [200-2, 200-7]					
Substance Use Disorder (SUD) Intensive Outpatient Services (ASAM 2.1)	Contact Member Services or the provider.	Registration	OSS	ASAM	Submit **Service Request Form**.
Substance Use Disorder (SUD) Outpatient Services (ASAM 1.0)	Contact Member Services or the provider.	BAN	N/A	ASAM	N/A
Tricyclic Antidepressant (TCA) Screening	Contact Member Services or the provider.	Prior Auth.	PES or CCM	State-Approved **MNC**	Use **PES Prior Authorization Template** during phone call.

3.10.2. Adult Services Authorization Requirements

3.10.2.1. Emergency Level of Urgency

Service	How to Access Services	Auth. Type	Who Provides Authorization	MNC	Required Submission to Obtain Authorization
Community Mobile Crisis Response Team (CMCRT) *(FKA Adult Mobile Crisis Team)*	Philadelphia Crisis Line, 215-685-6440	BAN	N/A	N/A	N/A
Crisis Intervention Response Team (CIRT)	Philadelphia Crisis Line, 215-685-6440	BAN	N/A	N/A	N/A
Crisis Walk-In (Crisis Response Center/CRC)	Walk in/Philadelphia Crisis Line, 215-685-6440 for help with 302	BAN	N/A	N/A	N/A

3.10.2.2. Urgent Level of Urgency

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
23-Hour Crisis Stabilization [100-25]	Evaluating physician recommends	Registration – Clinical call to CBH for referral	PES	State-Approved MNC	Use Preadmission Form during phone call.
Acute Inpatient Psychiatric Hospitalization [100-1, 100-4, 100-39]	Evaluating physician recommends	Registration – Clinical call to CBH for referral	PES or CCM	PSR: Appendix T	Use Preadmission Form during phone call.
Buprenorphine Induction at a Crisis Response Center [800-39]	Evaluating physician recommends	Registration – Clinical call to CBH for referral	PES	ASAM	Use preadmission form during phone call
Crisis Residence [800-5]	Physician recommends	Prior Auth.	CCM or PES	State-Approved MNC	Use PES Prior Authorization Template during phone call.
Enhanced Staffing [100-10, 100-22, 100-28]	Physician recommends	Prior Auth.	CCM	State-Approved MNC	Provide current clinical presentation including MSE and behaviors.
Private Room [100-32]	Physician recommends	Prior Auth.	CCM	State-Approved MNC	Provide current clinical presentation, including MSE and behaviors
Subacute Inpatient Psychiatric Hospitalization [100-2]	Physician recommends	Prior Auth.	PES	State-Approved MNC	Use Preadmission Form during phone call.
Substance Use Disorder (SUD) Medically Managed Intensive Inpatient Services – Withdrawal Management (ASAM 4WM) [150-1]	Substance use assessment, or contact provider, or Member Services	Registration – Clinical call to CBH for referral	CCM or PES	ASAM	Use PES Prior Authorization Template during phone call.
Substance Use Disorder (SUD) Medically Managed Intensive Inpatient Services (ASAM 4) [150-2]	Substance use assessment, or contact provider, or Member Services	Prior Auth.	CCM or PES	ASAM	Use PES Prior Authorization Template during phone call.

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Substance Use Disorder (SUD) Medically Monitored Inpatient Services – Withdrawal Management (ASAM 3.7WM) [200-1]	Substance use assessment, or contact provider, or Member Services	Registration – Clinical call to CBH for referral	PES or CCM	ASAM	Use PES Prior Authorization Template during phone call.

3.10.2.3. Non-Urgent Level of Urgency

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Acute Partial Hospitalization Program [325-5, 325-24]	Evaluating physician recommends	Prior Auth.	PES or CCM	PSR: Appendix T	Use PES Prior Authorization Template during phone call.
Adult Mental Health Residential (Project Transition) [900]	Physician recommends	Prior Auth.	CCM	State-Approved MNC	Referral form and requirements listed in MNC CBE and referral form are submitted to adultresidentialreferrals@phila.gov.
Assertive Community Treatment (ACT) [800-19]	Submit ACT referral directly to provider.	Registration	CBH/BHCMU	PSR: Appendix T (ACT and CTT)	Submit TCM authorization requests directly to CBH/BHCMU.
Blended Case Management [800-18]	Submit TCM Referral directly to provider.	Registration	OSS	PSR: Appendix T	Submit service authorization form to CBH/OSS.
Blended Case Management/Non-Fidelity ACT [800-3, 800-24, 800-22]	Submit TCM Referral directly to provider.	Registration	CBH BHCMU	PSR: Appendix T	Submit TCM authorization requests directly to CBH/BHCMU.

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Blood and Urine Alcohol (Ethynyl) Testing	Administered at assessment center or inpatient/ residential	Registration	N/A	See Footnote[5]	N/A
Certified Peer Specialist	Contact CBH CSS, Member Services, or Certified Peer Specialist provider directly.	BAN or CCM	N/A or CCM	State-Approved MNC	CSS referral submtited to cbhcss@phila.gov or contact Member Services
Clozapine	Contact provider or Member Services.	BAN	N/A	N/A	N/A
Community Integrated Recovery Centers (CIRC)	Contact provider or Member Services.	BAN	N/A	N/A	N/A
Community Treatment Team (CTT)	Submit TCM Referral directly to Provider	Registration	CBH/ BHCMU	State-Approved MNC	Submit TCM authorization requests directly to CBH/BHCMU.
Community Treatment Teams – Clinically Supported Living	Physician recommends	Prior Auth.	CCM	State-Approved MNC	Completed CBE is sent to adultresidentialreferrals@phila.gov.
Electroconvulsive Therapy (ECT)	Contact provider or Member Services.	Prior Auth.	PES or CCM	State-Approved MNC	Use PES Prior Authorization Template during phone call.
Extended Acute Care [140-1, 140-2]	Acute Inpatient recommends	Prior Auth.	CCM	State-Approved MNC	Use PES Prior Authorization Template during phone call.
Forensic Intensive Recovery (FIR) Case Management	Defender Association of Philadelphia	BAN	OSS	N/A	Authorization request form to OSS. Member must be a Philadelphia resident and have a substance use or co-occurring

[5] *MNC determined by whether the member requires alcohol testing in order to establish or exclude a diagnosis of alcohol intoxication, use or dependence in order to guide treatment; and whether the member's current clinical status prevents the use of a breath alcohol test.*

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
					diagnosis. Legal eligibility is determined by the Public Defender and DA's Office.
Integrated Behavioral Health in Long-Term Care (IBHLTC)	Submit referral packet to the Be Well MPAC once member is determined to be CBH-eligible, nursing home-eligible, and diagnosed with SMI	BAN	N/A	State-Approved MNC	Once approved and admission date is determined, packet is sent to CBH
Intensive Case Management [800-9]	Submit referral form directly to provider.	Registration	CBH/ BHCMU	PSR: Appendix T	Submit referral directly to provider using DBHIDS referral form. For intensive case management, submit service authorization form to CBH OSS at CBHauths@phila. gov.
Intensive Clinical Services (ICS)	CBH Complex Care Management will provide authorization	Prior Auth.	CBH Complex Care CCM	State-Approved MNC	Eligible members are those 18+ who are registered with IDS, have a behavioral health disorder with co-occurring ID/IDD, and are being discharged from a higher LOC to a community home (ID or MH).
Long-Term Structured Residence (LTSR)	Submit application through Transitions, Integrations, and Partnership (TIP) Unit	Prior Auth.	CCM	State-Approved MNC	TIP application is submitted to CBH after it is approved by TIP.
Medication-Assisted Treatment (MAT)	Contact provider or Member Services.	BAN	N/A	N/A	N/A
Mental Health Outpatient Services (MHOP)	Contact provider or Member Services.	BAN	N/A	N/A	N/A
Mobile Hoarding Intervention and Therapy Program	Contact provider or Member Services.	BAN	N/A	N/A	N/A

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
Mobile Psychiatric Rehabilitation Services (MPRS) [900-5]	Contact CBH CSS or Member Services.	BAN or CCM	N/A or CCM	State-Approved **MNC**	CSS referral submitted to **cbhcss@phila.gov** or contact Psych Rehab Provider directly
Non-Hospital EAC	Physician recommends	Prior Auth.	CCM	State-Approved **MNC**	Completed CBE is sent to **adultresidentialre ferrals@phila.gov**
Psychiatric Consult in a Medical Facility	Administered at medical facility	BAN	N/A		N/A
Psychological Testing (Outpatient) [300-7]	Contact provider or Member Services.	Prior Auth.	Director of Psychology	State-Approved **MNC**	Submit **CBH Psychological Testing Preauthorization Form** along with most recent CBE/R, including a description of what other psychological testing has been conducted or requested (e.g., neuro-psychological, psycho-educational, or vocational).
Psychosexual Evaluation	Contact Member Services or the provider.	Registration	BAN	N/A	Submit **Service Request Form**.
Residential Treatment Facilities for Adults (RTFA) [900-15]	Physician recommends	Prior Auth.	CCM	State-Approved **MNC**	CBE/R Court evaluation submitted for Forensic RTFA and sent to **adultresidentialre ferrals@phila.gov**.
Resource Coordination	Submit referral form directly to provider.	Registration	CBH/ BHCMU	**PSR:** Appendix T	Submit referral directly to provider using DBHIDS referral form.
Spravato® (Esketamine)	Contact Provider or Member Services		See **Spravato Protocol**		

Service	How to Access Services	Auth. Type	Who Provides Authorization and Procedures	MNC	Required Submission to Obtain Authorization
Substance Use Disorder (SUD) Clinically Managed High-Intensity Residential Services (ASAM 3.5) [200-28]	Substance use assessment, or contact provider, or Member Services	No Prior Auth. for Initial; Concurrent review due on LCD	PES or CCM	ASAM	Submit updated ASAM assessment to **CBH Provider Portal**.
Substance Use Disorder (SUD) Clinically Managed Low-Intensity Residential Services (ASAM 3.1) *(FKA Halfway Houses)* [200-5]	Substance use assessment, or contact provider, or Member Services	Prior Auth.	PES or CCM	ASAM	Use **PES Prior Authorization Template** during phone call.
Substance Use Disorder (SUD) Intensive Case Management [800-16]	Contact Targeted Case Management substance use provider directly.	Registration	OSS	Must have a SUD diagnosis and 2 or more services in place	Submit TCM Referral directly to provider using DBHIDS Referral Form. Submit Service Authorization Form to OSS.
Substance Use Disorder (SUD) Intensive Outpatient (ASAM 2.1)	Contact provider or Member Services.	Registration	PES or CCM	ASAM	Provide current clinical presentation, UDS
Substance Use Disorder (SUD) Medically Monitored Intensive Inpatient Services (ASAM 3.7) [200-27]	Substance use assessment, or contact provider, or Member Services	Prior Auth.	PES or CCM	ASAM	Use **PES Prior Authorization Template** during phone call.
Substance Use Disorder (SUD) Outpatient Services (ASAM 1.0) [375-11]	Contact provider or Member Services.	Registration	OSS	ASAM	Submit **Service Request Form**.
Substance Use Disorder (SUD) Partial Hospitalization Services (ASAM 2.5)	Substance use assessment, or contact provider, or Member Services	No Prior Auth. required	CCM	ASAM	Use **PES Prior Authorization Template** during phone call.
Transcranial Magnetic Stimulation (TMS)	Contact Provider or Member Services	Prior Auth.	CCM	State-Approved **MNC**	Use **PES Prior Authorization Template** during phone call.
Tricyclic Antidepressant (TCA) Screening	Contact provider or Member Services.	Prior Auth.	PES or CCM	**MNC**	Use **PES Prior Authorization**

Service	How to Access Services	Auth. Type	Who Provides Authori-zation	MNC	Required Submission to Obtain Authorization
					Template during phone call.

3.11. Applicable Documents

➡ **Medical Necessity Criteria**

➡ **Utilization Review Care Coordination Grid**

➡ **CBH Continua of Services**

➡ **IBHS Written Order (WO) Letter Form**

➡ **Children's Community/Family-Based Services (FBS) Referral Form**

➡ **Children's Community-Based Services Functional Family Therapy (FFT) Referral Form**

➡ **Children's Community-Based Services Multisystemic Therapy (MST) Referral Form**

➡ **Psychological Testing Pre-Authorization Request Form**

➡ **Children's Blended Case Management Referral Form**

➡ **Spravato® (Esketamine): Protocol and Procedures for Behavioral Health Provider Implementation of the Two-Hour Monitoring Period**

3.12. Applicable Appendices

➡ **Definitions Appendix**

➡ **Service Request Form Appendix**

➡ **PES Prior Authorization Template Appendix**

➡ **Concurrent Review Template Appendix**

➡ **Request/Concurrent Review Template for SUD Bed-Based Levels of Care**

➡ **Out-of-Network (OON) Request Form Appendix**

➡ **CBE Required Elements Appendix**

4. QUALITY

4.1. Quality Goals

CBH defines, evaluates, and monitors all aspects of behavioral health service delivery to individuals covered under HealthChoices for Philadelphia County. CBH's goal is to ensure that appropriate treatment options are provided to individuals in a culturally sensitive, quality-driven, and supportive environment. The Quality Management Department is responsible for monitoring the activities outlined in this chapter.

4.2. Provider Participation in Quality Improvement Activities

CBH requires that providers cooperate in activities that improve the quality of care and services and member experience. This includes the collection and evaluation of data and participation in the CBH's quality improvement (QI) programs. Such activities may include, but are not limited to:

➡ Providing information requested through **Provider Bulletins and Notices**

➡ Adhering to **Clinical Practice Guidelines** and **Performance Standards**

➡ Participating in Quality Management activities, including chart reviews, root cause analysis, complaints and grievances, onsite audits, action plans, and quality improvement plans

➡ Reporting on Performance Metrics requested through the P4P, VBP, and the performance evaluation processes

➡ Participating in quality improvement projects

➡ Engaging in credentialing, recredentialing, and compliance activities

4.3. Complaint Procedure (Member-Driven)

Providers should be aware that members have a right to complain and appeal. This process is detailed in the "Complaints, Grievances, and Fair Hearings" section of the **CBH Member Handbook** that is issued to all members.

A complaint is a dispute or objection regarding a network provider or the coverage, operations, or management policies of CBH, which has not been resolved by CBH and has been filed with CBH or with the Pennsylvania Insurance Department (PID), including but not limited to:

➡ A member's dissatisfaction with CBH or a provider

➡ A service denial because the requested service is not a covered service

➡ Failure of CBH to meet the required timeframes for providing a service

➡ Failure of CBH to decide a complaint or grievance within the specified timeframes

➡ A denial of payment by CBH after a service(s) has been delivered because the service was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program

➡ A denial of payment by CBH after a service(s) has been delivered because the service is not a covered service for the member

➡ A denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Anyone can file a complaint. A member may designate a personal representative through written authorization. Should CBH not receive a representative form, the information will be shared with the member only. The member has the right to withdraw any filed complaint at any point in the process by contacting CBH at 1-888-545-2600.

CBH has established and maintains an internal complaint process with two levels of review. Complaints can also be expedited. CBH must conduct an expedited review of a Complaint if CBH determines that the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a member or a member's personal representative (if designated) provides CBH with written certification indicating that the member's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy if the complaint is resolved in the standard timeframe of 30 days. If certification is accepted by CBH or CBH determines the complaint should be expedited, a decision will be made within 48 hours of receiving the provider's certification or 72 hours of receiving a request for an expedited review, whichever is shorter.

Complaints can be called in to CBH Member Services (1-888-545-2600) or received via mail. Complaints can also be received from individuals with disabilities using alternative formats.

4.3.1. First-Level Review Process

This process includes:

➡ A first level review committee consisting of

» one or more CBH employees who have not been involved in the subject of the complaint, and

» a CBH physician or psychologist for clinically related complaints

➡ Allowance of a written or oral complaint

➡ Allowance of participation in the complaint process by providing testimony or evidence to the review committee

➡ The allowance of written data or other supporting information

➡ An investigation of the complaint

➡ Written notification to the member regarding the decision of the initial review committee within 30 days from the date the complaint was filed (includes the basis for the decision and the procedure to file a second-level review of the decision of the initial review committee)

4.3.2. Second-Level Review Process

This process includes:

➡ A review of the first-level decision by a second-level committee, which will consist of

》 three or more individuals who did not participate in the initial review,

》 consumer representation (comprising one-third of the committee), and

》 an alternate CBH physician or psychologist (if one participated in the first level review)

➡ Notification to the member of the right to appear before the review committee 10 days prior to the scheduled date

➡ Allowance of a written or oral complaint

➡ Allowance of written data or other supporting information

➡ A review of the first-level review, which will be completed within 45 days of the receipt of the second-level complaint

➡ Written notification to the member and provider regarding the decision of the second-level review committee will occur within 45 days from when the complaint was filed, including the basis for the decision

4.3.3. Expectations for Providers During First-Level Process

In compliance with Appendix H of the **HealthChoices Program Standards and Requirements** (PSR), CBH is required to investigate and respond to all complaints brought to our attention by CBH members or, in the case of children, by parents/guardians. A CBH investigator will determine what is necessary to resolve the complaint, including but not limited to citing policies/procedures, touring provider sites, interviewing staff, interviewing the member and support system (when indicated), and reviewing medical records. If a member or legal guardian requests a copy of any correspondence received from the provider related to the complaint response, CBH is required to forward it to them at no cost to the member. Provider cooperation is essential and is documented in every complaint.

4.3.4. Expectations for Providers During Second-Level Hearings

CBH is compelled by Appendix H of the **PSR** to hold hearings for all second level complaints upon request by CBH members; the scheduling and execution of these hearings often requires a great investment of time for CBH, the provider, and our members. CBH expects providers to participate in second level complaint hearings if the member requests provider participation; providers should be prepared to address the questions and concerns of both the hearing panel and the CBH member(s) involved.

4.4. Complaint Procedure (Provider-Driven)

A provider can file a complaint regarding any CBH employee or CBH practice by calling 215-413-8581. The Senior Director of Quality Management or designee will contact the provider's Chief Executive Officer (CEO) to verify they want to proceed with the complaint. If the CEO wishes to proceed, the complaint will be resolved within 30 days, and a decision letter will be issued within five business days of the decision. The complaint committee will be led by the Senior Director of Quality Management (SDQM), and include the Employee Relations Manager or designee, the Director of Compliance or designee, and the director of the department, or designee, for which the complaint was entered.

4.5. Grievances

A grievance is a request by a member or member's representative which may include the member's provider to have CBH reconsider a decision solely concerning the medical necessity criteria (MNC), appropriateness, health care setting, level of care, or effectiveness of a covered service. If CBH is unable to resolve the matter, a grievance may be filed regarding the decision that:

➡ disapproves full or partial payment of a requested service

➡ approves the provision of a requested service for a lesser scope or duration than requested

➡ disapproves payment for the provision of a requested service but approves payment for the provision of an alternative service

CBH has established and maintains an internal grievance process with one level of review. A grievance can also be expedited, or CBH may determine it meets the grievance timeline criteria laid out by the National Committee for Quality Assurance (NCQA), which will take precedence. For CBH to process an expedited request, CBH must receive certification from the provider indicating the member's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy if the grievance is resolved in the standard timeframe of 30 days or if CBH determines that the member's life, physical or mental health, or ability to attain, maintain or regain maximum function would be in jeopardy by following the regular Grievance process. If certification is accepted by CBH, a decision will be made within 48 hours of receiving the provider's certification or 72 hours of receiving the request for an expedited review, whichever is shorter. The member may designate a personal representative through written authorization. Should CBH not receive a representative form, the information will be shared with the member only. Regarding NCQA, CBH will make its determination about response time based in NCQA criteria; these criteria concern initial or continued requests, urgent or non-urgent requests, and level of care. If specific NCQA criteria are met, CBH will make a determination within 48 hours of grievance filing.

4.5.1. Grievance Process

This process includes:

➡ Review of the denial decision by a review committee consisting of

» three or more persons who did not previously participate in any decision to deny payment for the health care service and,

» consumer representation (comprising one-third of the committee)

➡ Notification to the member or the healthcare provider of the right to appear before the review committee 10 days prior to the scheduled date

➡ Complete review and written notification sent to the member and healthcare provider regarding the decision of the review committee within 30 days of the file date, including the basis and clinical rationale for the decision and the procedure for appealing the decision

CBH has established and maintains an external grievance process by which a member, personal representative with the written consent of the member, or a healthcare provider with the written consent of the member can appeal the denial of a grievance following the completion of the internal grievance process. The external grievance process will be conducted by a certified review entity not directly affiliated with CBH. To file an external grievance with CBH, Member Services must be contacted within 15 days from the date the member receives the written notice of the grievance decision.

Additionally, a Fair Hearing can be filed at the conclusion of the grievance process by contacting the Pennsylvania Department of Human Services or CBH. The filing of a Fair Hearing must be no later than 120 days from the mail date on the written notice the member receives of the grievance decision.

4.6. Provider Teamings

An interdepartmental provider teaming is convened when CBH becomes aware of a significant provider-related issue. This may include quality concerns, significant member incidents, a Provisional Licensing status by the Office of Mental Health and Substance Abuse Services (OMHSAS) or the Department of Drug and Alcohol Program (DDAP), or a request initiated by the CBH Board of Directors. Any CBH Officer or staff person in consultation with the Director of Quality Management can convene a Provider Teaming. Depending on the nature of the concern, staff representing Quality Management, Program Integrity, Medical Affairs, Provider Operations, Clinical Management, Provider Relations, Member Services, Data Informatics, Consumer Satisfaction Team (CST), Behavioral Health Special Initiative (BHSI), and/or other DBHIDS staff may be included in the provider teaming. During the teaming, a review of all issues occurs, and a plan of action is determined. A plan of action may include, but not be limited to, a request for a Quality Improvement Plan or action plan, chart reviews, or site visit.

4.7. Quality Concerns

Quality of care issues are typically generated by Clinical Management and/or Medical Affairs as a result of clinical and service request reviews or by Member Services regarding incidents and member concerns when members do not wish to file a formal complaint. Quality of care concern issues include, but are not limited to, assessment, coordination of care, discharge planning, treatment, and prescribing practices.

4.8. Clinical Appeals Procedure

In accordance with Act 68, Quality Health Care Accountability, providers may submit a clinical appeal in writing to request retrospective reimbursement for days of service not authorized. Appeals can occur at two levels.

4.8.1. First Level Appeals

4.8.1.1. Step One

All first level appeal requests must be submitted no more than 90 days after the last day of the episode of care in question. The appeal packet must include:

➡ A cover letter with the following information:

  » Name/contact information of the person submitting the appeal

  » Member's name and an identifier such as SSN, DOB, or MA#

  » Exact level of care being requested

  » Exact dates of service in question

  » Brief explanation of the reason for the appeal

Cover letter should be addressed to:

Community Behavioral Health
ATTN: Quality Management/Appeals
801 Market Street, 7th Floor
Philadelphia, PA 19107

Or emailed to:

CBH.Quality.Review@phila.gov

AND

➡ All documentation related to the dates in question, including evaluations, assessments, progress notes, laboratory tests, discharge summary, documentation showing TPL appeals have been exhausted (if applicable), etc.

4.8.1.2. Step Two

CBH Clinical Appeals will review the case and determine if the case warrants:

➡ An **Administrative Review**, meaning the provider did not adhere to CBH protocols or the case involves a clerical or procedural error or there are other extenuating circumstances (for example, the member was unable to provide their name at the time of admittance but once their identify was verified, CBH approved services as requested)

OR

➡ A **Physician Review**, meaning the dates in question were denied by a CBH physician and the case needs to be reviewed by another CBH physician, or the dates in question were note reviewed due to an extenuating circumstance such as an inability to correctly identify the member until after discharge

4.8.1.2.1. Medicare Primary

CBH is required to pay as secondary payor for members who have Medicare as their primary insurance. The provider does not need to do a precertification or receive approval for Acute Inpatient Psychiatric Hospitalization from CBH if Medicare is paying as the primary insurer. The Clinical Department will generate the authorization for in-network providers. For out-of-network providers, the Clinical Department will submit an out-of-network form to the Provider Relations Representative.

4.8.1.3. Step Three

CBH will notify providers of the result of their appeal verbally and in writing within 30 days of receipt. CBH will comply with the timeframes set forth in 28 Pa. Code. 9.753(c). If the dates in question are denied after a Physician Review, the provider may submit a Second Level Appeal. Instructions for submitting the Second Level Appeal will be provided in the response letter. Please keep in mind that a provider cannot seek a Second Level Appeal if the First Level Appeal was denied due to an Administrative Review.

4.8.2. Second Level Appeals

If the provider disagrees with the First Level Physician Review Appeal decision, the provider may request a Second Level Appeal.

4.8.2.1. Step One

All second level appeals must be submitted in writing no more than 30 days from receipt of the First Level Appeal response letter. Providers do not need to resubmit clinical information.

All second level appeals should be addressed to:

> *Community Behavioral Health*
> *ATTN: Quality Management/Appeals*
> *801 Market Street, 7th Floor*
> *Philadelphia, PA 19107*

Or emailed to **CBH.Quality.Review@phila.gov**.

4.8.2.2. Step Two

A CBH physician who did not previously participate in any decision to deny payment for the service will review the clinical information and notify providers of the result of their appeal verbally and in writing within 30 days of receipt. CBH will comply with the timeframes set forth in **28 Pa. Code § 9.753.(c)**.

The decision of the Second Level Appeal is final.

4.9. Documentation and Significant Incident Reporting

All CBH providers are required to submit significant incident reports for all CBH funded members. Please also see **Bulletin 20-20**, the Provider Notice from November 8, 2021, "**Change to Significant Incident Reporting**," and the Provider Notice from February 5, 2024, "**Significant Incident Reporting**" for additional information.

A **Significant Incident** is any occurrence of a non-routine event which is inconsistent with standards or practice and has or has the potential to jeopardize the health and/or wellbeing of an individual receiving services. Reportable Significant Incidents include, but are not limited to, the following:

➡ Death of a member

➡ Restraints (physical, mechanical, and chemical)

➡ Seclusion

➡ Homicide committed by a member who is receiving services or has been discharged within 90 days

➡ Suicide attempt (with or without medical intervention)

➡ Act of violence requiring medical intervention (includes intervention provided by staff nurse/physician), by or to a member

➡ Alleged or suspected abuse (physical, sexual, verbal, financial) of or by a member

➡ Adverse reaction to medication and/or medication error administered by a provider (includes Medication Assisted Treatment dispensing errors)

➡ Any physical ailment or injury that requires non-routine medical attention at a hospital on an emergency, outpatient, or inpatient basis (includes visits to urgent care)

➡ Neglect which results in injury or hospital treatment (committed by provider)

➡ Elopement from facility:

» Adults

- An adult who is out of contact with staff without prior arrangement or who may be in "immediate jeopardy" based on their personal history

- Any time the police are contacted about a missing person, or the police independently find and return the member regardless of the time the member was missing

» Children/Adolescents

- A child/adolescent who is absent from the facility premises without the approval of staff

- Any time the police are contacted about a missing person

➡ Police involvement or arrest (excludes involuntary commitments [302s])

➡ Fire, flood, or serious property damage at a site where behavioral health services are delivered or a facility where members reside

➡ Infectious disease outbreak at a provider site

➡ All non-routine discharges from inpatient, residential rehabilitation (drug and alcohol), children's residential treatment, detoxification, or methadone maintenance treatment (i.e., administrative/involuntary discharges or leaving a facility against medical or facility advice [AMA, AFA])

➡ Any sexual contact involving a minor, non-coerced or otherwise, that occurs at a provider site

➡ Presence of contraband (illicit substances and synthetic cannabinoids) at a bed-based facility

4.9.1. Reporting Process

➡ Any **death** which occurs at a provider facility must be immediately reported to CBH's Psychiatric Emergency Services (PES) line. The PES line can be contacted at (215) 413-7171.

➡ A copy of all **reportable incidents** must be emailed to **CBH.Quality.Review@phila.gov** or faxed to the Quality Management Department at (215) 413-7132 on the attached Significant Incident Report form within 24 hours of an incident or upon notification of an incident. All Significant Incident Report forms must indicate the Provider Number in Section 7 if applicable.

» Exceptions:

- Reports of children who have not returned home or to the facility within 4 hours must be reported immediately.

- All CBH-funded Long-Term Structured Facilities (LTSR) will only enter the reportable incident into the Enterprise Incident Management (EIM) system within 24 hours of the occurrence.

➡ When an **internal investigation** is warranted, the provider must submit a copy of the investigative report to CBH within 14 days of the incident. Investigative reports must clearly document how the incident was investigated and the findings of the investigation, including any corrective actions taken to prevent further occurrence. Investigative reports may be emailed to **CBH.Quality.Review@phila.gov**, faxed to the Quality Management Department at (215) 413-7132 or mailed to:

Community Behavioral Health
Quality Management Department
801 Market Street, 7th Floor
Philadelphia, PA 19107

NOTE: If an investigation is not completed within the designated 14 days, the provider must notify the Quality Management Department of the investigation status, including preliminary findings, and a projected investigation completion date.

➡ Incidents involving **alleged physical abuse, sexual abuse, and/or neglect of children** must be reported to the Pennsylvania Department of Human Services (PA DHS). Providers are mandated by the PA DHS to report incidents directly by calling the Commonwealth's Childline at (800) 932-0313 or by submitting the information via **the online portal here**.

  » For incidents involving alleged abuse or neglect, providers must submit the PA DHS notification letter (indicated/unfounded) to the Quality Management Department upon receipt. If the provider has not received a notification letter, but has received verbal communication from the PA DHS, the provider must notify the Quality Management Department of the date the verbal determination was provided and the name of the investigator providing the verbal determination. If an allegation is deemed indicated or a Licensing/Approval/Registration Inspection Summary Violation is issued, the provider must submit a copy of the Licensing/Approval/Registration Inspection Summary Violation and the corresponding Corrective Action Plan submitted to the PA DHS.

➡ A missing person who may be at-risk should be reported to the Philadelphia Crisis Line by filling out the **DBHIDS Missing Persons Form** in addition to a police report being filed. Alternatively, and if you have any questions, please call Philadelphia Crisis Line at 215-685-6440 who can assist in filling out the form. The Philadelphia Crisis Line will then notify the Crisis Response Centers (CRC), so that they can notify the provider if the member presents at a CRC.

➡ A missing person who may be at-risk should be reported to the Philadelphia Crisis Line by calling 215-685-6440, and a police report should be filed. The Philadelphia Crisis Line will the notify the Crisis Response Center (CRC), so that they can notify the provider if the member presents at a CRC. In addition, the **DBHIDS Missing Persons Form** should be completed.

4.9.2. Where to Send Significant Incident Reports

All reportable incidents must be emailed or faxed to CBH Quality Management	CBH.Quality.Review@phila.gov Fax: 215-413-7132
Investigative reports may be emailed, faxed, or mailed to CBH Quality Management	CBH.Quality.Review@phila.gov Fax: 215-413-7132 Community Behavioral Health Quality Management Department 801 Market Street, 7th Floor Philadelphia PA, 19017
Incidents involving the suspected abuse/neglect of children must be reported to the Commonwealth's Childline or through the Child Welfare Portal.	800-932-0313 compass.state.pa.us/cwis/public/home
An at-risk missing person should be reported to the Acute Services Mental Health Delegates.	215-685-6440
Death of a member at a provider facility must be reported to the CBH PES Line.	215-413-7171
Incidents involving the suspected abuse/neglect of an adult between 18 and 59 years old who has a physical or mental impairment that substantially limits one or more major life activities must be reported to the Commonwealth's Protective Services Hotline.	800-490-8505

4.10. "Provider Preventable Conditions" Reporting

The Centers for Medicare and Medicaid Services (CMS) finalized a rule in 2011 (42 CFR parts 434, 438, 447) prohibiting Medicaid payments for the additional costs of medical services resulting from certain preventable healthcare-acquired events (referred to as Provider preventable conditions [PPCs]). There are two categories of PPCs: Health Care Acquired Conditions (HCACs), which apply to inpatient settings, and Other Provider Preventable Conditions (OPPCs), which may occur in any setting.

When a potential PPC is identified, CBH may withdraw payments made or deny claims that have not already been paid. CBH will ensure that all appropriate steps are taken to report these conditions in accordance with state and federal regulations.

For CBH covered services, most of these events will pertain to Falls and Trauma and Other Injuries. These events include, but are not limited to, the following that take place in an acute inpatient unit:

➡ Significant physical injury to the member by staff (e.g., fractures)

➡ Sexual assault of a member by staff

➡ Medication errors that result in a physical health intervention and/or prolong the member's hospital stay

➡ Suicide (completed suicide will be considered a PPC in instances where there is deviation from protocols or policies or significant findings around quality of care)

The member's case will be assessed by Quality Management staff in consultation with a Medical Director. Quality Management staff, under the direction of the Medical Director, may request supporting documentation from the Provider—including intake notes or lab results—to assist in the determination of the presence of a PPC. The Medical Director will review the documentation to determine if the event was PPC and what portion of the stay was related to treatment of the PPC.

Providers are responsible for submitting the **Other Provider Preventable Conditions (OPPC) Self Reporting Form** to CBH every time a PPC is identified, per state regulations. The form should be faxed to the Quality Management Department at 215-413-7132.

4.11. Pay-for-Performance (P4P) and Value-Based Payment (VBP) Performance Measures

The following tables contain performance measures and goals used for 2024 P4P and VBP reports. For detailed definitions of P4P measures, please see the **2024 P4P Operational Definitions Master Document**. For detailed definitions of VBP measures and your program's most recent performance report, please contact your provider representative.

4.11.1. 2024 P4P Performance Measures and Goals

Level of Care	Performance Metric	2024 Performance Goal
Acute Inpatient Extended Acute Care (EAC)	EAC 30-day Follow-up After Discharge	90.00%
Acute Inpatient Extended Acute Care (EAC)	30-day Readmission to Acute Inpatient Hospital	38.70%
ASAM 3.5	7-Day Follow-up After Discharge	Goals TBD
ASAM 3.5	30-Day Follow-up After Discharge	Goals TBD
ASAM 3.5	Percent Not Readmitted Within 90 Days of Discharge	Goals TBD
ASAM 3.5	Percent of Discharges Receiving Methadone or Buprenorphine within 7 Days or Vivitrol or Sublocade within 35 Days	Goals TBD
Children's Acute Inpatient	7-Day Follow-up After Discharge	63.00%
Children's Acute Inpatient	30-Day Follow-up After Discharge	75.00%

Level of Care	Performance Metric	2024 Performance Goal
Children's Acute Inpatient	30-day Readmission to Acute Inpatient	11.75%
Children's Case Management (CM)	Percent Having a CM Contact Within 2 Days of Inpatient Admission	90.00%
Children's Case Management (CM)	Percent Having a CM Contact Within 7 Days of Inpatient Discharge	90.00%
Children's Case Management	Percent of Authorizations Having At Least One 31-Day Gap Between Services	10.00%
Children's Case Management	Percent of Persons Having At Least One Inpatient Admission	10.00%
Journey of Hope	7-Day Follow-Up After Discharge (Stable Discharges)	84.43%
Journey of Hope	14-Day Follow-Up After Discharge (Stable Discharges)	90.00%
Journey of Hope	Percent Having Length of Stay Greater than or Equal to 3 Months (Stable Discharges)	86.40%
Journey of Hope	Percent Not Readmitted to Acute Levels of Care within 90 Days of Discharge (Stable Discharges)	90.00%
Mental Health Outpatient	Percent Discharged from Higher LOCs Having Follow-Up within 30 Days	Adults: 84.40% Children Non-ASD: 80.0%
Mental Health Outpatient	Percent Having at Least 2 Services Within 30 Days of Episode Start	Adults: 68.50% Children Non-ASD: 75.38% Children ASD: 48.15%
Mental Health Outpatient	Percent of Episodes Having Two or Fewer Services	Adults: 24.3% Children Non-ASD: 21.11% Children ASD: 36.30%

4.11.2. Table 2. 2024 VBP Performance Measures and Goals

Level of Care	Performance Metric	2024 Performance Goal
Assertive Community Treatment (ACT)	ACT claim within 7 days of discharge from acute inpatient hospital	95.00%
Assertive Community Treatment (ACT)	In-Community Days per total authorization days	92.70%

Level of Care	Performance Metric	2024 Performance Goal
Assertive Community Treatment (ACT)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	72.30%
Adult Acute Inpatient	7-Day Follow-up After Discharge	63.00%
Adult Acute Inpatient	30-Day Follow-up After Discharge	75.00%
Adult Acute Inpatient	30-day Readmission to Acute Inpatient	11.75%
ASAM Outpatient (OP)	Percent of Members with an Opioid Use Disorder (OUD) Receiving Medication-Assisted Treatment (MAT) and Counseling (MAT-OUD)	73.70%
ASAM Outpatient (OP)	Percent of Members with an Alcohol Use Disorder (AUD) Receiving Medication-Assisted Treatment (MAT) and Counseling (MAT-AUD)	10.60%
Children's Mobile Intervention Services (CMIS)	7-Day Follow-up After CMIS	28.30%
Children's Mobile Intervention Services (CMIS)	30-Day Follow-up After CMIS	48.70%
Children's Mobile Intervention Services (CMIS)	30-Day Readmission to Children's Crisis, Acute Partial Hospital (APH), or Acute Inpatient (AIP)	8.00%
Children's Mobile Crisis Team (CMCT)	7-Day Follow-up After CMCT	61.20%
Children's Mobile Crisis Team (CMCT)	7-Day Readmission to UCC, CRC, CSU, or CMCT	14.50%
Crisis Stabilization Unit (CSU)	7-Day Follow-up from CSU	71.60%
Crisis Stabilization Unit (CSU)	7-Day Readmission to AIP, CMCT, UCC, CRC, or another CSU service	8.80%
Crisis Stabilization Unit (CSU)	Percent of CSU Stays of 5 Days or Less	35.60%
Pediatric Crisis Response Center (CRC)	7-Day Follow-up from CRC	74.20%
Pediatric Crisis Response Center (CRC)	7-Day Readmission to CRC	1.10%
Pediatric Urgent Care Center (UCC)	7-Day Follow-up from UCC	48.70%

Level of Care	Performance Metric	2024 Performance Goal
Pediatric Urgent Care Center (UCC)	30-Day Follow-up from UCC	66.90%
Pediatric Urgent Care Center (UCC)	30-Day Readmission to CMCT, CRC, CSU, AIP, APH, or another UCC service	20.50%
Community Integrated Recovery Center (CIRC)	Percent Discharged from Psychiatric Inpatient Having Follow-Up with CIRC Within 30 Days	95.00%
Community Integrated Recovery Center (CIRC)	Percent Discharged from Psychiatric Inpatient Without an Inpatient Readmission Within 30 Days	84.40%
Community Integrated Recovery Center (CIRC)	Percent of WHO-QOL BREF Instruments Administered Every Six Months	90.50%
Community Integrated Recovery Center (CIRC)	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	70.8%
Community Integrated Recovery Center (CIRC)	Diabetes Monitoring for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SMD)	70.8%
Community Integrated Recovery Center (CIRC)	Lipid Monitoring For Members With Cardiovascular Disease And Serious Persistent Mental Illness (SMC)	50.4%
Intensive Behavioral Health Services (IBHS)	Percent of Crisis Services Concurrent with IBHS	4.0%
Intensive Behavioral Health Services (IBHS)	Percent of Acute Inpatient or Acute Partial Hospital Services Concurrent with IBHS	3.0%
Intensive Behavioral Health Services (IBHS)	Average Number of Days from Written Order to Assessment	23 Days
Residential Treatment Facilities for Children (RTF)	180-Day Community Tenure	76.90%
Residential Treatment Facilities for Children (RTF)	Referral Acceptance Rate	35.60%
Residential Treatment Facilities for Children (RTF)	Percent of Admissions within 60 Days of Referral	77.70%
Residential Treatment Facilities for Children (RTF)	Restraints per 1000 Authorized Units	ASD/ID RTF: 34.4 General RTF: 8.0

Level of Care	Performance Metric	2024 Performance Goal
Adult Targeted Case Management (TCM)	Percent Having a TCM Contact Within 2 Days of Acute Inpatient Admission	Non-Fidelity ACT: 66.30% TCM: 56.50%
Adult Targeted Case Management (TCM)	Percent Having a TCM Contact Within 7 Days of Acute Inpatient Discharge	Non-Fidelity ACT: 82.5% TCM: 70.60%

5. PROGRAM INTEGRITY

5.1. Overview

CBH requires its provider network to act in a legal manner consistent with all applicable governmental standards and requirements and CBH contractual obligations and policies. CBH established a Program Integrity Department to facilitate adherence to these standards and policies and to prevent, detect, and mitigate incidences of fraud, waste, and abuse within the provider network. The Program Integrity Department is also responsible for credentialing independent and group practitioners, Federally Qualified Health Centers (FQHC), and their Behavioral Health Consultants (BHC).

The Program Integrity Department is composed of two distinct yet integrated units: the Clinical Audit Team (CAT) and the Network Personnel Analysis Unit (NPAU).

The CAT's primary functions are auditing and assisting providers in processing self-audits. The CAT conducts Corrective Action Plan (CAP) and Directed Corrective Action Plan (DCAP) monitoring, educational, probe, prepayment, and targeted audits. Additionally, the unit ensures that effective training related to fraud, waste and abuse is provided to CBH, across the Department of Behavioral Health & Intellectual disability Services (DBHIDS), and to provider staff.

The NPAU conducts staff file reviews to assure that the requirements associated with delegated credentialing are being met for facilities. The NPAU conducts initial and re-credentialing of independent and group practitioners, Federally Qualified Health Centers (FQHCs), and their Behavioral Health Consultants (BHCs). The NPAU is also responsible for maintaining the **Manual for the Review of Provider Personnel Files (MRPPF)** section of the Provider Manual and analyzing data to identify potential staffing gaps and/or training issues within the system. The NPAU is responsible for collecting, maintaining, and analyzing network personnel rosters.

All clinical auditing activities are conducted under the direction of the CBH Program Integrity Committee. For all personnel review matters, and credentialing of independent practitioners, group practices, and FQHCs and BHCs, the CBH Program Integrity Department reports to the CBH Credentialing Committee.

5.1.1. Definitions of Fraud, Waste, and Abuse

➡ **Abuse:** "Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program." – *42 CFR § 455.2*

➡ **Fraud:** "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law." – *42 CFR § 455.2*

➡ **Waste:** "Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources." – *HealthChoices Program Standards and Requirements*

5.1.2. Key Responsibilities of the Program Integrity Department

➡ Develop and carry out an annual Program Work Plan

➡ Monitor CBH provider network for compliance with Medicaid regulations and CBH requirements

- ➡ Perform audits of providers' clinical records and personnel files

- ➡ Implement processes to impose sanctions and/or corrective action plans for providers who violate Medicaid program standards and requirements or CBH policies; monitor CAPS and DCAPs

- ➡ Perform initial and re-credentialing for independent and group practitioners, FQHCs and BHCs

- ➡ Provide regular reviews of overall compliance efforts to the CBH Board of Director's Program Integrity and Credentialing Committees and other components of the DBHIDS as necessary

- ➡ Establish and maintain mechanisms for the reporting of non-compliance/fraud, waste, and/or abuse to appropriate commonwealth oversight agencies and law enforcement

- ➡ Maintain a cooperative relationship with government oversight agencies and fully cooperate in any investigation of suspected fraud, waste, and abuse

- ➡ Maintain a database of provider rosters

5.1.3. Federal and Commonwealth Laws Pertaining to False Claims and Statements

It is the policy of CBH to comply with all relevant federal and commonwealth laws related to fraud, waste, and abuse.

The Federal False Claims Act (FCA), 31 U.S.C. § 3729 et seq. prohibits the intentional submission of a false or fraudulent claim for payment to the federal government, and the use of false statements or records for the purpose of obtaining an improper payment or concealing the receipt of such a payment.

The FCA applies to all claims for payment of an item or service furnished to a beneficiary of Medicare, Medicaid, or other federally financed health care program. It also applies to certain claims-related filings and reports such as Medicare and Medicaid cost reports.

The FCA also authorizes private whistleblowers to file a suit against another private party for alleged false claims. The federal government has the option to join the suit or let the original private party pursue the matter on their own. If the suit ultimately results in a recovery, the whistleblower that initially brought the suit may be awarded a percentage of the funds recovered, plus their reasonable attorney's fees and costs. A whistleblower's share may be reduced or eliminated if they are found to have planned and initiated the false claims violation.

The FCA prohibits retaliation against an employee who files a whistleblower suit. An employee may not be discharged, demoted, suspended, threatened, harassed, or otherwise retaliated against in his or her employment as a result of the employee's lawful acts in furtherance of a false claims action. The whistleblower may be entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorney's fees.

42 U.S. Code § 1320a-7b details criminal penalties for acts involving federal health care programs. Providers found to be noncompliant could face substantial fines, temporary and permanent exclusions from the Medicare and Medicaid programs, and criminal prosecution and imprisonment. Penalties will apply not only to those who knowingly engage in improper practices, but also those who deliberately or recklessly disregard their legal obligations or endanger the health and/or welfare of a member.

Pennsylvania's Medical Assistance program prohibits

➡ the knowing presentation of a false claim,

➡ the knowing presentation of a claim for medically unnecessary services,

➡ the knowing submission of false information to obtain an excessive payment, and

➡ the knowing submission of false information to obtain authorization or certification to provide such services.

Pennsylvania law also prohibits an individual from knowingly making a false statement, failing to disclose a material fact, or concealing an event regarding such person's eligibility for medical assistance benefits. Commonwealth officials may seek criminal penalties for violations of these laws.

While Pennsylvania's Medical Assistance regulations do not include whistleblower protection against workplace retaliation, Pennsylvania's Whistleblower Law generally prohibits an employer from discharging, threatening, or otherwise discriminating or retaliating against an employee who makes a good faith report about an instance of wrongdoing or waste, or an employee who participates in an investigation, hearing, or inquiry.

5.2. Reporting Concerns Regarding Fraud, Waste, Abuse, and False Claims to Oversight Entities

Upon identification of any instances of suspected or substantiated fraud, waste, or abuse, CBH expects immediate corrective action. If fraud, waste, and/or abuse is suspected, CBH involves Pennsylvania's Department of Human Services Bureau of Program Integrity (BPI)/Office of Attorney General Medical Fraud Control Section (OAG MFCS) or the Federal Office of the Inspector General (OIG), the Pennsylvania State Inspector General, and the United States Justice Department, and/or law enforcement as appropriate. CBH will also immediately notify BPI and the OAG MFCS, as appropriate, when a provider, staff member, contractor or vendor has been identified as being excluded from federal programs, including Medicaid. This will apply to existing providers in the network and those applying to enter the CBH provider network.

5.2.1. CBH Program Integrity Department's Compliance Hotline

CBH maintains telephonic and electronic reporting mechanisms to allow any CBH employee, member, employee, vendor, or agent of a CBH provider, or the public at large to report concerns of fraud, waste, and/or abuse by CBH employees, vendors, contractors, members, and network providers. It is mandatory that providers display the hotline posting in a location visible to CBH members and provider staff. Versions of the posting in English and Spanish are available upon request. CBH on-site audits may include requests to view the posting.

Reports to the hotline can be made confidentially via phone or email.

The CBH Compliance Hotline, 1-800-229-3050, is staffed 9:00 to 11:00 a.m. and 2:00 to 4:00 p.m. Monday through Friday and messages can be left at any time. The Program Integrity Department also maintains a confidential inbox at **CBH.ComplianceHotline@phila.gov** for electronic reporting of fraud, waste, and/or abuse.

Individuals may also contact the Pennsylvania Department of Human Services (DHS) Fraud and Abuse Hotline at 1-866-DPW-TIPS (1-800-379-8477) or online through the **MA Provider Compliance Hotline Response Form**.

5.3. Provider Responsibilities Regarding Fraud, Waste, and/or Abuse

CBH expects its providers, contractors and/or agents, as well as their employees, to comply with all applicable federal and state laws and regulations in addition to all applicable CBH policies, rules and contractual terms and requirements. These include but are not limited to:

➡ Providers are required to develop a corporate compliance program that is designed to minimize an organization's risk of violating federal statutes and regulations related to the Medicare and Medicaid programs.

➡ Providers must have a system to ensure that employees know, understand, and comply with the legal requirements that apply to the business, including those for submitting claims for payment to CBH.

➡ Providers must be able to provide documentation to support that all services billed to CBH were rendered.

➡ Providers must have documentation to support that the services billed were covered by CBH.

➡ Providers must have mechanisms to identify, investigate, and take corrective action for suspected or substantiated fraud, waste, and abuse activities.

➡ Providers must notify the CBH Program Integrity Department of suspected program, staff, or member fraud, waste, and/or abuse immediately upon discovery. Upon receipt of suspected fraud, waste, and/or abuse allegation, the Program Integrity Department will investigate and determine the outcome.

➡ Providers are required to conduct self-audits that are consistent with the self-audit protocol as described on the **DHS Medicaid Provider Self-Review Protocol webpage**. Providers must notify the CBH Program Integrity Department prior to initiation of a self-audit, and complete the Program Integrity Department Self-Audit Protocol (see **Provider Bulletin 18-17: Self-Auditing Process for CBH Providers** and the **Provider Self-Auditing Form**), which follows the commonwealth's.

5.3.1. Examples of Specifically Prohibited Activities

➡ Billings for services not rendered

➡ Misrepresenting the services rendered

➡ Falsely certifying that services met medical necessity criteria

➡ Submitting a claim for physician services by an unlicensed individual or by a person who has a lesser credential

➡ Making false statements or representations related to an institution's compliance with its Conditions of Participation

➡ Retaining Medicare or Medicaid funds that were improperly paid

➡ Billing multiple funding streams for the same services

➡ Billing for a more expensive service when a less intensive services was actually provided (upcoding)

➡ Provision of service to CBH members by an individual who has been excluded from participation in Medicaid, Medicare, or other federal agencies

5.3.2. Compliance Plans

Providers are reminded that the CBH Provider Agreement requires them to have a written Compliance Plan. The seven elements of an effective compliance plan include:

➡ Implementing written policies, procedures, and standards of conduct

➡ Designating a compliance officer and/or compliance committee

➡ Conducting effective training and education

➡ Developing effective open lines of communication

➡ Enforcing disciplinary standards through well-publicized guidelines

➡ Conducting internal monitoring and auditing

➡ Responding promptly to detected offenses and developing corrective action

5.4. Program Integrity Department Work Plan

The Program Integrity Department maintains an annual work plan detailing the department's planned targeted activities for the following calendar year. The annual work plan will highlight areas of targeted interest for the coming year focusing the Program Integrity Department's efforts and utilizing resources effectively and efficiently. The plan is developed utilizing agency-wide goals, the U.S. Department of Health and Human Services Office of Inspector General Annual Work Plan and other oversight entities.

The annual work plan may include training activities or reviewing specific levels of care to ensure consistency across providers.

5.5. Program Integrity Department Audits

CBH Program Integrity Department audits and provider self-audits will often identify fraud, waste, and/or abuse resulting in financial consequences for providers. CBH will recoup payments, paid units, settlements, and/or extrapolated amounts for unsubstantiated services.

Program Integrity Department audits may be conducted on both in-network and out-of-network providers.

5.5.1. Types of Audits

Several types of audits are conducted, including the following:

5.5.1.1. Educational Audits

CBH providers may request an educational audit for the agency, program(s), or specific level(s) of care. CBH Program Integrity or other departments may recommend educational audits for new providers or programs. These audits review the comprehensiveness and sufficiency of clinical documentation as it relates to supporting the service provided. In educational audits, most observed errors will be reported as "non-variance", with no financial impact. Non-variance

concerns are those noted by the CBH Program Integrity Department as concerning that could have financial impacts as part of future audits but carry no financial impact for the current audit. Certain error types: missing documentation, services provided by unqualified staff, and services not rendered, will always be considered an overpayment and the financial impact calculated accordingly. A probe or targeted audit may be scheduled when an educational audit identifies significant concerns. Probe or targeted audits resulting from an educational audit will typically be scheduled only after sufficient time has passed for the agency to implement corrective actions to ensure documentation meets CBH minimum standards.

5.5.1.2. Prepayment Review Audits

Audits conducted prior to the release of payments for claims received by CBH. All providers should be prepared for a prepayment review at any time, along with the longer payment cycles and possibly higher claims denials as a result.

The CBH Program Integrity Department may conduct prepayment reviews of billing information and supporting medical record documentation. Prepayment reviews may be recommended for any of the following reasons:

➡ Unusual claims activity

➡ Claims submitted following Program Integrity Department audits and provider self-audits yielding high instances of errors and/or overpayment recoveries

➡ Patterns of claims and coding errors

➡ Hotline contacts indicating improper conduct related to billing or documentation

➡ Referrals and tips

➡ Submissions of late/retroactive claims

➡ Providers who are new to the network

➡ Providers who have returned to the network after leaving with compliance-related concerns

➡ Requests from CBH Chief Financial Officer, Claims Department, or Program Integrity Committee

➡ Prior to/in lieu of termination and/or payment suspension efforts to mitigate risks from credible allegations of fraud

The Program Integrity Department will notify a provider in advance of a prepayment review. The provider's related claims, as they are processed, will be identified as part of the prepayment review. The provider must submit supporting documentation, which is then reviewed by the department, and the claims will be either released for payment, or declined.

Prepayment reviews may be conducted on a provider's entire universe of claims, or for selected programs and/or levels of care. The scope of the audit will be communication to the provider upon notification of the review. The duration of the review, and the thresholds that must be met in order to terminate the review, will be described in the notification to the provider.

Prepayment reviews may be conducted via desk audit, on-site audit, or a combination.

Prepayment reviews will be completed within the normal adjudication cycle from the date of claim receipt but may delay claims from the standard adjudication timeline.

If the provider fails to make documentation available, all related claims will be declined for payment.

5.5.1.3. Probe Audits

Probe audits may be scheduled in response to a tip or referral, or as part of a review of documentation and billing for a provider/group of providers or level of care and may reflect priorities in the Program Integrity Department Annual Work Plan. These audits investigate a provider and/or program's compliance with service and documentation rules and regulations.

5.5.1.4. Targeted Audits

Targeted audits may be conducted by either or both Program Integrity Department units, the CAT and Network Personnel Analysis Unit (NPAU). Other departments across the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) may assist in the completion of targeted audits. Possible sources of referral that would initiate an audit include, but are not limited to, the CBH Program Integrity Department fraud, waste, and abuse reporting mechanisms, member and/or provider complaints, trends, or questionable billing identified through data mining, results from probe audits, and referrals from other departments. Referrals are also received from licensing visits, the BPI and OAG MFCS. Targeted audits may include the use of statistically valid random samples and/or extrapolation.

5.5.1.5. Self-Audits

An audit conducted by a provider in accordance with the **Pennsylvania DHS Medicaid Provider Self-Audit Protocol**, and the CBH Program Integrity Department Self-Audit Protocol (see **Provider Bulletin 18-17: Self-Auditing Process for CBH Providers** and the **Provider Self-Auditing Form**).

5.5.1.6. NPAU Targeted and Level of Care Specific Audits

The NPAU conducted targeted and level of care- specific audits of provider personnel files. The following may be reviewed: licensure (when required), diploma and/or transcript, foreign degree and/or accreditation (when required), verification of requisite experience, clearances, trainings, and any other required documentation as outlined in the MRPPF, as well as materials specific to the targeted areas.

5.6. What to Expect from a Program Integrity Audit

Audits may be conducted on-site at a provider, via desk audit, or a combination of the two. Desk audits may consist of review of provider-submitted documentation, remote access to an electronic medical record, and/or an in-house review of trends or questionable billing identified through claims data mining.

5.6.1. On-Site Audits

For audits at the provider's location, the Program Integrity team will arrive between 8:45 and 9:00 a.m. and present the chart list to the provider representative. Audits may be announced or unannounced, at the CBH Program Integrity Department's discretion. Conducting unannounced visits to review and assess potential fraud, waste, and/or abuse is a widely accepted practice for Special Investigation/Program Integrity Units across the country. In general, the notice provided will be determined, at least in part, by the type of audit being conducted; a summary is detailed below. CBH reserves the right to amend these guidelines based on the precipitating circumstances of the review.

Typical Time Amount of On-Site Audit Notice	
Educational	One Week

Typical Time Amount of On-Site Audit Notice	
Probe	24-48 Hours
Targeted Unannounced	No notice (including extrapolation)

5.6.1.1. Request for Documentation for Audits at Provider's Location

CBH providers receiving an on-site audit will be required to provide Program Integrity Analyst(s) access to requested records in a timely manner. This includes paper charts and electronic medical records.

5.6.1.2. Document Scanning During On-Site Audits

To ensure integrity of documentation and deter alterations following a Program Integrity review of clinical records or personnel files, CBH Program Integrity Analyst(s) may scan potentially problematic documentation during a field audit. CBH Program Integrity Analysts will be equipped with portable scanners programmed to save documentation to HIPAA compliant, encrypted laptop computers. Documents will be transferred to CBH's secure network and deleted from the laptop upon an analyst's return to the office. When reviewing medical records in an electronic health records system, analysts may capture screen shots for future review. Potentially problematic documentation may include, but is not limited to re-use of content, missing signature(s), date/time errors, overlapping services, discrepant information, and insufficient documentation. Providers will be notified during the audit exit meeting if records were scanned/electronically captured during the audit.

5.6.2. Announced Audits

When the chart list is given to providers a day in advance (i.e., the workday prior to the audit day), providers must provide access to all paper charts and/or Electronic Health Records (EHR) records starting at 9:00 a.m. For instances when the chart list for an announced audit is given to providers the morning of the audit, providers must start allowing access to paper charts and/or EHR records by 9:30 a.m. and continue in a constant flow until all charts are presented during the course of the audit day. The audit team lead will communicate the end time that access to all of the charts is needed, basing this time on the number of charts being audited. For providers with multiple programs requiring multi-day visits, chart lists will be presented each morning for each additional program to be audited that day.

If the provider requires the chart list the day prior to the audit to allow the provider's Information Technology department to create auditor accounts, charts are to be made available upon Analysts' arrival at 9:00 a.m.

5.6.3. Unannounced Audits

Providers must provide access to paper charts and/or EHR records starting at 10:00 a.m. and continue in a constant flow until all charts are presented during the course of the audit day. The Audit Leader will communicate the end time that access to all of the charts is needed, basing this time on the number of charts being audited. For providers with multiple programs requiring multi-day visits, chart lists will be presented each morning for each program to be audited that day.

CBH reserves the right to apply more strict deadlines for chart availability when allegations have been made related to fraudulent note creation.

Providers are reminded that with the initiation of extrapolation and use of random claims selection for probe audits, Program Integrity Department audits may include more charts than providers are accustomed. Audits, particularly those requiring large numbers of charts, can put significant strain on medical records departments. We encourage provider

agencies to have a plan and mechanism in place for the retrieval of significant numbers of charts with no prior notice. It is vital that charts are complete and easily accessible in the event any oversight entity arrives for an unannounced audit. Each CBH provider must have written policies and procedures for the maintenance of clinical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. These policies and procedures must also address the prompt retrieval of records that may be housed off-site.

In the event Analysts are unable to complete the review of charts during the audit day, they will return to the provider location the following day. In this case, all charts must be made available upon Analysts' arrival at 9:00 a.m. on the second and subsequent days.

If a provider fails to provide sufficient charts in a timely manner, the Analyst(s) consider the audit cancelled by the provider and will leave the on-site audit and return to the CBH office. The CBH Program Integrity Department will then notify the CBH Program Integrity Committee, which will determine whether all payments for the unseen records will be recouped, or the audit rescheduled, and if so, if it will be announced or unannounced.

Providers are responsible for ensuring documentation of services is present in the clinical record within seven days of the service or before the service is billed, whichever comes first. Providers will be required to locate the documentation during the audit in the event CBH Program Integrity Analysts are unable to locate documentation related to a paid claim.

The CBH Program Integrity Audit Leader, or designee, will communicate with the provider representative periodically throughout the audit day when an Analyst is unable to locate required documentation in the record. The provider representative will be asked to review the member record in the presence of the CBH auditing team to determine if the documentation is present. Documentation not filed in the record at the time of the audit, for example, progress notes and/or treatment plans located in a clinician's desk or field folder, will not be accepted for credit. Providers may not create new documentation to replace that which is unable to be located. CBH does not accept new paper claims for the correct dates and types of service as part of the provider's compliance audit response.

5.6.4. Desk Audits

5.6.4.1. Request for Documentation for Desk Audits

Some Program Integrity audits may be conducted as desk audits. The written request for records may come through the CBH Program Integrity or Quality Departments and will detail specific documents to submit including, but not limited to, admission/discharge summaries, psychiatric evaluations, physician orders, treatment plan(s) – if applicable, individual progress notes, group psychotherapy notes, and lab/consultation reports. All treatment plans that cover services for the identified time period are to be submitted. When required for the level of care, copies of encounter forms are to be submitted with the chart. Neither CBH nor the Medical Assistance Program will reimburse the provider for the cost of copying records. Failure to submit requested documentation will result in related claims being considered overpayments and subject to recoupment. Unless otherwise specified, the provider may choose to submit records in electronic or paper form. Electronic records may be submitted via encrypted email or in hard copy. Copies of paper records may be delivered to CBH reception, mailed, or faxed. Original paper documentation must not be submitted.

Regarding Confidentiality	
Mental Health Services	Refer to the PA Mental Health Procedures Act (5100.32) concerning nonconsensual release of information (See: PA code, Title 55 Public Welfare, ch. 5100. 32, MH Procedures, nonconsensual release of information).

Regarding Confidentiality	
Substance Use Services	All member identifying information will be maintained in accordance with the security requirements provided by 42 C.F.R., Subpart D, Subsection 2.53 Audit and Evaluation Activities.

5.7. Provider Scanned Documents and Digital Record-Keeping

Providers electing to store clinical records digitally without retaining the hard copy must comply with current federal and state guidelines related to record retention. Records must be readily accessible. CBH Program Integrity Analysts may request to see the provider's policies and procedures for ensuring transformation and authentication of paper documents to digitally stored records. Providers are encouraged to review *OMHSAS Policy Clarification #08-13-02 issued June 25, 2014* for guidance on verification and authentication of digitally stored records.

5.8. Audit Codes Used in Audits

➡ **Program Integrity Audit Codes** (Updated December 2024)

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.

5.9. Use of Extrapolation in Audits

The CBH Program Integrity Department will use standardized practices of statistically valid random sampling of paid claims and extrapolate audit findings as appropriate. If the use of extrapolation in an audit is warranted, the information will be brought to the CBH Program Integrity Committee in a de-identified format for approval of the use of extrapolation. In general, extrapolation is utilized in instances where previous efforts such as clinical chart audits, education, and provider meetings have been ineffective.

Audit results, both aggregated total and by strata of actual lines in the overpayment and extrapolated counts, will be presented to the CBH Program Integrity Committee for final review and approval, including any extrapolated overpayment amounts. Challenges made to the methodology utilized in the audit and/or the sample selection will be reviewed in partnership with staff from other departments and other outside subject matter experts, as needed.

5.10. Post-Audit Steps

Findings of CAT audits will be reviewed in a de-identified format by the CBH Program Integrity Committee, which will determine action steps to be taken. Action steps may include, but are not limited to, processing claim adjustments for identified overpayments, sanctions as outlined in the Provider Agreement, expanded audit(s), requiring a Corrective Action Plan (CAP) or Directed Corrective Action Plan (DCAP), referrals to CBH's oversight entities and/or other CBH and DBHIDS departments. When appropriate, following Program Integrity Committee review, the results of the audit will be communicated to the provider via secure email.

Sanctions for continued non-compliance may be taken. Recommendations for sanctions will be made by the CBH Program Integrity Committee. Sanctions may include all sanctions or remedies as stated in the current Provider Agreement.

Post-Audit actions may include requiring a CAP or DCAP from providers. These are defined as follows:

5.10.1. Corrective Action Plan (CAP)

Provider documentation of purposeful steps to effect change based on recommendations and requirements from the Program Integrity Department. CAPs are requested to address ongoing audit concerns and ineffective compliance programs.

5.10.2. Directed Corrective Action Plan (DCAP)

Is issued by CBH in response to a provider's inability to appropriately address identified concerns via QIP, CAP or other process.

5.11. CBH Program Integrity Committee

The activities of the Clinical Audit Team (CAT) of the CBH Program Integrity Department are overseen by the CBH Program Integrity Committee. The Committee consists of members from CBH Officers and DBHIDS leadership. The responsibilities of the Program Integrity Committee include, but are not limited to, review and approval of all Program Integrity Department priorities, Annual Work Plan, policies and procedures, review and decisions regarding all CAT audit recommendations and results, and evaluation of the Program Integrity Department's effectiveness and performance. The CBH Program Integrity Committee will review the initial financial impact for each audit conducted by the Program Integrity Department Clinical Audit Team (CAT) in a de-identified summary format. The Committee will also make decisions regarding payment suspensions and some provider requests for repayment plans or settlement requests to comply with overpayment requirements.

5.12. Appealing Audit Decisions

Providers have the opportunity to dispute the findings of CAT audits. Audit Results letters sent to provider leadership will contain a due date for a provider to respond. Attachments to the letter include a Compliance Report summarizing the audit and an Excel Attachment listing each claim line identified as problematic. Providers can dispute all or some of the audit findings by responding to the Program Integrity Operations Specialist in writing by the identified date.

For on-site audits, provider responses should contain copies of progress notes and/or other documentation to support the appeal. For desk audits conducted on provider-submitted documentation, providers should confirm what information is needed for the response, so as to not resend documentation already received by CBH.

Responses will be reviewed by a CBH Program Integrity Analyst not involved in the audit. Providers will receive an Audit Resolution letter with the results of the review. An updated Provider Response Attachment will be included if any of the original decisions have been overturned.

Providers still in disagreement with the audit decisions after this review can request that the appeal receive an additional review by the CBH Program Integrity Committee. Decisions by the Committee will be final, and the results will be communicated to the provider's leadership via secure email.

5.13. Self-Auditing

5.13.1. Pennsylvania DHS Requirements of Medicaid Providers

CBH is required to inform all providers of the **Pennsylvania Medicaid Provider Self-Audit Protocol** that was established by the Pennsylvania Department of Human Services (PA-DHS) in 2001.

The Self-Audit Protocol:

➡ Reminds Medicaid providers of their ethical and legal duty to protect the financial integrity of the Medicaid program

➡ Reminds Medicaid providers of their ethical and legal duty to promptly return MA overpayments and improper payments

➡ Encourages Medicaid providers to engage in the voluntary disclosure of overpayments or improper payments they have received from the MA program and to facilitate repayment

➡ Recommends each Medicaid provider have a compliance plan that adheres to federal and state laws, regulations, and policies applicable to the Medicaid program. The compliance plan should incorporate periodic self-auditing in order to identify and return instances of overpayments or improper payments that are non-compliant with Medicaid program requirements

➡ Emphasizes self-audits initiated by Medicaid providers. This occurs when Medicaid providers self-identify potential payment violations and audit their own records, facilitating the return of overpayments or improper payments in accordance with the self-audit protocol.

To assist Medicaid providers with facilitating the return of Medicaid overpayments and improper payments, the Self-Audit Protocol advises providers of two methods for conducting self-audits in order to return identified overpayments and improper payments of Medicaid funds:

➡ Option 1: 100 Percent Claim Review

➡ Option 2: Provider-Developed Review Work Plan (CBH pre-approval required)

    » A work plan proposing the use of a statistically valid random sample (SVRS) is classified under Option 2

In the Centers for Medicare & Medicaid Services (CMS) Pennsylvania Comprehensive Program Integrity Review, third-party initiated self-audits are also highlighted as one of the DHS program integrity measures. Self-audits are initiated by a third party if a potential concern is identified through compliance-related activities (e.g., data mining, hotline reports, third-party audits, etc.) To initiate the self-audit, the third party (i.e., the CBH Program Integrity Department) contacts the MA provider, requests they conduct a self-audit, and both parties mutually agree to the audit methodology and scope. Findings are then reviewed by the third party (i.e., the CBH Program Integrity Department), and overpayments and improper payments are returned in accordance with the Self-Audit Protocol.

5.13.1.1. References

➡ Commonwealth of Pennsylvania. (2001). HealthChoices Behavioral Health Amendment, Appendix F, page 7.

➡ Department of Human Services Medical Assistance. (2001). **Provider Self-Audit Protocol**.

➡ Commonwealth of Pennsylvania. (2013). Medical Assistance Bulletin # 99-02-13, The Bureau of Program Integrity and the Medical Assistance Provider Self-Audit Protocol Issue/Effective Date 12/2/2002.

➡ Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2012). Medicaid Integrity Program Pennsylvania Comprehensive Program Integrity Review Final Report

➡ Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2016). Medicare Claim Review Programs

5.13.2. Self-Auditing Process for CBH Providers

In accordance with the PA Medicaid Provider Self-Audit Protocol, the CBH Program Integrity Department developed two documents that are required for CBH providers to complete for their self-audits:

➡ The **Provider Self-Auditing Form** contains details of the self-audit and should be completed and submitted for any overpayments or improper payments that need to be returned to CBH and/or any evidence of fraud, waste, and/or abuse involving staff or a CBH member. This Form must also be completed and submitted when prepayment reviews, or reviews of claims prior to payment, find evidence of fraudulent conduct.

➡ The **Overpayment Spreadsheet** must be completed for any identified overpayments or improper payments that are to be returned to CBH.

5.13.2.1. Instructions for CBH Providers

1. **Follow the Protocol.** Providers are encouraged to review and follow **the commonwealth's protocol**.

2. **Notify CBH.** Providers must contact the Program Integrity Department when identifying the need for a self-audit. This can be initiated by emailing **CBH.ComplianceContact@phila.gov** with the subject line "Self-Audit". To note, protected health information (PHI) must be sent securely, and the Program Integrity Department will assist with the secure submission of content and documents containing PHI. Providers should review the timeframe established in the Code of Federal Regulations when an overpayment is identified (see **42 CFR § 438.608(d)(2)**).

3. **Notify BPI of an Excluded Employee or Contractor (if applicable).** Providers must follow **MA Bulletin 99-11-05** when identifying an employee or contractor who is excluded from participating in MA or any other federally funded health care program.

4. **Receive CBH Pre-Approval (if applicable).** There are two general options for providers completing self-audits: 100 Percent Claim Review (Option 1) and Provider-Developed Review Work Plan (Option 2). Option 2 requires CBH pre-approval which can be obtained by following the instructions outlined in the Provider Self-Auditing Form. To note, a work plan proposing the use of a statistically valid random sample (SVRS) is classified under Option 2.

5. **Respond to Requests for Self-Audits.** The Program Integrity Department may request providers complete self-audits when potential compliance concerns are identified. Self-audit documents are still required in these cases.

6. **Respond to Requests for Supporting Documentation.** The Program Integrity Department may ask providers for documentation that supports the self-audit rationale, methodology, and outcome. It is important to maintain all relevant records in the event they are requested.

7. **Request Support.** The Program Integrity Department will manage the return of compliance overpayments to CBH, so claim adjustment forms are not needed for these cases. Providers can request the department generate a list of CBH data to identify potential overpayments and improper payments. The department can also assist in developing SVRS. Depending on the needs of the provider, the Program Integrity Department offers trainings, one-to-one support, and additional assistance.

8. **Submit Self-Audit.** When the self-audit is ready to be submitted to the Program Integrity Department, providers should email **CBH.ComplianceContact@phila.gov** or contact a CBH Program Integrity representative in order to determine the best way to securely share the self-audit documents. CBH currently utilizes Box, Inc. (See the corresponding **CBH Provider Notice** issued March 18, 2022).

9. **Finalize Self-Audit.** In general, self-audits are processed by Program Integrity Analysts, who finalize self-audits with provider representatives. All self-audit outcomes are reviewed by the CBH Program Integrity Committee. Once finalized, resolution letters are then securely shared to providers via Box, Inc., concluding the self-audit and announcing upcoming claim reversals.

CBH providers may send supplemental documentation to the CBH Program Integrity Department in addition to (but not in replacement of) the Provider Self-Auditing Form and the Claims Overpayment Spreadsheet. If a prepayment review is conducted by a CBH provider and there is evidence of fraud, the Provider Self-Auditing Form and corresponding attestation is also required to be submitted to the CBH Program Integrity Department (the Claims Overpayment Spreadsheet will not be applicable).

5.14. Overpayment Recovery

Overpayments, including those determined through the use of extrapolation, will be recouped through future payments. In cases in which CBH determines that recouping overpayments through claims take-backs is not feasible, providers must submit a repayment check(s) to resolve the identified overpayment. All checks will be made payable to "Community Behavioral Health".

When the resultant financial impact from a Program Integrity Department audit or provider self-audit poses a financial hardship, providers may request a repayment plan in cases in which an overpayment or extrapolated settlement would threaten the solvency of the provider. Providers may be asked to submit financial documents to assist in the decision-making process.

The standard repayment plan is 20% of the provider's weekly pay from CBH until the overpayment is reimbursed in full. Providers may also request a customized payment plan if the 20% repayment is still a hardship. Repayment plans will be contained within one calendar year when possible.

Providers requesting such an arrangement must make the request in writing to the CBH Program Integrity Operations Specialist no later than ten calendar days from the date of the Audit Resolution Letter. The CBH Program Integrity Committee will then determine whether to approve the request. If the provider does not request a payment plan within that time period, CBH will proceed to recoup the full amount. Providers whose plans are not accepted will need to re-submit a new payment plan request. If a second payment proposal is rejected, or if the provider does not submit a revised plan, the CBH Program Integrity Department will default to the standard 20% payment plan.

For extrapolation audits, the Program Integrity Department will have claims for the observed overpayment retracted and will request a check from the provider for the extrapolated difference. In some cases, CBH will work with a provider regarding a settlement amount for larger audits. Decisions regarding settlement amounts will be made by the CBH Program Integrity Committee.

In accordance with the Federal False Claims Act, CBH reserves the right to demand additional penalties in damages in particularly egregious or ongoing issues.

5.15. Service Delivery Verification

In accordance with the requirements of CBH's HealthChoices contract with the commonwealth, CBH verifies that its members have received the behavioral health services as billed by the provider. CBH Program Integrity Department staff will periodically do so by conducting surveys of a sample of members each quarter to verify service delivery.

5.16. Excluded Entities and Individuals

CBH requires its provider network to have processes and procedures in place for checking the requisite exclusion databases for excluded individuals monthly and the Social Security Death Master File (DMF) upon hire and annually. See **CBH Provider Bulletin 21-01: Social Security Death Master File**. Excluded entities or individuals 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/or state and commonwealth Medicheck lists. CBH providers are required to report to CBH within three business days if they discover that currently employed or contracted staff or individuals applying for employment are on an excluded list (see the **Exclusion Lists section** of this Provider Manual).

5.17. Payment Suspension

The practice of suspending payments for services rendered by providers contracted by CBH while the provider is under investigation of a credible allegation of fraud. The federal and commonwealth governments require CBH to suspend payments upon notification of the investigation of a credible allegation of fraud by the Pennsylvania Department of Human Services and/or the MFCS. Credible allegations of fraud are defined as "Allegations are considered to be credible when they have indicia of reliability and the commonwealth has reviewed all allegations, facts, and evidence and acts judiciously on a case-by-case basis". – *42 CFR § 455.2*

CBH follows the Patient Protection and Affordable Care Act of 2010 (ACA) and HealthChoices contract regarding payment suspensions when providers have open investigations of credible allegations of fraud. CBH is required to suspend payments to providers in cases where credible allegations of fraud exist, except when a possible good cause exception exists. A good cause exception is defined as "compelling rationale for why payments, in part or whole, should continue to an entity during the course of an active investigation of a credible allegation of fraud." – *CMS Medicaid Payment Suspension Toolkit*

Payment suspensions are designed to be temporary in nature. When the payment suspension is lifted, payments for valid, provided services will be released to the provider. The CBH Program Integrity Department will conduct a targeted audit of paid claims from the suspension period.

5.18. Clinical Documentation Requirements

CBH has developed documentation requirements, both for general reference and for specific levels of care.

5.18.1. General Record Maintenance

The documentation in an individual's record allows behavioral health professionals to evaluate and plan for treatment, monitor progress over time, and facilitate communication and continuity of care among healthcare professionals involved in the individual's care. It ensures accurate and timely claims review and payment, promotes appropriate utilization

review and quality of care evaluations, and can be used for research and education. **55 Pa. Code § 1101.51** outlines ongoing responsibilities of providers related to service documentation including:

➡ The record must be legible throughout

➡ The record must identify the individual on each page

➡ Entries must be signed and dated by the provider

➡ Alterations of the record must be signed and dated

➡ The record must contain the diagnosis from the Licensed Practitioner

➡ The treatment plan must be entered in the record

➡ The record must indicate the progress towards goal at each session, change in support and response to behavioral interventions

➡ 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 progress notes for all services, at a minimum, must include:

  » The specific services rendered

  » The date the service was provided

  » The name(s) of the individual(s) who rendered the services

  » The place where the services were rendered

  » The relationship of the services to the treatment plan – specifically, any goals, objectives, and interventions

  » Progress at each session, changes in support and response to support

  » The actual clock hours that services were rendered, including start and end time

➡ CBH expects progress notes to be entered and considered final prior to the submission of a claim for that date of service or within seven days of the date of service, whichever occurs first

CBH also has the following requirements for all documentation:

➡ Final and complete clinical notes must be entered into the clinical record within seven days of the date of service or prior to the submission of claims for payment for the service, whichever occurs first.

➡ Record should be in its original form, including signature.

➡ Records should be organized in a way that allows for ease of location and referencing.

➡ Records should be sequential, and date ordered.

➡ Signatures must be legible and indicate position/credentials and/or have printed name and credentials provided with signature. Signatures that are not legible must contain a printed legible name.

➡ Paper-based records should be typed, written, or printed only in ink.

➡ Records should not include names of other individuals receiving treatment (other group members, for example).

➡ Records should be individualized to meet the needs of each person receiving services.

➡ Correcting errors: correction tape/fluid, scribble over, etc. should not be used. If there is an error, draw a single line through the error and initial, date, then enter correct material. (Note: only original authors may make alterations).

➡ Records should only contain universal and county-designated acronyms and abbreviations.

➡ Signatures must include the date signed and those dates may not be pre-printed for paper-based records. The signature must reflect the date the note was signed.

➡ Providers must have an auditable trail for tracking signatures in electronic medical records.

➡ Each CBH member must sign an encounter form that includes a signature date completed by the member, demonstrating that the member was present for the service and provide evidence of the start time, end time, and duration of their attendance.

For telehealth services, progress notes must indicate that the service was delivered via telehealth and specify the service delivery platform.

5.18.2. Storage, Retention, and Destruction of Records

5.18.2.1. Storage

Clinical records contain Protected Health Information (PHI) covered by both state and federal laws. Providers are required to protect the record against loss, defacement, tampering or use by unauthorized persons.

Clinical records should be "double locked" for storage (e.g., records placed in a locked filing cabinet within a locked office). Practitioners should have a safe and confidential filing system and retrieval system for access, accountability, and tracking.

Electronic records should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access. Electronic records should be stored in a password-protected computer located within a locked room. Electronic records should also comply with applicable legal and ethical requirements.

5.18.2.2. Retention/Destruction

Clinical records contain Protected Health Information (PHI) covered by both state and federal laws. Providers are required to protect the record against loss, defacement, tampering, or use of unauthorized persons.

Clinical records should be "double locked" for storage (e.g., records placed in a locked filing cabinet within a locked office.) Practitioners should have a safe and confidential filing system and retrieval system for access, accountability, and tracking.

Electronic records should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access. Electronic records should be stored in a password-protected computer located within a locked room. Electronic records should also comply with applicable legal and ethical requirements.

Full records should be retained for seven years after the last date of service delivery for adults and until one year after a minor reaches the age of majority even if this requires the record to be retained longer than seven years (**49 Pa. Code § 16.95.** Medical records. For hospitals: **28 Pa. Code § 115.23.** Preservation of medical records.). Records should be retained beyond seven years if an audit involving those records is pending, until the audit findings are resolved and completed.

Providers must ensure that CBH members have continued access to their records after the provider leaves the CBH network or ceases to function.

Records should be destroyed in a manner to preserve and assure confidentiality.

5.18.2.3. Consents

No service may be provided to a CBH member without appropriate consent of the member. Records must contain valid consents for the specific service(s) that are to be provided to the member. Consents must comply with agency policy related to frequency of updates or renewals and any applicable state requirements.

5.18.3. Program Integrity Treatment Planning Guide

The CBH Program Integrity Department has been tasked with ensuring that our providers adhere to documentation standards presented in state regulations, bulletins, CBH contractual documents, OMHSAS-approved service descriptions, etc. Complying with rules and regulations related to treatment planning remains a significant concern and accounts for a large portion of overpayments identified in audits.

Effective treatment plans are crucial to providing a construct for effective treatment and successful outcomes. Additionally, treatment plans are required for behavioral health services to be reimbursed through Pennsylvania Medicaid. Over time, different "levels of care" have developed specific requirements regarding treatment plans.

CBH Program Integrity Treatment Planning Guide (updated April 2025)

5.18.4. Clock Times

Unit-based services (non-per diem and non-event services) must be documented using clock times. The start and end clock times for the service must be documented (e.g., 7:15 a.m. to 8:15 a.m.). It is not sufficient to document only the duration, the start, or the end time. Through the audit process, CBH Program Integrity has, and will continue to, recoup payment made for unit-based services lacking clock times. Providers must also designate a.m./p.m. or utilize military style time (1:00 p.m. = 1300) in the documentation of start and end times for the service. Failure to document a.m./p.m. or military time will also result in recoupment of payment for those services. Medical Assistance Bulletins **99-97-06** (Accurate Billing for Units of Service Based on Periods of Time) and **29-02-03, 33-02-03, 41-02-02** (Documentation and Medical Record Keeping Requirements) support this requirement.

5.18.5. Clinical Documentation Requirements by Specific Levels of Care

➡ **Program Integrity Clinical Documentation Requirements: Specific Levels of Care** (updated April 2025)
See this document for complete clinical documentation requirements.

5.19. IBHS Billing Guide

This Intensive Behavioral Health Services (IBHS) Billing Guide was developed in collaboration with the CBH Clinical Management and Program Integrity Departments. Every effort was made to provide clear and accurate answers to providers' questions. This guide covers the services under the IBHS individual and applied behavior analysis (ABA) levels of care (LOC). This guide does not cover group services or some CBH LOCs.

➡ **IBHS Billing Guide** (updated May 2023)

6. FINANCE

6.1. Value-Based Programs (VBP)

After the passage of the ACA in 2010, the US healthcare system began to experience a shift in the way that healthcare services are delivered and paid for. Many healthcare delivery reforms were put in place to emphasize quality of care over quantity. These reforms, collectively, are often referred to as value-based healthcare.

The aim of a value-based payment (VBP) model is to reward health care providers with incentive payments for the quality of care they provide and aim to pay for value not volume, improve and reward quality, and bend the cost curve. VBPs require that a provider (eventually) accepts risk against their performance.

In 2018, PA-DHS/OMHSAS expanded VBP requirements to begin the Behavioral HealthChoices system in shifting an increasing percentage of their total medical expenses to VBP models. OMHSAS has set forth requirements for CBH to increase, annually, the percent of medical spend expended through VBP strategies since 2018:

Year	VBP
Year 1 (CY 2018)	5% Any Models
Year 2 (CY 2019)	10% (50% in Medium/High Risk Arrangements)
Year 3 (CY 2020)	20% (50% in Medium/High Risk Arrangements)
Year 4 (CY 2021)	20% (50% in Medium/High Risk Arrangements)*
Year 5 (CY 2022)	30% (50% in Medium/High Risk Arrangements)
Year 6 (CY 2023)	30% (50% in Medium/High Risk Arrangements)*

DHS/OMHSAS implemented a strategic pause in 2021 and 2023 due to COVID-19.

In January 2022, CBH established a dedicated VBP unit within the Finance division that coordinates activities related to the transition to value-based payments in alignment with HealthChoices requirements, while maintaining fidelity to CBH's mission, vision, and values. The VBP unit falls under the leadership of CBH's Chief Financial Officer and consists of a director and two implementation specialists. The VBP unit works to support clinical strategies in tandem with CBH Finance leadership and the CBH Performance Evaluation teams. The VBP unit reports to the VBP Committee, comprised of Clinical, Finance, Quality, Program Integrity, and Operations leadership. The VBP Committee provides guidance and support in the transition to a system-wide model of value-based care.

CBH's VBP strategy includes a phased-in approach of target populations/services and VBP models that reflect movement toward more advanced VBP models over time. Initially, the first services CBH moved to a VBP model were those that were already paid through Alternative Payment Arrangements (APA) and/or those that fulfilled other requirements identified by PA-DHS/OMHSAS.

CBH submits an in-depth proposal of VBP plans to OMHSAS annually. This proposal, submitted in October for the upcoming calendar year, includes updates to current plans and additions of new program models. Each VBP plan consists

of a payment strategy and opportunity to earn incentives based on performance goals. Additional components, such as engagement of a community-based organization (CBO), may be required. The chart below specifies current performance measures for each level of care in a VBP arrangement.

6.1.1. VBP Performance Measures and Goals

Level of Care	Performance Metric	2023 Performance Goal
Assertive Community Treatment (ACT)	ACT claim within 7 days of discharge from acute inpatient hospital	95.00%
Assertive Community Treatment (ACT)	In-Community Days per total authorization days	92.70%
Assertive Community Treatment (ACT)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	72.30%
Adult Acute Inpatient	7-Day Follow-up After Discharge	63.00%
Adult Acute Inpatient	30-Day Follow-up After Discharge	75.00%
Adult Acute Inpatient	30-day Readmission to Acute Inpatient	11.75%
ASAM Outpatient (OP)	Percent of Members with an Opioid Use Disorder (OUD) Receiving Medication-Assisted Treatment (MAT) and Counseling (MAT-OUD)	73.70%
ASAM Outpatient (OP)	Percent of Members with an Alcohol Use Disorder (AUD) Receiving Medication-Assisted Treatment (MAT) and Counseling (MAT-AUD)	10.60%
Children's Mobile Intervention Services (CMIS)	7-Day Follow-up After CMIS	28.30%
Children's Mobile Intervention Services (CMIS)	30-Day Follow-up After CMIS	48.70%
Children's Mobile Intervention Services (CMIS)	30-Day Readmission to Children's Crisis, Acute Partial Hospital (APH), or Acute Inpatient (AIP)	8.00%
Children's Mobile Crisis Team (CMCT)	7-Day Follow-up After CMCT	61.20%
Children's Mobile Crisis Team (CMCT)	7-Day Readmission to UCC, CRC, CSU, or CMCT	14.50%

Level of Care	Performance Metric	2023 Performance Goal
Crisis Stabilization Unit (CSU)	7-Day Follow-up from CSU	71.60%
Crisis Stabilization Unit (CSU)	7-Day Readmission to AIP, CMCT, UCC, CRC, or another CSU service	8.80%
Crisis Stabilization Unit (CSU)	Percent of CSU Stays of 5 Days or Less	35.60%
Pediatric Crisis Response Center (CRC)	7-Day Follow-up from CRC	74.20%
Pediatric Crisis Response Center (CRC)	7-Day Readmission to CRC	1.10%
Pediatric Urgent Care Center (UCC)	7-Day Follow-up from UCC	48.70%
Pediatric Urgent Care Center (UCC)	30-Day Follow-up from UCC	66.90%
Pediatric Urgent Care Center (UCC)	30-Day Readmission to CMCT, CRC, CSU, AIP, APH, or another UCC service	20.50%
Community Integrated Recovery Center (CIRC)	Percent Discharged from Psychiatric Inpatient Having Follow-Up with CIRC Within 30 Days	95.00%
Community Integrated Recovery Center (CIRC)	Percent Discharged from Psychiatric Inpatient Without an Inpatient Readmission Within 30 Days	84.40%
Community Integrated Recovery Center (CIRC)	Percent of WHO-QOL BREF Instruments Administered Every Six Months	90.50%
Intensive Behavioral Health Services (IBHS)	Percent of Crisis Services Concurrent with IBHS	5.60%
Intensive Behavioral Health Services (IBHS)	Percent of Acute Inpatient or Acute Partial Hospital Services Concurrent with IBHS	3.70%
Residential Treatment Facilities for Children (RTF)	180-Day Community Tenure	76.90%
Residential Treatment Facilities for Children (RTF)	Referral Acceptance Rate	35.60%

Level of Care	Performance Metric	2023 Performance Goal
Residential Treatment Facilities for Children (RTF)	Percent of Admissions within 60 Days of Referral	77.70%
Residential Treatment Facilities for Children (RTF)	Restraints per 1000 Authorized Units	ASD/ID RTF: 34.4 General RTF: 8.0
Adult Targeted Case Management (TCM)	Percent Having a TCM Contact Within 2 Days of Acute Inpatient Admission	Non-Fidelity ACT: 66.30% TCM: 56.50%
Adult Targeted Case Management (TCM)	Percent Having a TCM Contact Within 7 Days of Acute Inpatient Discharge	Non-Fidelity ACT: 82.5% TCM: 70.60%

Providers should contact their Provider Representative for their program's most recent performance report.

6.1.2. Payment Strategies

A detailed explanation of payment strategies will be published in the CBH News in April each year following final submission to OMHSAS.

6.1.3. Community-Based Organization (CBO) Involvement

CBH VBP complies with the PA Department of Human Services (DHS) initiative in addressing social determinants of health (SDOH). In the *2021 Roadmap to Whole Person Health Report*, DHS stated that "addressing SDOH is essential in improving health care value and addressing health equity. […] CBOs have historically provided the social services that address unmet SDOH needs, whether they be related to food, housing, clothing, utilities, financial strain, employment, and more. They are also comprised of a labor force that usually live within the communities they are aiding, and many are well-known and trusted entities. This trust is highly important—interventions aimed at reducing racial inequities have been shown to be effective when built using local, trusted community partners." In recognizing the importance of incorporating more CBOs to address SDOH, DHS emphasized the importance of ensuring that CBOs have reliable and sustainable funding to handle any increase in referrals. In 2021, requirements were set for VBP arrangements to incorporate CBO involvement into a percentage of VBP models in a medium- or high-risk arrangement, noting, "these types of arrangements provide incentives for the reductions in the total cost of care—and we know that addressing unmet SDOH needs such as food and housing can cause reduced health care utilization and costs."

CBH VBP commits to improving collaboration with both physical and behavioral health providers and CBOs for 2023 and beyond. One important factor in enhancing this collaboration is the collection of proper SDOH data. CBH VBP, along with other CBH departments (Clinical, Performance Evaluation, Population Health, and others), will be looking into creating a more formal process to collect the data needed to appropriately address the specific SDOH needs in different communities in Philadelphia. In addition to the data, CBH VBP will be focusing on adding more CBOs to the level of care in a medium- or high-risk VBP arrangement in addition to the ones that currently have CBO involvement.

Questions related to VBP activities should be directed to **CBH.VBP@phila.gov**.

6.2. Claims

6.2.1. Submission Policies and Procedures

Local, state, and federal governments seek clinical and cost data to carefully monitor the use of public healthcare funds. To comply with governmental mandates for information, CBH must obtain detailed claims data from providers.

Timely submission of accurate claims information is an essential part of the provider's role in delivering care, tracking clinical activity, and maintaining fiscal stability. CBH is committed to working with providers to help the process go as smoothly and efficiently as possible. Providers may submit their questions to **CBHClaim.Support@phila.gov** or contact the Claims Hotline at (215) 413-7125 with specific questions about claims. All in-network providers are assigned a Claims Analyst who can assist in navigating the claims processing system.

This chapter explains the procedure for providers to bill CBH for services rendered.

6.2.1.1. Claims Categories and Timeframes

➡ **Clean Claim:** a claim submitted with all essential provider or third-party details; it can therefore be processed "as is." Providers must submit a clean a clean claim within 90 days of the service date. Providers must obtain an Explanation of Benefits (EOB)/Final Determination within 180 days of date of service and submit a clean claim to CBH within 90 days of the EOB/Final Determination.

➡ **Unclean Rejected Claims:** claims returned to the provider or third party with requests for additional information. Unclean Rejected Claims must be resubmitted as clean claims, within 90 days of the service date. Providers must obtain an Explanation of Benefits (EOB)/Final Determination within 180 days of date of service and submit a clean claim to CBH within 90 days of the EOB/Final Determination for Third Party Liability claims.

➡ **Clean Rejected Claims:** claims returned to the provider or third party due to ineligible recipient or service.

➡ **Coordination of Benefits:** the process a provider pursues to obtain a final determination from the primary payer (when members have a primary insurance and CBH is secondary). The final determination must be dated no more than 180 days following the date of service, and providers must submit a clean claim within 90 days after receipt of determination from the primary payer.

CBH reserves the right to make no payments for claims received beyond the time requirements stated herein.

6.2.1.2. Claims Process
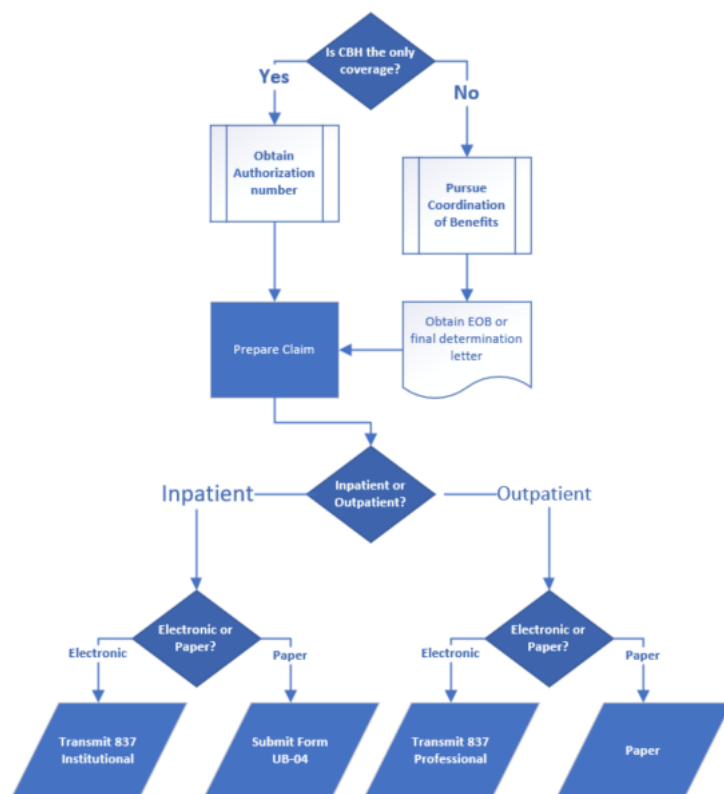
6.2.1.3. Before You Bill CBH

6.2.1.3.1. Verify Eligibility

In order to receive payment for services rendered, providers must check member eligibility. Providers can access the DHS daily eligibility file by phone by calling 800-766-5387. Providers may also use the various methods described on the DHS website under **Eligibility Verification Information**, such as the **PROMISe™ Internet**.

6.2.1.3.2. Obtain Authorization Number

All claims must include the appropriate authorization number for services rendered. For services requiring a prior authorization, providers will obtain the authorization number from the CBH Clinical Care Manager (CCM). For services that can begin without a prior authorization but require a specific authorization number for payment, providers will obtain this number from the CBH Operations Support Services Coordinator (OSS). For all other services, providers will obtain a Blanket Authorization Number (BAN) corresponding to the service as per the Schedule A. For a complete list of types of authorizations and related processes, see **Authorizations section**. Claims submitted without required authorization number will be rejected.

6.2.1.3.3. Claim Submission

Providers can choose to submit electronic or manual/paper claims. Filing claims electronically helps providers minimize data entry errors after submission and expedite the processing of their claims. To submit claims electronically, the provider must have the appropriate software and complete a claims test process. The four types of claims forms are:

➡ 837I Institutional (electronic claims form for inpatient levels of care)

➡ 837P Professional (electronic claims form for community-based levels of care)

➡ UB-04 (paper claims form for inpatient levels of care)

➡ CMS-1500 (paper claims for community-based levels of care)

See the **Electronic Claims section** below for submission companion guides.

6.2.1.3.4. Ensure Pricing and Information Modifiers are added as needed

Certain services (both authorized and non-authorized) require pricing and/or information modifiers. Please refer to Schedule A to identify the services that require modifiers. When completing the claim form, place the pricing modifier in the first modifier field and the information modifier in the second modifier field.

6.2.1.3.5. Enter Date Information Correctly

One of the most common causes of claims rejection is entering date information incorrectly. When entering inpatient treatment days, please enter the date of admission as the "begin date" and the day of discharge as the "service end" date and count the length of the stay according to the number of "nights" of stay. The day of discharge is not counted as a day of treatment.

When completing the UB-04 or CMS-1500 (02-12) claim forms, the provider must use the complete four-digit year. For example, enter the full year as "2022" rather than "22." Any manual claims submitted without the full-year date format be reject.

Per Provider **CBH Bulletin 22-22**, the following billing practices are to be followed:

➡ Professional and institutional claims with Dates of Service that span over different months and years within the same claim (Loop 2300) will reject.

➡ For all Service Lines (Loop 2400) within the same CLM Loop (Loop 2300): » Dates of Service (DTP*472*D8 and DTP*472*RD8) MUST be for the same MONTH. » Dates of Service (DTP*472*D8 and DTP*472*RD8) MUST be for the same YEAR.

➡ For institutional claims, statement dates MUST not span over different months and years: » Loop 2300, DTP03 the statement from and to date span MUST be within the same MONTH. » Loop 2300, DTP03 statement from and to date span MUST be within the same YEAR. Claims that do not adhere to the above requirements will reject with a 277 Front End Edit acknowledgement.

Per Provider **CBH Bulletin 20-18** the following billing practices are to be followed:

➡ CBH requires the member to be admitted to the appropriate unit at the receiving facility by midnight (head in bed) for the date of service to be considered billable to CBH.

➡ When a member leaves prior to midnight on a given day, that date of service is not billable to CBH, even if the provider has provided an entire day of service.

➡ When a member is admitted to the appropriate unit at a facility prior to midnight but did not receive a full day of service at that facility, the date of admission is billable.

Examples of the above instances include:

➡ If a member arrives to the unit at 11:15 p.m. on January 15, 2022, then the provider can bill for January 15, 2022, assuming that admission documentation is completed.

➡ If a member is present and receives services all day but the member leaves at 11:15 p.m. on January 15, 2022, then the provider cannot bill for January 15, 2022.

Per the **Program Integrity Specific Levels of Care Clinical Documentation Requirements**, section 4.6., withdrawal management providers cannot bill for the overnight date of service, even if the member is present in the unit by midnight, if the following requirement has not been met:

> *"...any individual admitted to a withdrawal management unit prior to 4 p.m. should receive their first dose of a withdrawal management-related taper on the day of admission. If the individual is admitted prior to 4 p.m. and does not begin a withdrawal management-related taper, the date of admission is not billable."*

Per diem services are all-inclusive, and therefore services such as psychiatric consultations on members currently in psychiatric beds are not separately billable.

6.2.1.3.6. Ensure Appropriate Billing for Consecutive Days (Span Billing)

When billing for per diem services that were provided on consecutive days, the provider does not need to enter each individual date of service on the claim form. Instead, a provider may "span bill" the entire period of service. "Span billing" means that the provider notes on the claim the dates that treatment began and ended and the number of units of service provided. Both the "service begin" date and the "service end" date must be within the authorized period. The day of discharge from inpatient treatment does not count for units of service.

For example, member was admitted on 7/1/2021 and discharged on 7/15/2021. You would bill 7/1/2021 through 7/15/2021 for 14 units, as discharge date is not covered. Claim should also be submitted with the correct patient status code.

Patient Status Codes (Form Locator 17)	
01	Discharge to home or self-care – Routine Discharge
02	Discharged/transferred to another hospital for inpatient care
03	Discharged/transferred to a skilled nursing facility
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to another type of institution for inpatient care
07	Left against medical advice or discontinued care
20	Expired

Patient Status Codes (Form Locator 17)	
30	Still a patient

6.2.1.3.7. Ensure Appropriate Billing for Non-Consecutive Days

When billing for non-consecutive days within a particular authorization period, the provider must note each date of service individually. Do not span date for non-consecutive days of service or non-per diem services. Such claims will be rejected.

For example, member was admitted on 7/1/2022 and continues to receive services at the time of billing on 7/15/2022. You can submit a claim from 7/1/2022 through 7/15/2022 for 15 units with the patient status code 30, to indicate the member continues to receive services.

If the member has an authorization from 7/1/2022 to 7/15/2022 for 15 units, however, the member left the program on 7/12/2022. You can't bill 7/1/2022 to 7/15/2022 for 11 units. You will need to bill from 7/1/2022 to 7/12/2022 with a Patient status code indicating the member left the program on 7/12/2022 and submit the claim with 11 units.

6.2.1.3.8. Follow Requirements for Provider Signature

The provider rendering the service must sign all invoices for claims, whether they are submitted electronically or manually. The signature certifies that the service has been rendered according to the Medical Assistance (MA) Billing Guide. All claims received that do not meet the provider signature requirements will not be processed.

The following are acceptable methods of signing claims:

➡ For claims submitted via secured file transfer and claims submitted through CBH Converter Application:

   » An electronic certification is incorporated into the submission process.

➡ For paper claims:

   » An actual handwritten authorization signature of the provider directly on the signature line of the invoice. The provider's initials or printed name are not acceptable signatures.

   » Signature stamp of the provider placed directly over the signature line of the invoice is acceptable if the provider authorizes its use and assumes responsibility for the information in the invoice.

   » An actual handwritten authorization signature of the provider directly on the **MA-307 Invoice Transmittal Form**, a form used to certify that treatment services have been delivered by the provider for the attached claim(s).

6.2.2. Overview of Special Circumstances

6.2.2.1. *Third Party Liability (TPL) Billing*

Third Party Liability (TPL) refers to entities other than CBH, such as Medicare and Blue Cross, that may be liable for all, or part of a member's healthcare expenses. When third-party resources are available to cover behavioral health, services provided to Medicaid recipients, CBH is the "payor of last resort."

Once the provider determines that a member has other insurance, the bill should be sent first to the primary insurance carrier(s) for payment consideration. CBH will consider for payment all balances for behavioral health services that are unpaid by the other insurance carriers.

Before CBH can consider a TPL claim for payment, the provider must submit the completed claim form, the Explanation of Benefits (EOB), and/or the denial letter(s) information sent to the provider by any and all other carriers.

The claim must be fully considered and resolved with the primary carrier before it is billed to CBH. If the services are rejected by the primary carrier due to missing, incomplete, or incorrect information, the service must be re-billed to the primary carrier before CBH will consider payment. The EOB and/or the denial letter(s) must be the final determination. If the primary carrier rejects the claim, the primary carrier's internal appeals process must be exhausted before CBH will consider the claim for payment.

It is important that the provider's claim matches the EOB information. This applies to the billed amount, beginning and ending dates, Primary Insurance paid amount. Primary Insurance Company proprietary codes for coordination of benefits are no longer accepted by CBH. EOB data sent electronically, via CBH Claims Converter Application and/or on paper must contain the Claim Adjustment Group Codes, Claim Adjustment Reason Code (CARC), and/or the Remittance Advice Remark Code (RARC) if the CARC code requires it. This information must be submitted for each claim line on the EOB billed to CBH. See CBH **Bulletin 15-02** and the forms below.

When submitting paper claims if the EOB form is larger than letter size, please reduce the EOB to 8 1/2" by 11" in size. Please include a copy of the EOB with each paper claim. Do not attach several claims to one EOB.

Members with Medicare coverage must be treated at Medicare-licensed facilities and by Medicare-credentialed staff. CBH shall pay Healthcare Provider up to the rates identified in Schedule A. If, however, Healthcare Provider accepts payment under an agreement with a CBH Member's Primary insurer as payment in full at a rate that is less than the rate in the Schedule A for the same or equivalent service, CBH will not pay the provider the difference between the two rates.

6.2.2.2. TPL Inpatient Claims

When submitting Medicare and other insurance carriers' third-party liability claims for one inpatient stay, CBH requires separate claim(s) for each authorization number issued for the various levels of care during the stay. Be sure to use the appropriate authorization number on each claim for the authorized period.

Once a provider receives the Medicare or other insurance EOB, complete the 837I or UB-04 Claim Form for each authorized period. The billed charges must be for the authorized period. The UB-04 Claim Form requires that you attach a copy of the EOB with the Claim Adjustment Group Codes, CARC, and the RARC if the CARC code requires it. This information should be included with each claim prior to submitting to CBH. It is essential to submit these claim(s) together to ensure proper processing. The payment must be prorated accordingly on each claim.

6.2.2.3. Exhausted Medicare Inpatient Lifetime Psychiatric Days

If the member's lifetime psychiatric days have been exhausted, submit both the Medicare Part A and Part B EOBs with the Claim Adjustment Group Codes, CARC, and the RARC if the CARC code requires it on the claim.

The Medicare Part A EOB must show the Medicare Lifetime Exhaustion rejection code (i.e., PR119 or PR35). If the provider does not have the Medicare Part A EOB, the provider must submit the Health Insurance Query Access (HIQA) Inquiry Form from the Medicare system. However, the Medicare HIQA Inquiry Form will only be accepted if the inquiry date is the admission date or the date on which the benefits were exhausted during the stay, or it should be covered in the Date of Earliest Billing (DOEBA) or Date of Last Billing (DOLBA) time period.

For Medicare Part B, the provider must use the appropriate value code in the 837I or Field 39 on the UB-04 claim form to indicate the Medicare Part B payment. The Part B value amount on each claim must reflect only the portion that applies to the dates of services on the claim.

6.2.2.4. Medicare Remittance Advice(s)/Other Insurance Carrier Remittance Advice(s)

For CBH to process Medicare claims correctly, the following information is needed on the remittance advice(s):

1. From and Through Date

2. Total Days (Cost Days)

3. Covered Days

4. Non-Covered Days

5. Total Charges

6. Covered Charges

7. Non-Covered Charges

8. Claim Adjustment Group Codes, CARC, and the RARC if the CARC requires it.

For CBH to process Commercial Insurance Carriers and Medicare Advantage Plans claims, the following information is needed on the remittance advice(s):

1. From and Through Date

2. Total Days

3. Covered Days

4. Non-Covered Days

5. Claim Adjustment Group Codes, CARC, and the RARC if the CARC requires it.

If you or your vendor are unable to include the CARC and the RARC data on your remittance advice(s), please add the information to your EOB. This will help to ensure that your claim(s) are processed and paid correctly. Otherwise, CBH will reject your claim to allow the provider to correct and resubmit the claim(s) with all of the necessary requirements. The Committee on Operating Rules for Information Exchange has developed different **business scenarios for the usage of CARCs and RARCs**.

6.2.2.5. ACT 62 Pennsylvania Mandate for Autism

As of 7/1/2009, the PA DHS requires many private health insurance companies to cover the cost of diagnostic assessment and treatment of autism spectrum disorder (ASD) for children under the age of 21. The amount is adjusted annually, and the cap is currently $38,276, with coverage subject to copayment, deductible, coinsurance, and other exclusions of limitations to the same extent as other medical services covered by the policy; however, some plans do not impose any cap. Be sure to check with the health plan first. The Act 62 coverage mandate applies to employer group health insurance policies (including HMO's and PPOs) issued in Pennsylvania to groups of 51 or more employees. Act 62 does not apply

to policies that are issued outside of Pennsylvania or that are "self-funded" and therefore subject to the Employer Retirement Income Security Act of 1974 (ERISA).

It is the responsibility of the provider to contact the parents and the primary carrier of each member with ASD to determine whether or not they have the Pennsylvania Mandate for Autism, **ACT 62**. If the member has the ACT 62 mandate, the benefits must be coordinated with the primary carrier for all levels of care, except the ones noted below, which CBH will continue to pay as the primary. Once the EOB with the CARC, RARC, and/or Final Determination letter is obtained, the claims must be submitted electronically or manually with a copy of an EOB/Final Determination letter attached to each claim.

If a member is being seen, and CBH does not have a record of the ACT 62 benefit, and CBH finds the member does have the ACT 62 benefits, then all the claims will be identified for which CBH should not have paid as the primary carrier and the claim(s) will be backed out as noted in the Post Payment Recovery section.

Members with the ASD diagnosis and seeking Intensive Behavioral Health Services (IBHS) must seek services from providers that are in-network with their primary insurance, which meets all the primary's insurance requirements.

6.2.2.6. Post-Payment Recoveries

According to the City of Philadelphia's contract with the Pennsylvania Department of Human Services (DHS-PA), Community Behavioral Health (CBH) is required to take all reasonable measures to ensure CBH is the payor of last resort when other third-party resources are available to cover the cost of medical services.

When CBH becomes aware of payments made on behalf of a CBH member who has valid third-party resources, post-payment recoveries will be pursued. If a provider is identified as having received an inappropriate payment, a post-payment recovery letter will be sent to the provider listing all the impacted claims that were retracted by CBH. Providers who receive such letters are required to bill the primary carrier(s) and resubmit the claim with an EOB/Final Determination. If the claims that are being resubmitted are outside the timely filing, providers need to complete the appeal process before resubmitting the claims.

In cases where Providers receive information that member's coverage with the primary was terminated, the TPL discrepancy process should be completed.

The DHS-PA will pursue all cases that CBH is unable to recover.

6.2.3. Methods in Billing CBH

6.2.3.1. Electronic Claims

CBH prefers all claims be submitted via Electronic Data Interchange (EDI). Filing claims electronically helps providers minimize data entry errors after submission and expedite the processing of their claims. CBH has issued Companion Guides to assist with billing EDI:

➡ **CBH 5010 Institutional Companion Guide V1.12**

➡ **CBH 5010 Professional Companion Guide V1.9**

➡ **CBH 5010 Health Care Claim Acknowledgement Companion Guide V1.2**

➡ **CBH 5010 Health Care Claim Payment/Advice Companion Guide V 1.1**

➡ **CBH 5010 Trading Partner Companion Guide V1.2**

More reference materials are available under the Finance tab of the **CBH Provider Manual webpage**.

6.2.3.2. Filing Manual Claims

Providers filing manual claims must use one of two printed claim forms designated for that purpose. Please refer to Schedule A of your CBH Provider Agreement for all contractual services and the appropriate CPT codes, pricing and information modifiers, and BANs. This section provides specific information about which forms are to be submitted for the specific types of treatment. It also provides examples of each form.

You can either mail or email your claims.

Claims can be mailed via United States Postal Service (USPS) to:

CBH Claims Department
801 Market Street, 7th Floor
Philadelphia, PA 19107

Hand-deliveries will not be accepted.

You can email your claims to **CBHclaims.InProvider@phila.gov**. Out of Network Providers should send in their claims to **CBHClaimsOON@phila.gov**.

➡ You can submit up to 25 claims per email.

➡ All claims in the email should either be TPL or Non-TPL.

➡ Subject line should be: Parent#/TPL vs Non-TPL/Number of Claims/Late submission #0000 (if the claim is beyond the timely filing process)

➡ Each TPL Claim must be submitted with an EOB/Final Determination

6.2.3.2.1. Inpatient Claims, UB-04 Claim forms

All inpatient hospital or RTF-Accredited claims must be submitted using the UB-04 Claim Form.

6.2.3.2.2. Outpatient Claims, CMS-1500 (02-12) Claim form

Outpatient and Community Based service claims must be submitted using the CMS-1500 (02-12) Claim Form.

6.2.3.2.3. Completion of the UB-04 Claim Form

The UB-04 Claim Form is used when an inpatient (hospital inpatient or RTF Accredited) stay has been provided. Revenue codes are used exclusively on the UB-04 claim form. Please see the UB-04 example below.

Listed below are the required fields that must be completed on the UB-04 Claim Form, which are the same required fields for 837I Institutional.

Remember:

➡ All services require an authorization number for billing and only one authorization number per claim form is allowed. When an item is "not applicable," do not use zero. Leave it blank. Please see the reference below.

➡ The place of service indicated on the claim needs to be an allowable Place of Service for the level of care being billed.

➡ All diagnosis codes submitted on the claim need to be valid and consistent with the services provided.

6.2.3.2.3.1. UB-04 Patient Information, Provider Name, and Compensable Behavioral Health Services

Form Locator #	Description for Paper	Usage	837I Companion Guide for EDI	ASC 837I v5010A2 Loop, Segment for EDI
01	Billing Provider, Name, Address, and Telephone Number	REQUIRED		Loop 2010AA, NM1/85/03, N3 segment, N4 segment
02	Pay-lo-Name and Address (required when different from form locator 01)	SITUATIONAL		Loop 2010AB, NM1/85/03, N3 segment, N4 segment
03a	Patient Control Number	REQUIRED	It is a requirement that the value submitted MUST be unique for EACH individual claim	Loop 2300, CLM01
03b	Medical Record Number	SITUATIONAL		Loop 2300, REF/EA/02
04	Type of Bill	REQUIRED	Code values: 0 = Non-Payment/Zero 1 = Admit through Discharge Claim 2 = Interim – First Class 3 = Interim – Continuing Claim 4 = Interim – Last Claim 8 = Void/Cancel of Prior Claim Recommended value is "1" to Indicate an "Original" claim unless one of the other codes is more appropriate. *See notes on declaration of Discharge Time (Loop 2300 DTP03)	Loop 2300, CLM05-1, CLM05-3
05	Federal Tax ID	REQUIRED		Loop 2010AA, NM109, REF/EI/02
06	Statement Covers Period (MMDDYY)	REQUIRED		Loop 2300, DTP/434/03
08b	Patient Name	REQUIRED		Loop 2010BA, NM1/IL/03, 04, 05, 07
09a-d	Patient Address a) State b) City c) State d) ZIP Code	REQUIRED		Loop 2010BA, N301, N401, 02, 03, 04
10	Patient Birth Date	REQUIRED		Loop 2010BA, DMG02

Form Locator #	Description for Paper	Usage	837I Companion Guide for EDI	ASC 837I v5010A2 Loop, Segment for EDI
11	Patient Sex	REQUIRED		Loop 2010BA, DMG02
12	Admission/Start of Care Date	REQUIRED		Loop 2300, DTP/435/03
13	Admission Hour	SITUATIONAL		Loop 2300, DTP/435/03
14	Admission Type	SITUATIONAL	See UB-04 Desk Reference for Hospitals	Loop 2300, CL101
15	Source of Admission	REQUIRED	Code Values: 1 = Non-Health Care Facility Point of Origin 2 = Clinic or Physician's Office 4 = Transfer from Hospital (Different Facility) 5 = Transfer from Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Assisted living Facility (ALF) 6 = Transfer from Health Care Facillty 8 = Court/Law Enforcement 9 = Information Not Available CBH will ONLY accept numeric values for this data segment.	Loop 2300, CL102
16	Discharge Hour	SITUATIONAL	If Discharge Time Is declared then the Type of bill (CLM05-3) value MUST be "1" or "4"	Loop 2300, DTP/096/03
17	Patient Discharge Status	REQUIRED	See UB-04 Desk Reference for Hospitals	Loop 2300, CL103
18-28	Condition Codes	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=BG) Loop 2300, HI02-2 (HI02-1=BG) Loop 2300, HI03-2 (HI03-1=BG) Loop 2300, HI04-2 (HI04-1=BG) Loop 2300, HI05-2 (HI05-1=BG) Loop 2300, HI06-2 (HI06-1=BG) Loop 2300, HI07-2 (HI07-1=BG)
29	Accident State	SITUATIONAL		Loop 2300, CLM11-4
31-34	Occurrence Code/Date	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=BH) HI01-4 Loop 2300, HI02-2 (HI02-1=BH) HI02-4 Loop 2300, HI03-2 (HI03-1=BH) HI03-4 Loop 2300, HI04-2 (HI04-1=BH) HI04-4 Loop 2300, HI05-2 (HI05-1=BH) HI05-4 Loop 2300, HI06-2 (HI06-2=BH) HI06-4 Loop 2300, HI07-2 (HI07-1=BH) HI07-4

Form Locator #	Description for Paper	Usage	837I Companion Guide for EDI	ASC 837I v5010A2 Loop, Segment for EDI
				Loop 2300, HI08-2 (HI08-1=BH) HI08-4
35-36	Occurrence Span Code/Date	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=BI) HI01-4
				Loop 2300, HI02-2 (HI02-1=BI) HI02-4
				Loop 2300, HI03-2 (HI03-1=BI) HI03-4
				Loop 2300, HI04-2 (HI04-1=BI) HI04-4
39-41	Value Code/Amount	REQUIRED	Value codes must be entered in numeric sequence, starting in Form Locator 39a through 41a, 39b through 41b, 39c through 41c, and 39d through 41d. See UB-04 Desk Reference for Hospitals.	Loop 2300, HI01-2 (HI01-1=BE) HI01-5
				Loop 2300, HI02-2 (HI02-1=BE) HI02-5
				Loop 2300, HI03-2 (HI03-1=BE) HI03-5
				Loop 2300, HI04-2 (HI04-1=BE) HI04-5
				Loop 2300, HI05-2 (HI05-1=BE) HI05-5
				Loop 2300, HI06-2 (HI06-1=BE) HI06-5
				Loop 2300, HI07-2 (HI07-1=BE) HI07-5
				Loop 2300, HI08-2 (HI08-1=BE) HIOB-5
				Loop 2300, HI09-2 (HI09-1=BE) HI09-5
				Loop 2300, HI10-2 (HI10-1=BE) HI10-5
				Loop 2300, HI11-2 (HI11-1=BE) HI11-5
				Loop 2300, HI12-2 (HI12-1=BE) HI12-5
42	Revenue Code	REQUIRED	See CBH Schedule A	Loop 2400, SV201
43	Revenue Description	SITUATIONAL		Not Required by Medicare
44	HCPCS/Rate/HIPPS Code	SITUATIONAL		Loop 2400, SV202-2 (SV202-1=HC/HP)
45	Service Date	SITUATIONAL		Loop 2400, DTP/472/03
45 (23)	Creation Date	REQUIRED		
46	Service/Units	REQUIRED		Loop 2400, SV205
47 (23)	Total Charges	REQUIRED		Loop 2400, SV203
50 a-c	Payer Name	REQUIRED	Enter the name of each payer organization from which the provider might expect some payment for the bill	Loop 2330B, NM1/PR/03
51 a-c	Identification Code Other Payer Primary Identifier	REQUIRED		Loop 2330B, NM1/PR/09
52 a-c	Release of Information	REQUIRED		Loop 2300, CLM07
53 a-c	Assignment of Benefits Certification	REQUIRED		Loop 2300, CLM08

Form Locator #	Description for Paper	Usage	837I Companion Guide for EDI	ASC 837I v5010A2 Loop, Segment for EDI
54 a-c	Prior Payment Amounts	SITUATIONAL	If coordination of benefits is involved, then enter the covered charges amount on the EOB (for Medicare, or the other insurance carrier's payment amount).	Loop 2320, AMT/D/02
55 a-c	Estimated Amount Due	SITUATIONAL	Enter the estimated amount you expect to be paid by CBH.	Loop 2300, AMT/EAF/02
56	National Provider Identifier (NPI)	REQUIRED		Loop 2010AA, NM1/85/09
57c	Billing Provider Specialty Information	REQUIRED	This information must be sent in all CBH claims for the purpose of adjudication.	Loop 2000A, PRV03
58 a-c	Insured's Name Other Insured's Name	REQUIRED		Loop 2010BA, NM1/II/03, 04, 05 Loop 2330A, NM1/IL/03, 04, 05
59 a-c	Patient Relationship	REQUIRED		Loop 2000B, SBR02
60 a-c	Subscriber Identification Code	REQUIRED	Length of 10.	Loop 2010BA, NM1/IL/09, REF/SY/02
63	Treatment Authorization Codes	REQUIRED		Loop 2300, REF/G1/02
67 a-q	Diagnosis	REQUIRED		Loop 2300 HI01-2 (HI01-1=BK)
69	Admitting Dx	REQUIRED		Loop 2300 HI01-2 (HI02-1=BJ)
70 a-c	Patient Reason for Visit	SITUATIONAL		Loop 2300, HI01-2 (HI02-1=PR)
71	Diagnosis Related Group (DRG) Code	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=DR)
72 a-c	External Cause of Injury Code	SITUATIONAL		Loop 2300, HI03-2 (HI03-1=BN)
74	Principal Procedure Code Principal Procedure Date	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=BR) Loop 2300, HI01-4 (HI01-1=BR)

➡ **PA PROMISe™ UB-04 Desk Reference for Hospitals**

6.2.3.2.4. Completion of the CMS-1500 (02-12) Claim Form

The CMS-1500 (02-12) Claim Form is used when an outpatient service has been provided. Current Procedure Terminology (CPT Codes) or Healthcare Common Procedure Coding System (HCPCS Codes) are only allowed on this claim form. Please see the CMS-1500 (02-12) example below.

Listed below are the required fields that must be completed on the CMS-1500 (02-12) Claim Form, which are the same required fields for 837P Professional. Remember that all services require an authorization number for billing and only one authorization number per claim form is allowed. The place of service indicated on the claim need to be an allowable Place of Service for the level of care being billed. All diagnosis codes submitted on the claim need to be valid and consistent with the services provided.

6.2.3.2.4.1. CMS 1500 (02-12) Outpatient Information, Provider Name, and Compensable Behavioral Health Services

Item #	Description for Paper	Usage	Loop ID for EDI	837P Segment/ Data Element for EDI	Segment/Data Element Name for EDI
1	Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Required	2000B	SBR09	Claim Filing Indicator Code
1a	Insured's ID Number	Required	2010BA	NM109	Subscriber Primary Identifier
2	Patient's Name	Required	2010CA or 2010BA	NM103	Patient Last Name
				NM104	Patient First Name
				NM105	Patient Middle Name or Initial
				NM107	Patient Name Suffix
3	Patient's Birth Date, Sex	Required	2010CA	DMG02	Subscriber Birth Date
				DMG03	Subscriber Gender Code
5	Patient's Address	Required	2010CA	N302	Patient Address Line
				N401	Patient City Name
				N402	Patient Sate Code
				N403	Patient Postal Zone or ZIP Code
6	Patient Relationship to Insured	Required	2000B	SBR02	Individual Relationship Code
			2000C	PAT01	Individual Relationship Code
9	Other Insured's Name	Situational, if TPL information present then Required	2330A	NM103	Other Insured Last Name
				NM104	Other Insured First Name

Item #	Description for Paper	Usage	Loop ID for EDI	837P Segment/ Data Element for EDI	Segment/Data Element Name for EDI
				NM105	Other Insured Middle Name
				NM107	Other Insured Name Suffix
9a	Other Insured's Policy or Group Number	Situational, if TPL information present then Required	2320	SBR03	Insured Group or Policy Number
9d	Insurance Plan Name or Program Name	Situational, if TPL Information present then Required. You Must use the Carrier Name listed In Appendix A of the CBH Companion Guide.	2320	SBR04	Other Insured Group Name
10a	Is Patient's Condition Related to Employment	Required	2300	CLM11	Related Cause Code
10b	Is Patient's Condition Related to Auto Accident	Required	2300	CLM11	Related Cause Code
10c	Is Patient's Condition Related to Other Accident	Required	2300	CLM11	Related Cause Code
11d	Is There Another Health Benefit Plan?	Required			
12	Patient's or Authorized Person's Signature	Required	2300	CLM09	Release of Information Code
13	Insured's or Authorized Person's Signature	Required	2300	CLM08	Benefits Assignment Certification Indicator
17	Name of Referring Provider or Other Source	Required	2310A (Referring)	NM103	Referring Provider Last Name
				NM104	Referring Provider First Name
				NM105	Referring Provider Middle Name or Initial
				NM107	Referring Provider Name Suffix
17b	NPI#	Required	2310A (Referring)	NM109	Referring Provider Identifier
18	Hospitalization Dates Related to Current Services	Situational	2300	DTP03	Related Hospitalization Admission Date

Item #	Description for Paper	Usage	Loop ID for EDI	837P Segment/ Data Element for EDI	Segment/Data Element Name for EDI
21	Diagnosis or Nature of Illness or Injury	21A = Required 21B-L = Situational	2300	HI01-2	Diagnosis Code
				HI02-2	Diagnosis Code
				HI03-2	Diagnosis Code
				HI04-2	Diagnosis Code
22	Medicaid Resubmission and/or Original Reference Number	Situational	2300	CLM05-3	Claim Frequency Code
				REF02	Payer Claim Control Number
23	Prior Authorization Number	Required	2300	REF02	Prior Authorization or Blanket Authorization Number
24A	Date(s) of Service	Required	2400	DTP03	Service Date
24B	Place of Service	Required	2300	CLM05-1	Place of Service Code
			2400	SV105	Place of Service Code
24D	Procedures, Services, or Supplies	CPT/HCPCS: Required MODIFIER: Situational	2400	SV101 (2-6)	Product/Service ID and Procedure Modifier
24E	Diagnosis Pointer	Required	2400	SV107 (1-4)	Diagnosis Code Pointer
24F	$ Charges	Required	2400	SV102	Line Item Charge Amount
24G	Days or Units	Required	2400	SV104	Service Unit Count
25	Federal Tax ID Number	Number Field: Required SSN/EIN: Required	2010AA	REF02	Billing Provider Tax Identification Number
					Billing Provider License and/or UPIN Information
26	Patient's Account No.	Required	2300	CLM0I	Patient Control Number
27	Accept Assignment?	Required	2300	CLM07	Assignment or Plan Participation Code
28	Total Charge	Required	2300	CLM02	Total Claim Charge Amount

Item #	Description for Paper	Usage	Loop ID for EDI	837P Segment/ Data Element for EDI	Segment/Data Element Name for EDI
29	Amount Paid	Situational, if TPL information present then Required	2300	AMT02	Patient Amount Paid
			2320	AMT02	Payer Paid Amount
31	Signature of Physician or Supplier Including Degrees or Credentials and Date	Required	2300	CLM06	Provider or Supplier Signature Indicator
32	Service Facility Location Information	Situational, if laboratory services then Required	2310C	NM103	Laboratory or Facility Name
				N301	Laboratory or Facility Address Line
				N401	Laboratory or Facility City Name
				N402	Laboratory or Facility State or Province Code
				N403	Laboratory or Facility Postal Zone or ZIP Code
32a	NPI #	Situational, if laboratory services then Required	2310C	NM109	Laboratory or Facility Primary Identifier
33	Billing Provider Info and Phone #	Required	2010AA	NM103	Billing Provider Last or Organizational Name
				NM104	Billing Provider First Name
				NM105	Billing Provider Middle Name or Initial
				NM107	Billing Provider Name Suffix
				N301	Billing Provider Address Line
				N401	Billing Provider City Name
				N402	Billing Provider State or Province Code
				N403	Billing Provider Postal Zone or ZIP Code
				PER04	Communication Number

Item #	Description for Paper	Usage	Loop ID for EDI	837P Segment/ Data Element for EDI	Segment/Data Element Name for EDI
33a	NPI #	Required	2010AA	NM109	Billing Provider Identifier
33b	Other ID #	Required	2000A 2010AA	PRV03	Provider Taxonomy Code
				REF01	Reference Identification Qualifier
				REF02	Billing Provider Tax Identification Number

➡ **Regular Claim Form (Sample with Required Fields)**

➡ **Lab Claim Form Required Fields (Sample with Required Fields)**

➡ **TPL Claim Form Required Fields (Sample with Required Fields)**

6.2.4. CBH Claim Process Cycle and Returned Data

6.2.4.1. Adjudication Process

CBH will adjudicate all clean claims within 45 days and adjudicate all claims within 90 days. Adjudicate means to pay or reject a claim.

6.2.4.2. Payment of Claims

Payment will be Electronic Funds Transfers to the Bank designated by the provider in the **CBH Direct Deposit Agreement Form**. Changes in Bank must be reported in writing under the signature of the Chief Executive Officer or Chief Financial Officer to the provider's assigned Provider Relations Representative.

6.2.4.3. Returned Claim Data

Whether a claim is accepted or rejected, claims data will be made available to the provider through the CBH Ipswitch secure file transfer, available via **se.DBHIDS.org**. All data returned to the provider is via EDI. The National Implementation Guides which provide detailed explanation of EDI format and Claim Acknowledgements are published by Washington Publishing Company and can be obtained at **X12**.

➡ Returned Claim Acknowledgement:

  » TA1 – Acknowledges the receipt of the EDI File

  » 999 – Implementation Acknowledgement

  » 277 – Healthcare Claim Acknowledgement

➡ Returned Remittance Advice:

» 835RA – Healthcare Claim Payment Advice

6.2.5. CBH Provider Follow-up Process

On occasion, after a payment has been issued, either CBH Claims staff, or the provider may detect an error in the processing of the claim that was paid. The void or adjustment process deals with the correction of those claims that have been through the adjudication cycle and been paid. If a claim has been rejected and not yet paid, it is not subject to a "void or adjustment." Only those claims that have already been paid can be voided or adjusted. Claims voids or adjustments generally occur for the following reasons:

➡ Claim was submitted and paid twice

➡ Claim was paid at an incorrect rate

➡ Claim was paid for the incorrect date(s) of service

➡ Claim was paid at an incorrect level of care

➡ Claim was submitted with excessive units of service within the time period

➡ Services were span billed with overlapping days on more than one claim

➡ A Program Integrity audit was conducted

➡ Post payment recoveries

6.2.5.1. Submitting Provider Initiated Voids via the 837I or 837P

➡ Provider must have completed and passed both phases of Provider Initiated Void testing before submitting void files in production.

➡ The Void files need to have the following components:

» Claim frequency code 8 at the CLM05-3 segment

» Claim number (the original claims CLM01 number) at the REF*F8

➡ Await the acknowledgment that the Provider Initiated Void has been accepted and processed correctly before sending the new claim(s) for payment consideration.

➡ If the corrected claim you are submitting is passed the timely filling, please complete the appeal process first before reversing the claim.

6.2.5.2. Submitting Adjustments Manually

➡ Providers can submit their adjustment request to CBH via email. CBH only will reverse the claim through this process and notify the provider once the reversal is completed.

➡ To complete a manual claim reversal, provider must complete the following steps:

» Complete **CBH Claims Adjustment Request Form**. Only one form needs to be completed for all adjustments.

- When adjustment is being requested for multiple members, or different auths, programs, and NPIs, indicate "various" on the form. The reason for the adjustment should be clearly stated on the form.

  » The reason for reversing the claims should be clearly identified on the form.

  » A spreadsheet in CSV Comma Delimited (*.csv) Format with the claim/invoice numbers should be completed.

  » The adjustment form and spreadsheet should be emailed to **CBHClaimsBackout@phila.gov**.

➡ You will receive an email once your request is received and when the reversal is completed.

6.2.5.3. Claims Appeals Process

There are three categories of claims rejections that providers may appeal.

6.2.5.3.1. Appealing Rejected Claims for TPL Caused by Discrepancies

Providers should submit Third Party Liability (TPL) Discrepancy request for the following reasons:

➡ Claim rejects for TPL coverage and EVS indicates member has no TPL

➡ Provider obtains termination letter from primary carrier

➡ For Medicare members, providers are required to submit a Health Information and Quality Authority (HIQA) form for verification purposes with the effective or termination dates.

TPL Discrepancy request must be submitted within 90 days of the rejection

6.2.5.3.1.1. Procedure for Providers

➡ Complete the **CBH TPL Discrepancy Form** and send it to **cbh.tpl.discrepancy@phila.gov**. Please ensure the following information has been completed:

  » Facility name

  » Facility parent number

  » Member information

  » Include any supporting documentation, i.e., termination letter from primary carrier and/or Eligibility Verification System printout

➡ Maximum of 10 members per submission

Once your TPL discrepancy appeal is reviewed, you will receive a response by email

➡ If it is determined the member has no TPL coverage and the dates-of-service are within the timely filing, resubmit the claims as per standard process

  » A TPL discrepancy letter will emailed to provider

» The Internal Office Use only section will be completed with our findings and sent electronically or emailed to the provider

➡ If it is determined the client has no TPL coverage and the DOS is beyond 90 days

» The provider will receive a TPL discrepancy letter indicating the CBH system was updated to reflect member no longer has TPL coverage.

» To submit the claims following the late submission process. You will need to complete an appeal to submit the claims.

➡ If it is found that the client does have TPL coverage

» CBH will reply with a TPL discrepancy letter identifying the primary carrier's name, policy number and effective date of coverage

» Provider will have to obtain a final determination from the primary carrier no more than 180 days from the date of the TPL discrepancy letter

» Provider must submit a claim to CBH within 90 days per standard process

6.2.5.3.2. Appealing Rejected Claims for "Recipient not Eligible"

6.2.5.3.2.1. *Caused by Discrepancies Between EVS and the Claims System*

If the provider accesses the eligibility information and it indicates that the client is eligible for treatment on a particular date, but during the processing of the claim CBH does not show the individual to be eligible and rejects the claim, within 90 days from the date of rejection the provider must do the following:

➡ Send email to **CBHClaim.Support@phila.gov** with the subject line Eligibility Discrepancy

➡ Include member Medical Assistance number and date of service range

➡ CBH will review the information and respond back with the results of our investigation

6.2.5.3.2.2. *Caused by Member Losing Eligibility While Receiving Inpatient or Residential Services (Appendix V)*

Claims for members who are receiving inpatient services and children in substitute care, who were eligible at the time of admission and lose their CBH benefits during their authorized stay may be eligible for payment under *HealthChoices Behavioral Health Program Standards and Requirements*: *Appendix V*. Appendix V covers services at Inpatient Psychiatric Acute (100 Levels of Care), Inpatient Psychiatric Acute-Extended Stay (140 Levels of Care), Inpatient Drug and Alcohol (150 Levels of Care), Non-Hospital Drug and Alcohol (200 Levels of Care), Youth Residential Treatment Facility (500 and 550 Levels of Care), and Host Homes (450 Levels of Care). Providers must complete the following process:

➡ Send email to **CBHClaim.Support@phila.gov** with the subject line Appendix V

➡ Include member name, Medical Assistance number, authorization number, and date of service range.

➡ CBH will review the information and respond back with the result of the investigation.

6.2.5.3.3. Appealing Rejected Claims for "Timely Filing Limit or Late Submission"

Claims rejected for late submission or being submitted outside of the timely filing period may be appealed only due to processing errors made by CBH. Providers need to complete the following steps to appeal for late submission:

➡ Complete the **CBH Claims Electronic Appeals Process Form**. Only one form needs to be completed for all outstanding claims. If submitting appeals spanning over different years, there should be a separate form for each year.

➡ The reason for the appeal should be clearly stated on the form.

➡ The form should be emailed to **CBHClaims.Appeal@phila.gov**

➡ A confirmation email will be sent once the appeal is received.

➡ The result of your appeal will be communicated via email. An approval number will be provided which you will need to ensure the late submission edit is removed when processing your claims.

➡ You will have five business days to submit your claims.

Electronic Claims:

» Upload the file to the late submission folder in the CBH Provider Portal

» Email in the file name to **CBHClaim.Support@phila.gov**

» The subject line of the email should include your approval number and state "Late Submission"

» CBH will remove the late submission edit when processing the file.

CBH Converter Application Claims:

» Email **CBHClaims.Support@phila.gov** indicating claims approved for late submission are being submitted through the CBH Converter Application

» The subject line of the email should include your approval number and state "Late Submission"

» Choose "late submission" option from the New Claim Menu

» Enter the claim and submit

» Claim will stay in adjudication until the late submission edit is removed

Paper Claims:

» Email your claims to **Claims.InProvider@phila.gov**

» The subject line of your email should be Parent #/TPL vs Non-TPL/Number of Claims/Late submission/Appeal Approval #

7. SECURE FILE TRANSFER

7.1. Overview

This section outlines reports that are available for exchange to or from Providers via our Secure Managed File Transfer.

The following reports will be sent to providers:

- ➡ Weekly Schedule A Report/Contract

- ➡ Daily, Weekly, and 90-Day Authorization Reports

- ➡ Daily TA1, 999, and 277 Claims Acknowledgement response files for every claim file loaded to CBH

- ➡ Weekly 835 Remittance Advise file

- ➡ Weekly Claims Rejected/Denied Reports

The following reports are expected from providers:

- ➡ E-Packets

7.2. Reference Guide

This section is a reference guide for CBH's secure file transfer system, including information about how to upload and download reports.

7.2.1. Overview

This web-based file transfer secure server allows simple and secure uploading and downloading of E-Packets, and Claims Files, including 837 Submission files, 277 Response files, 835 Remittance Advise Files, TA1 and 999 response files, Authorization Reports, and Schedule A Contracts.

7.2.2. Gaining Access

To begin, users gain access to the system by obtaining login credentials via the **Request to Secure Exchange for Provider Access form** sent to providers upon request from CBH through a provider-user's Provider Relations Representative.

When the form is completed, usernames and temporary passwords are sent to the email address submitted on the form.

Using the CBH-provided login information, users navigate to **se.DBHIDS.org** to begin the login process.

Note: Temporary passwords expire and must be changed within 72 hours.

7.2.3. Login

To begin the log-in process, use an Internet browser to navigate to **se.DBHIDS.org**.

Before logging in, please read the Security Notice located under the log-in section carefully. Keep in mind, for security purposes, that you should not share login information with anyone.

To log in, enter the supplied username and password, and click *Sign On*.

7.2.4. Changing Temporary Passwords

New users receive temporary passwords via a *New User Account* email when they are first granted access to the portal.

As noted above: *Initial passwords are temporary and must be changed within 72 hours. Use the link supplied in the "New User Account" or "Password Reset" email to log in and change a temporary password.*

It is recommended that users copy and paste the temporary password contained in the *New User Account* email into the *Enter Your Old Password* box (below), as temporary passwords contain many special characters.

Clicking the link will bring users to a dialog like the one below.

Change Your Password...

Enter Your Old Password: [   ] [⌨]

New Password:

Requirements:
- Must be at least 8 characters.
- Must not contain or resemble Username.
- Must contain at least one letter and one number.
- Must not contain dictionary words.
- Must contain both upper- and lower-case letters.
- Must contain at least one non-alphanumeric character.
- Must not match any of the previous 4 passwords.

Enter Your New Password: [   ] [⌨]

Enter Your New Password Again: [   ] [⌨]

Change Password

Enter the temporary password into the *Enter Your Old Password* box. Then create a new password that meets the system password requirements and enter it twice in the appropriate boxes. Finally, click "Change Password" to update an old or temporary password.

Users will receive a reminder to change passwords every 90 days. Account information must be kept secure. Follow your organization's requirements for managing credentials.

7.2.5. Multi-Factor Authentication

The last step in the login process is called Multi-Factor Authentication. In this process, a six-digit code is sent to users as a second security step.

After a user's second login, a "Remember this device" checkbox will be visible. Checking this box allows users to "opt out" of Multi-Factor Authentication for the specific device on which they are working.
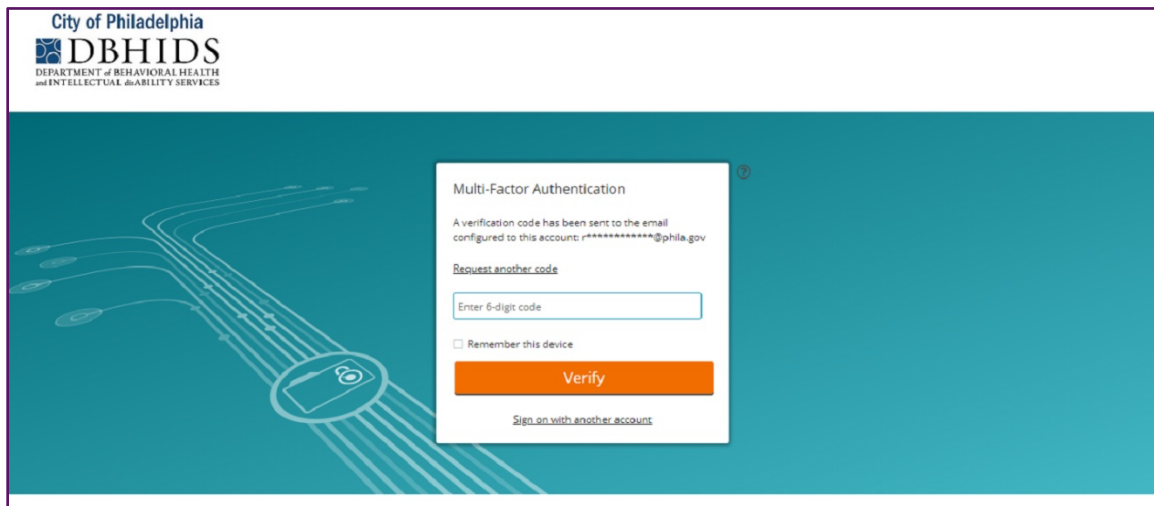
7.2.6. Navigation

Once logged in, notice the structure of the user portal *Home* page. There are three main sections:

1. *Navigation and Search*

2. *Announcements*

3. *Upload Files Section*
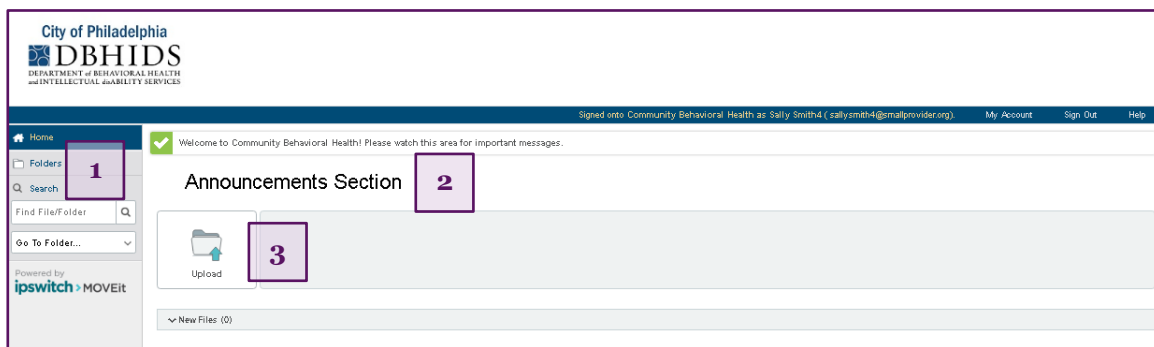
➡ The Navigation Section contains a *Folder* link, a *Find File/Folder* search box, and a *Go To Folder* drop-down selection list that allow users to browse existing folders, search for existing files and folders, or select a folder to "go-to" from a drop-down menu.

➡ Announcements placed in Section 2 above allow users to see any relative communications regarding claims file submission or claims file response from CBH.
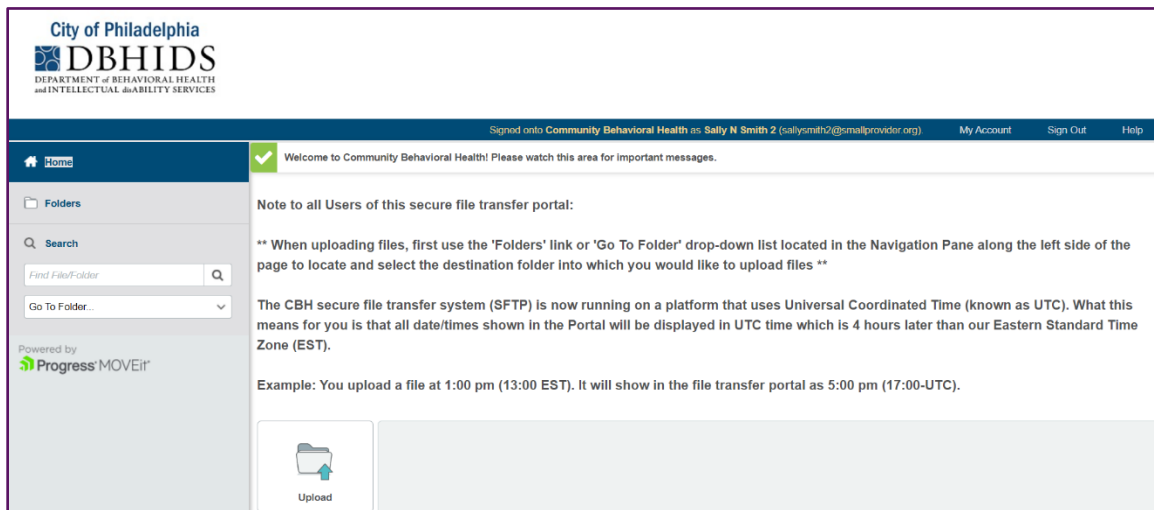
In the new file transfer system, files are processed as they have been historically.

E-Packet Files are uploaded to the appropriate folder:
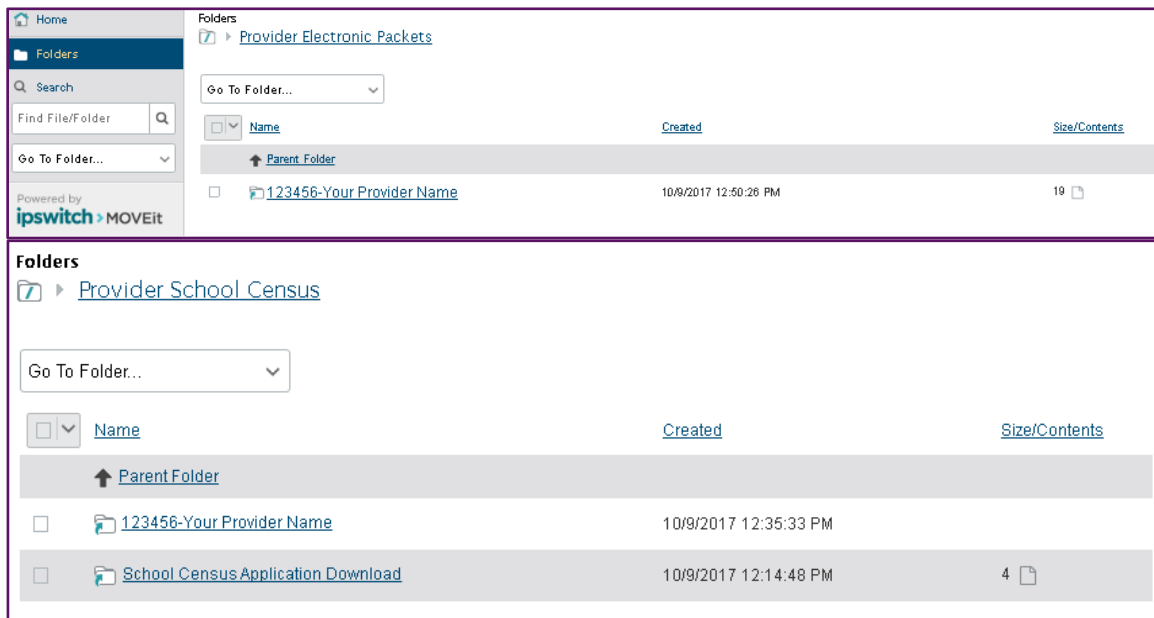
Claims Response Files are returned to providers via the *Download Claims Files* folder and placed in sub-folders by type for provider review and downloading.[6]
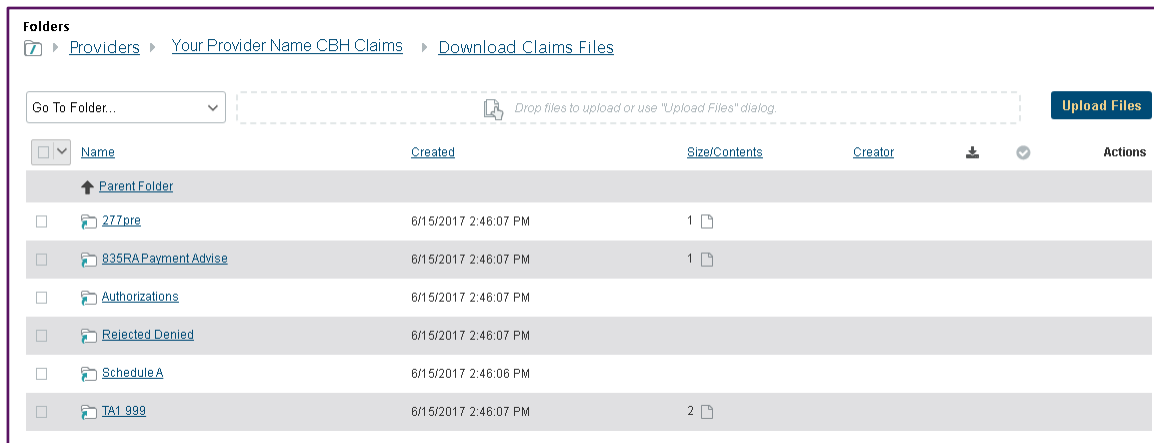
7.2.7. Claims Folder Structure

Navigating in the Secure File Transfer System for claims processing begins by knowing what folders are open and where to go for claims file uploading and downloading. To assist in these items, the new system displays what folder a user has open in the upper-center portion of the main screen (1).

---
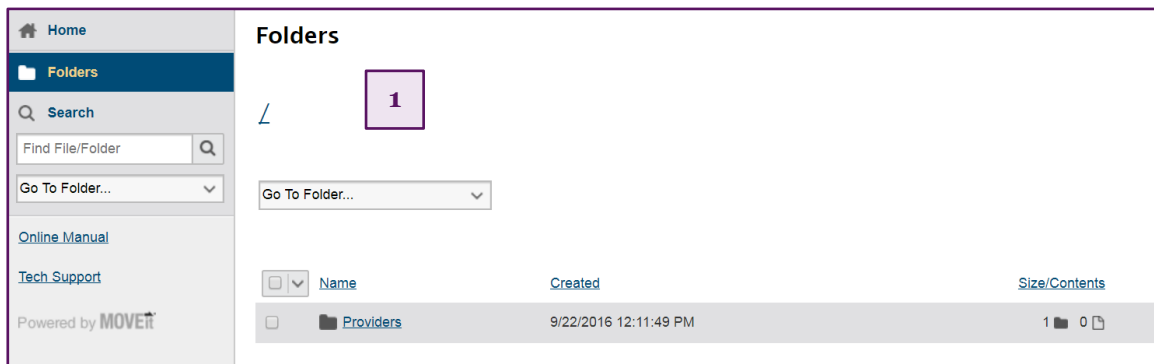
[6] *In the Download Claims Files folder, separate folders exist for 277pre forms, 835RA Payment Advise documents, Authorizations, Rejected Denied Claims, Schedule A forms, and TA1/999 documents. For users with E-Packet or School Census access, separate folders also exist for uploading E-Packets and School Census files (see above images).*

The image below shows the main folder areas containing destinations for testing claims processing (*Claims TEST*), sending claims (*Upload Claims Files*), and receiving claims responses (*Download Claims Files*):
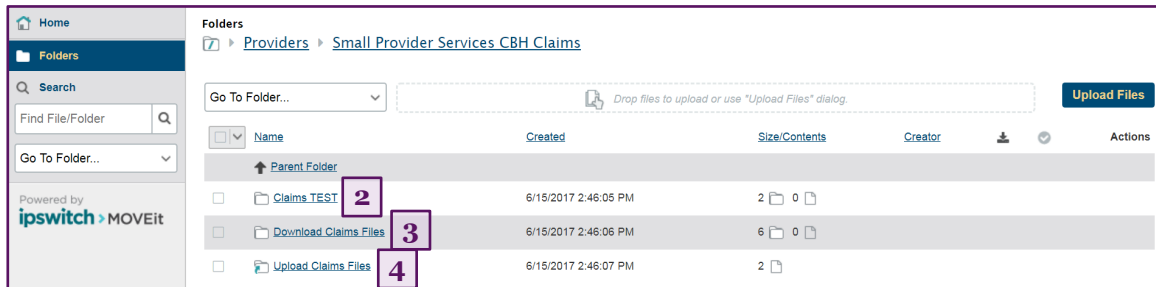
➡ *Claims TEST*: contains folders for testing initial connectivity and testing changes to existing claims processing. (2)

➡ *Download Claims Files*: contains responses to submitted claims, i.e., 277s, 835RAs, Authorizations, Schedule As, TA1s, and 999s. (3)

➡ *Upload Claims Files*: the location where 837 claim files are uploaded. (4)

7.2.8. Uploading Claims Files

Navigate to the *Upload Claims Files* folder to begin uploading files for claims processing. The steps are:

1. Navigate to the *Upload Claims Files* folder and click the *Upload Files* (1) button.
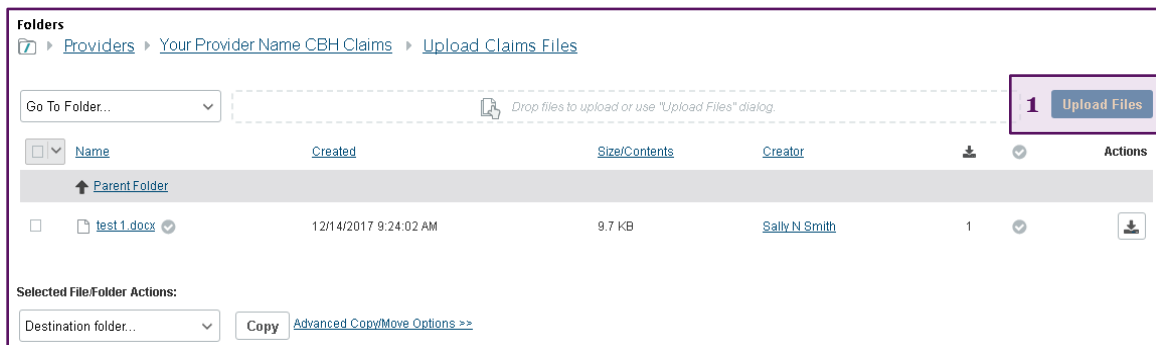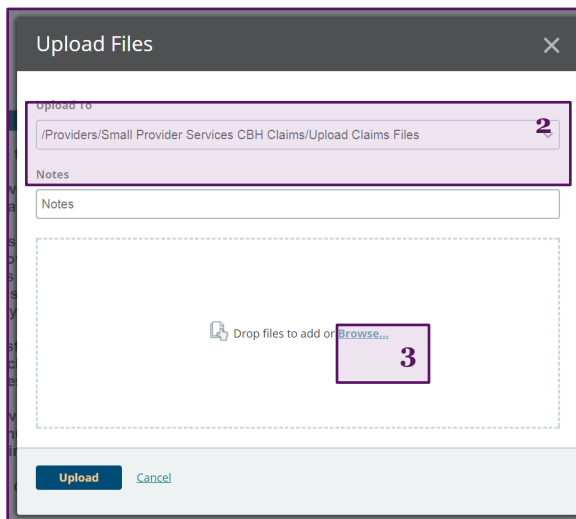
2. Select the correct folder in the *Upload To* drop-down menu.

3. Click the *Browse* link to open the file explorer on your local computer system.

4. Select the appropriate file on your local computer system. Once the desired file is selected, click *Open*.
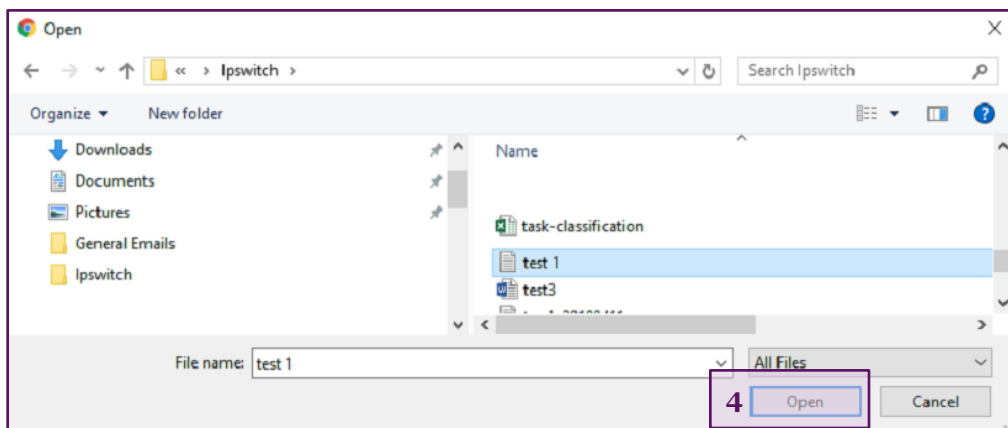
5. When a file is selected for uploading, both the target location (*Upload To*) and the file appear in the MOVEit *Upload Files* window. This allows the user to confirm the file that is being uploaded and that the file will be placed in the correct target location.

6. Now the user simply clicks the *Upload* button to place the file where they have chosen.

7. The MOVEit *Upload Files* window shows the location of the successful upload and the file that has been uploaded with a green checkmark. This window can now be closed.
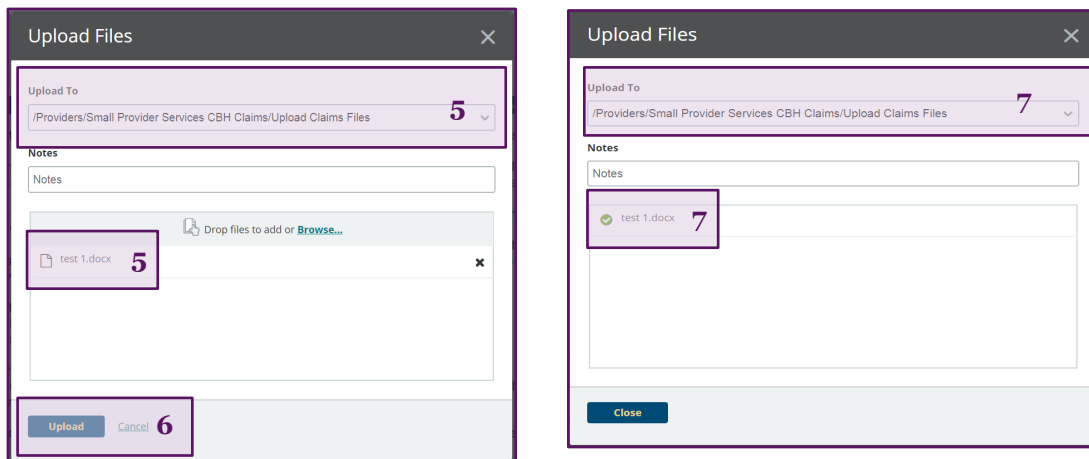
7.2.9. Downloading Claims Responses

Downloading Claims Responses is a simple process. For illustration, this section will use the *Go To Folder* drop-down method, though users may choose to navigate directly through folders to reach the same destination.

1. First, select the Folders item in the Navigation section of the portal's main page.
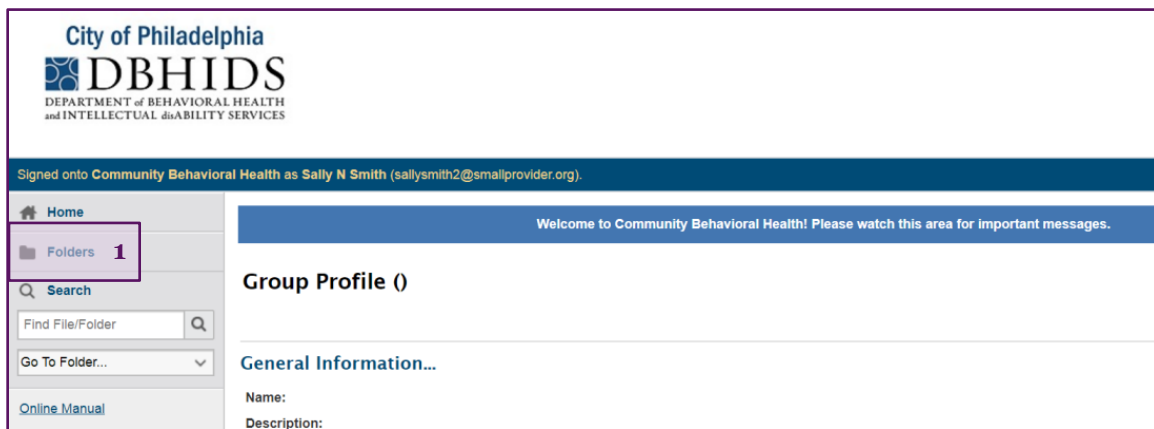
2. In the main window, click the Providers folder.
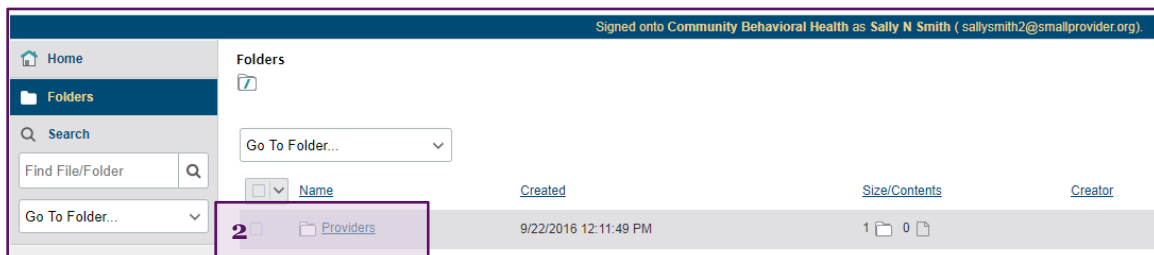
3. Then click the CBH Claims folder marked with the Provider Name (here the Provider Name is "Small Provider Services").
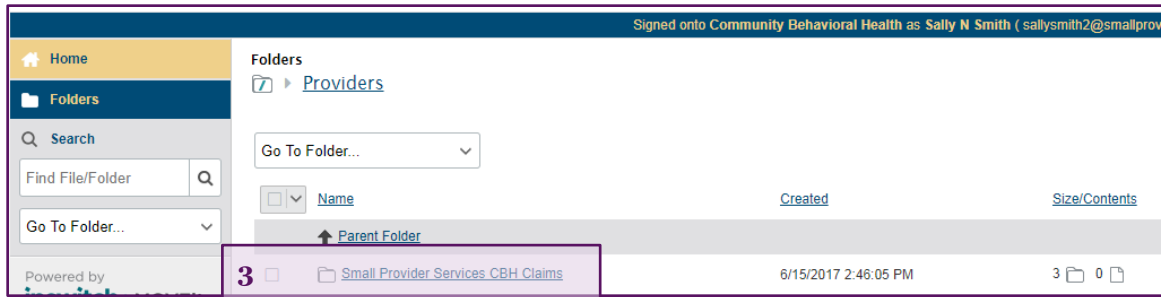
4. Select the desired response folder, i.e., 277pre, 835A Payment Advise, etc.
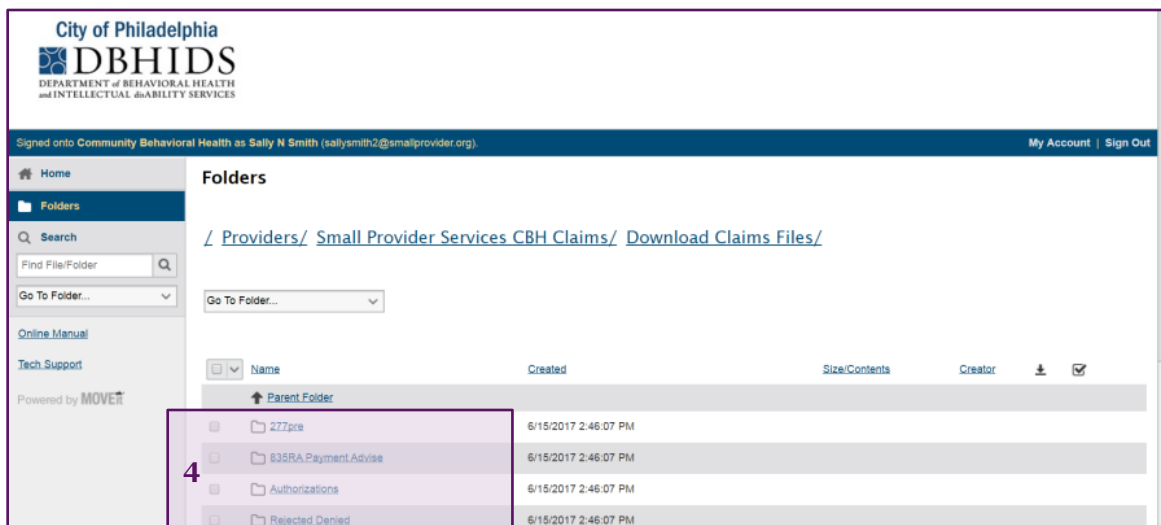
5. With the desired folder open, click the download icon (highlighted below right) or simply click on the file name to move the file from the portal to your computer.
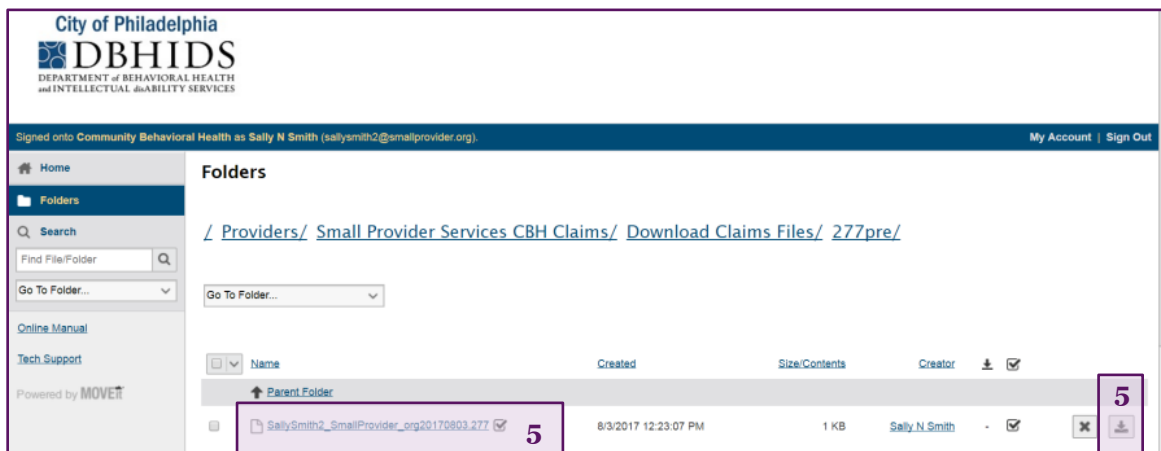
6. From the File Actions section, click the Download button.
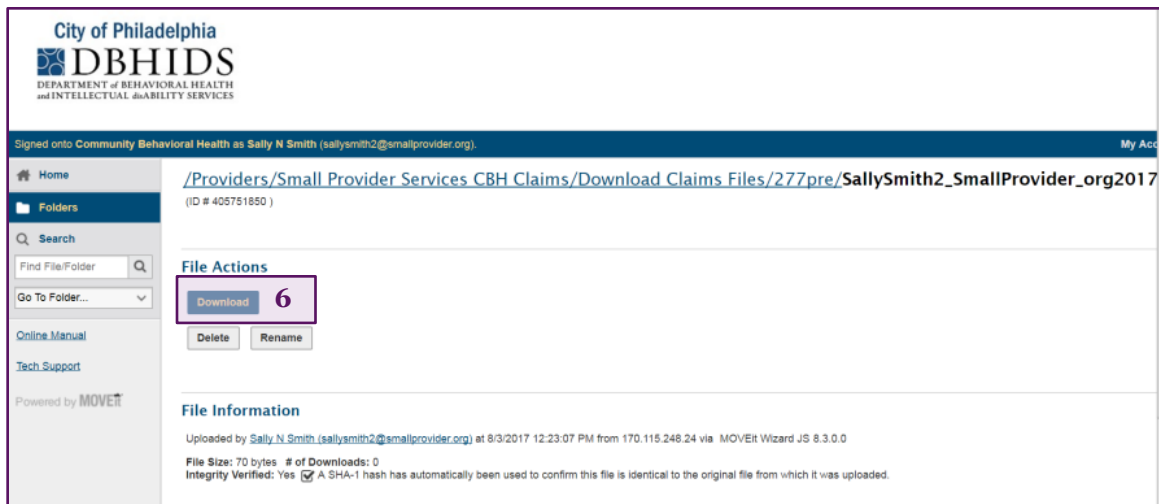
» Clicking the Download button brings up a browser window that asks the user what they would like to do with the file. It is recommended that the file be saved to a pre-determined location on the local computer system. In this example, the user would click Save in the Internet Explorer dialogue box and then choose a location in which to save the file (a).
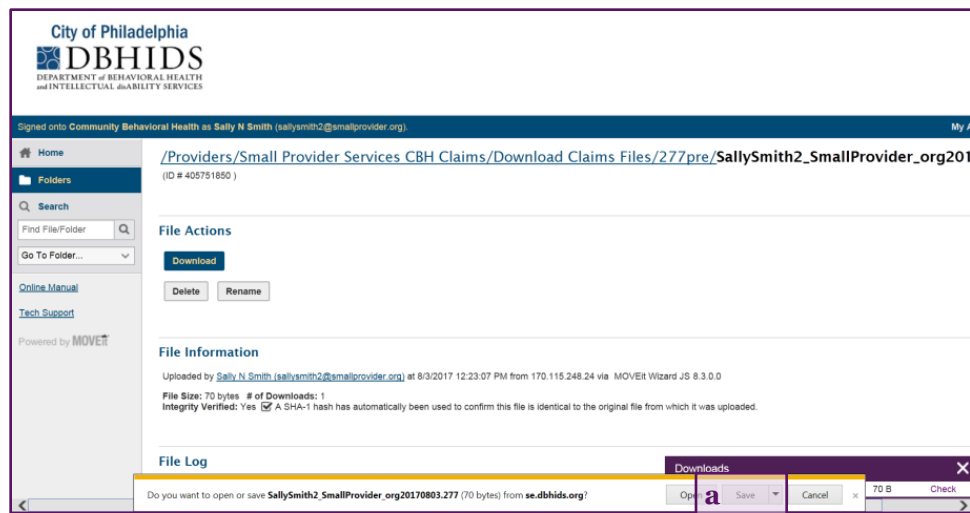
» Sometimes, browsers automatically save files in a location named "Downloads". In these cases, go to the "Downloads" folder on your computer to open the file.

» Notice the icon that sits to the left of the file below (b). The icon is blank because the computer does not know with what software opens the file.
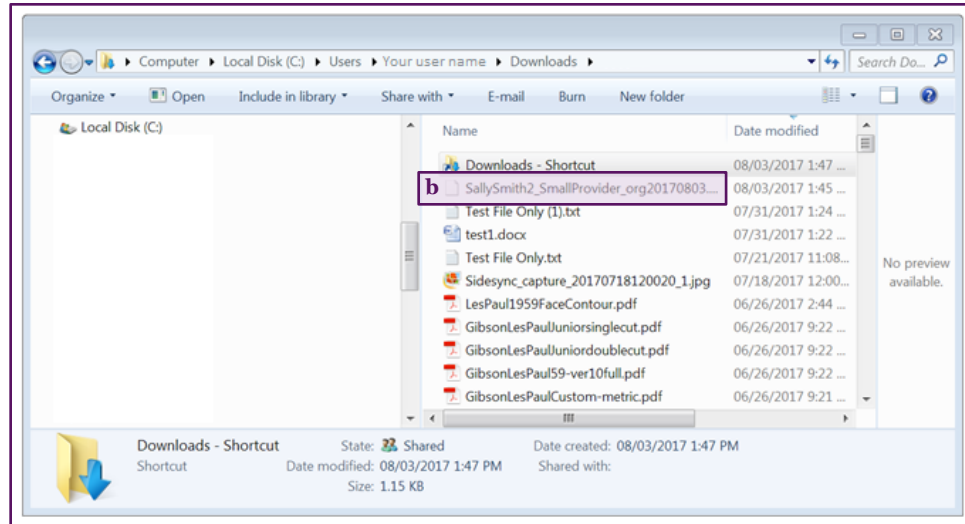
» Since all the response files—except Schedule A files—are text files with strange endings like .277pre or .835ra, again, the computer is unsure how to open them.

» Telling the computer how to open a file is a simple but seldom-used process. See the steps below.

7. With the downloaded file highlighted, right-click and select *Open with*.
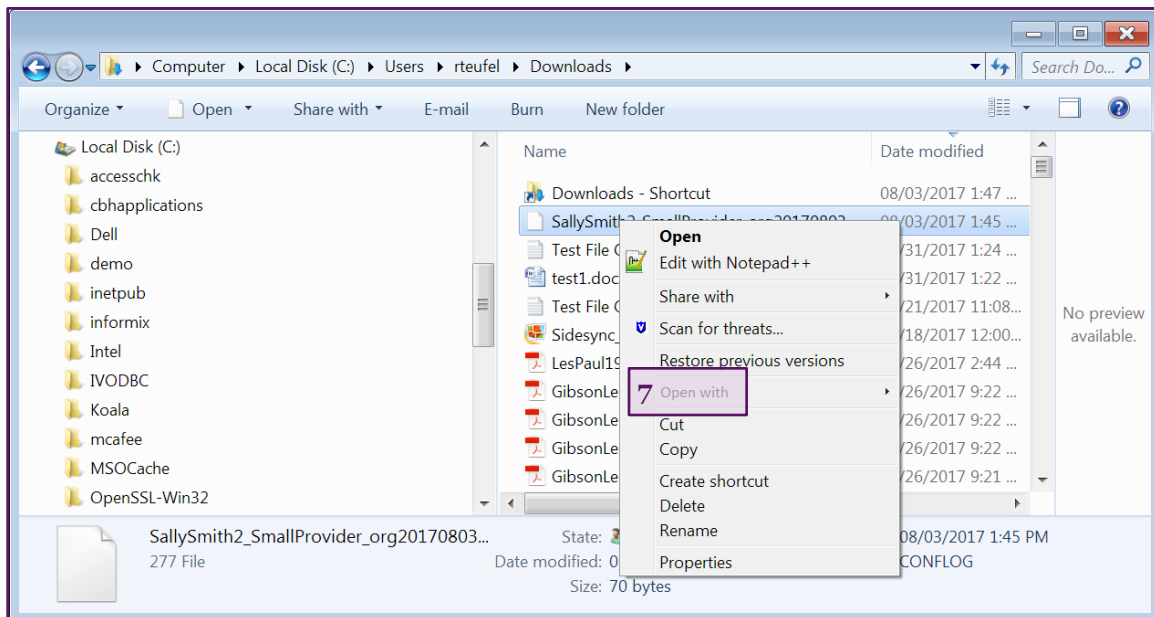
8. All of the response files are simple text files; however, they end in uncommon file extensions like .277, .835ra, .999, etc. So, using the Open with Windows menu, direct your computer to use Microsoft Word or WordPad.
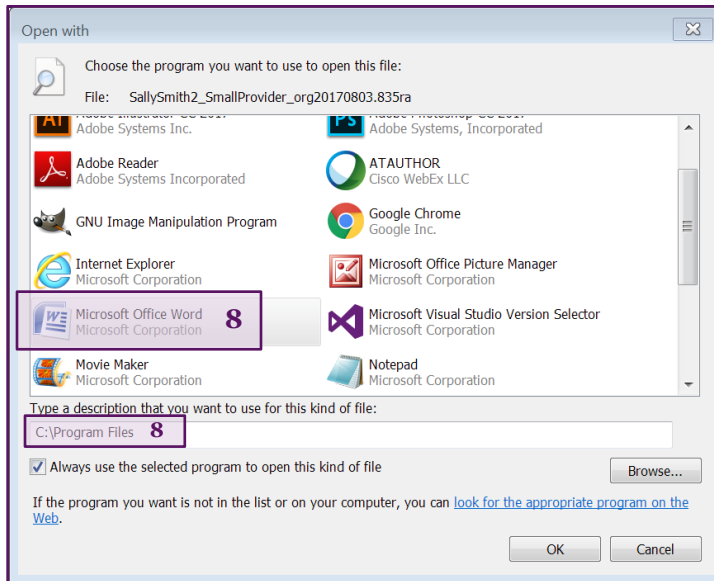

A note about assigning a program to open responses:

» If the Microsoft Word or WordPad icons do not appear in the Open with window, use the Browse button (lower right) to search for a program with which to open the file. Program files can exist in a number of places, though they are normally found in the computer's "Program Files" or "Program Files (x86)" folders. A simple way to find an appropriate program to use when opening downloaded claims responses is to look in the computer's C: drive for a program called:

• Winword.exe – for Microsoft Word (c)

• Excel.exe – for Microsoft Excel

» Again, the location of executable files varies with the operating system. If executables cannot be found in the described folders, use the "Search" function on your computer to locate where files ending in the extension '.exe' are stored.
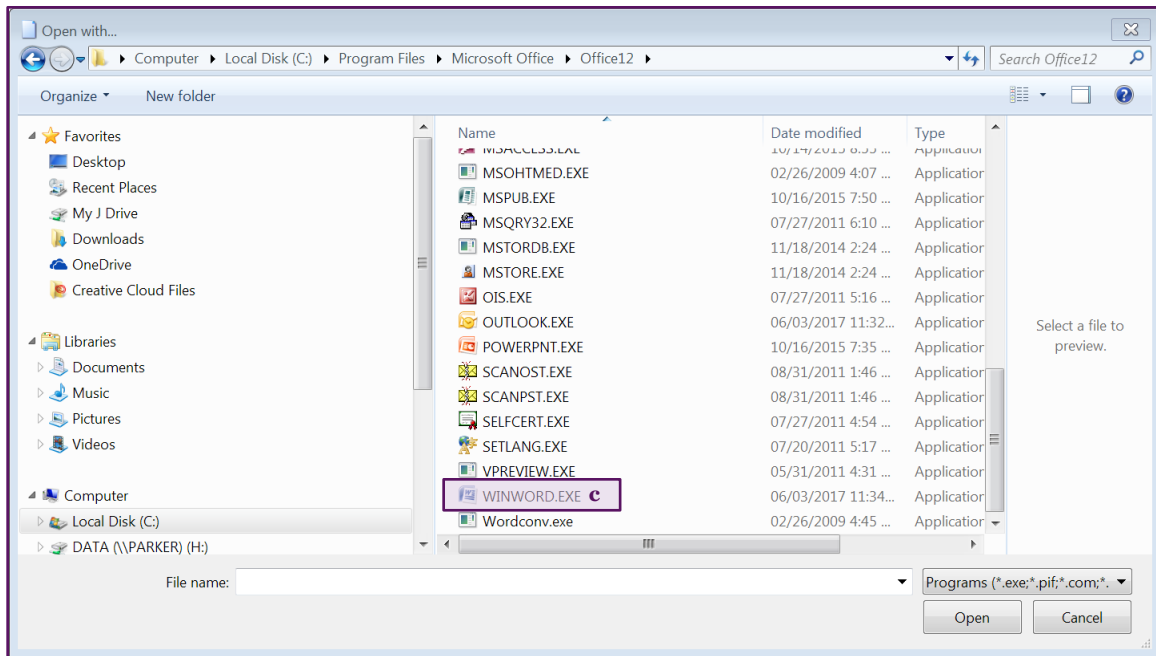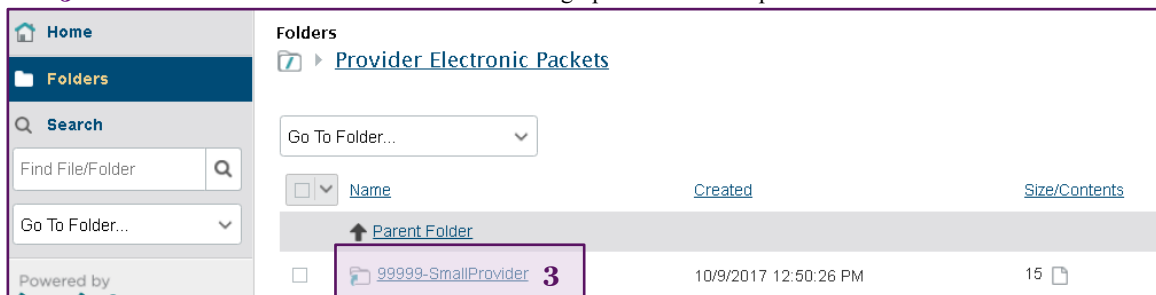
## 7.2.10. E-Packet and School Census Folder Structure

1. Click on the Folders link to be taken to the parent folders for E-Packet and School Census File submission.

2. Click on the appropriate folder for the type of transfer desired (E-Packets, in this example).
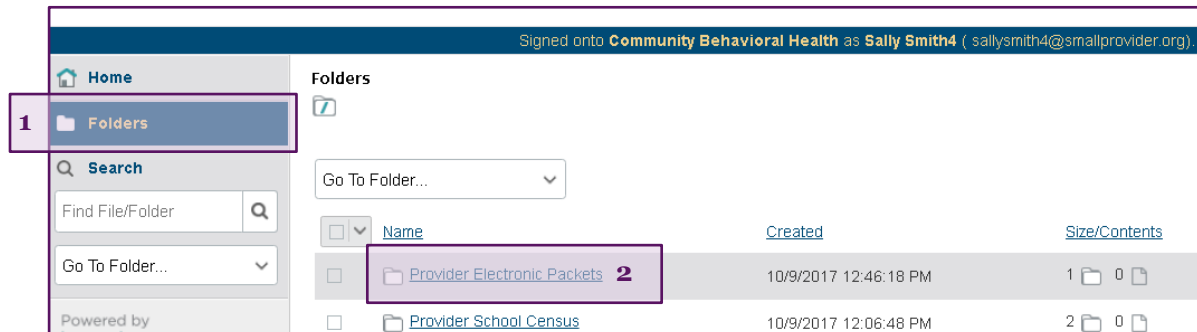

3. Click on the folder titled with the correct six-digit provider number prefix.

4. To upload files to the secure file server, simply click the Upload Files button located in the upper-right section of the main or content window.
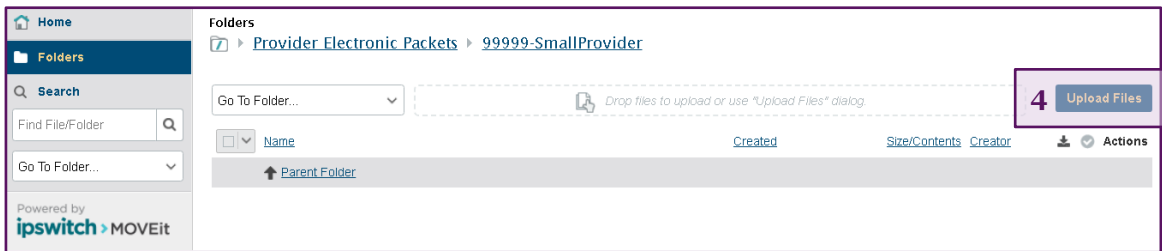

5. Verify the correct upload folder is selected in the Upload to drop-down list.

6. Click Browse to select the desired file on your local computer system.

7. Click Upload to upload the desired file to the server.
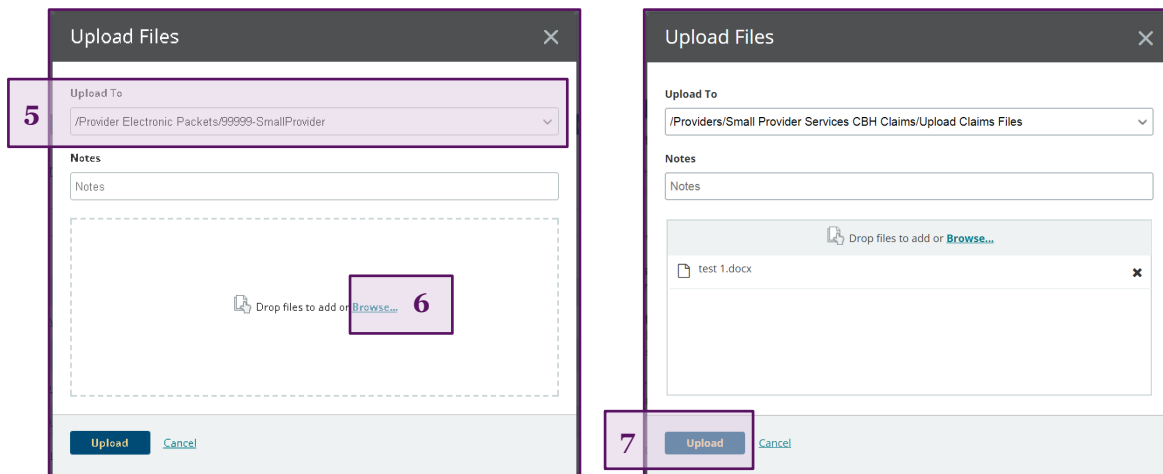
8. Verify the correct file has been transferred by checking the uploaded file name next to the check icon.
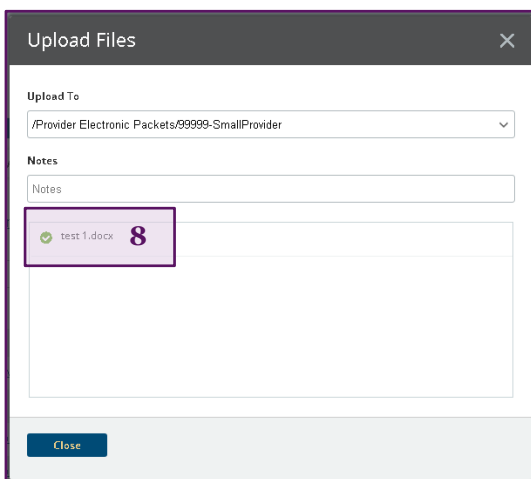
9. After closing the Upload Files window, check to see that the desired file exists in the correct upload folder.
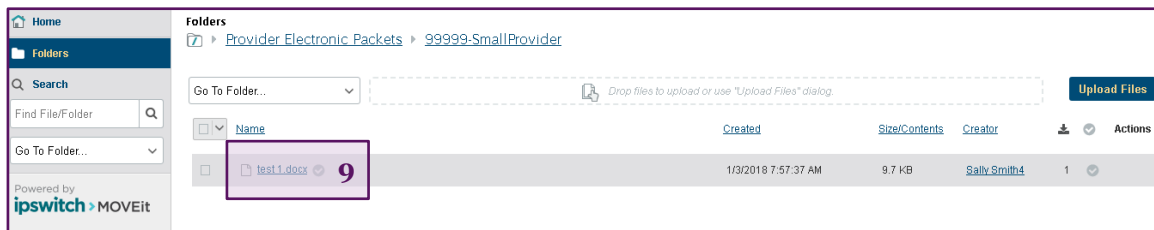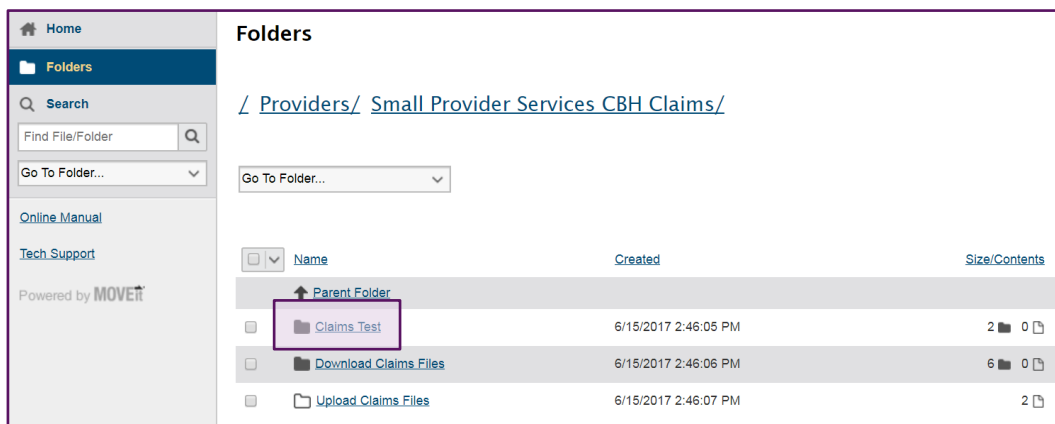

7.3. Claims Testing

7.3.1. Overview

This section outlines some basic information related to Claims Testing when a user moves to electronic billing or Third-Party Liability, and VOID testing.

### 7.3.2. Main Claims Test Folder Structure

Within the secure file server, in the provider's folder (a folder named after the provider) a "Claims Test" folder (highlighted below) exists which allows providers to test the claims submission transfer function of the website. "Claims Test" contains folders for uploading test files. It also contains folders for downloading test file responses and folders for testing initial connectivity before a provider begins using the website.


7.3.3. Testing and More on Claims Test Folder Structure

On the website, the "Claims Test" folder exists for two purposes:

1. "Test Claims", for testing of file structure and claim processes that may have changed while providers are using the system (The "Test Claims" folders will always be available to the provider in the event that any type of claims testing is needed.)

2. "Test Connectivity", for initial connectivity testing for providers who are beginning to use the system (The "Test Connectivity" folder will not be visible once the provider is in production with the new system.)
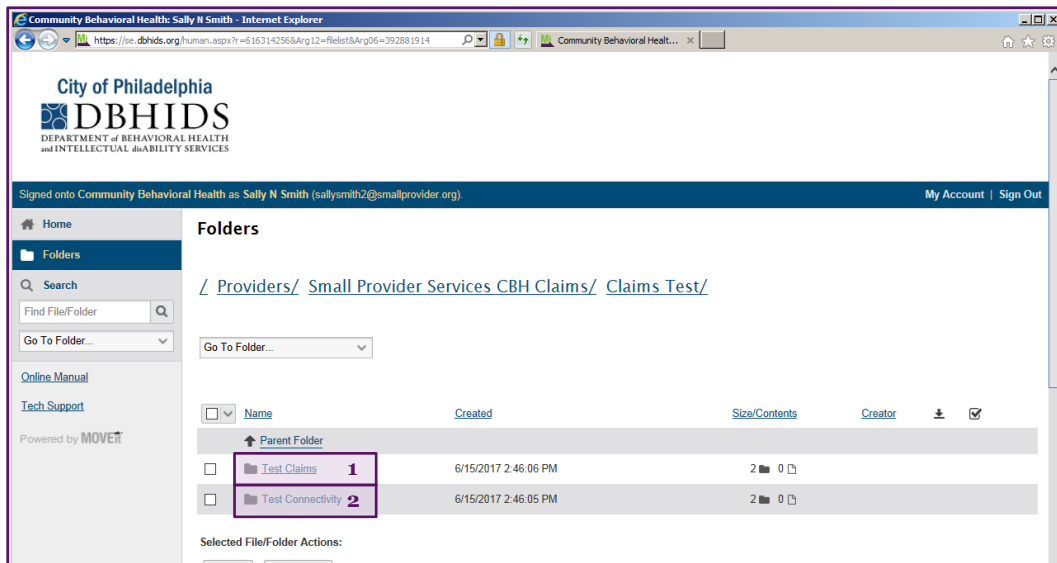
3. For initial connectivity testing, the "Test Connectivity" folder is used and will not be visible once a provider is moved to Production Status.

4. Inside the "Test Connectivity" folder, upload and download tests are handled through "Upload Claims Files Test" and "Download Claims Files", respectively.
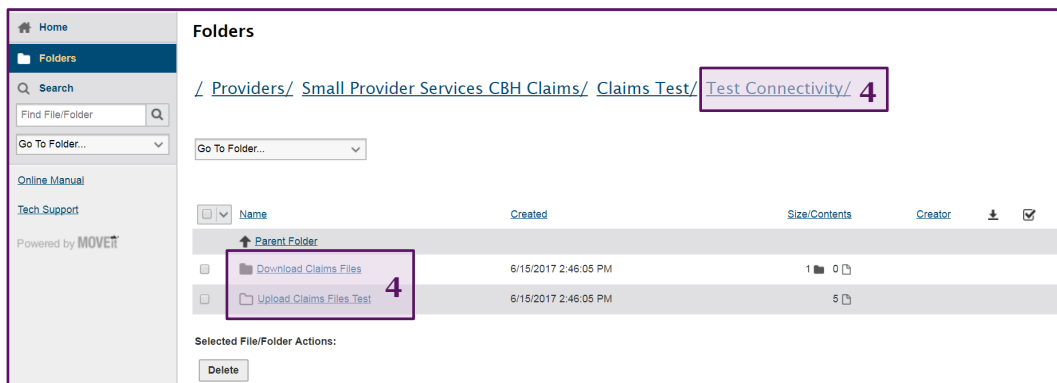
8. ADDITIONAL DOCUMENTS AND LINKS

8.1. Clinical Practice Guidelines

Community Behavioral Health (CBH) has adopted clinical practice guidelines (CPGs) to outline best practices for the treatment of specific disorders or certain populations. These CPGs will be used by CBH to assess the quality of care provided to CBH members. As such, providers are advised to review and, where appropriate, implement these practices in their care. These CPGs apply to all clinical settings where members are seen with these disorders. These CPGs should be used in conjunction with any level-of-care-specific performance standards, as well as all other required CBH, state, and federal regulations and standards.

CBH CPGs draw from evidence-based practices, and practice guidelines from leading expert groups. The aim is to articulate best practices and quality monitoring standards and to help providers design and monitor their services. CBH CPGs are maintained and updated collaboratively with providers and system stakeholders to reflect evolving evidence-based practice or changes in the national guidelines. Information on special populations as well as a listing of resources and referenced materials can be found in the appendices.

While designed for the CBH network, it is intended that the CPGs can also be used/accessed by other Philadelphia Medicaid providers, including physical health providers, to facilitate high quality evidence-based care for CBH members in all treatment settings.

For the most up-to-date versions of the below CPGs, visit the **CBH Clinical Practice Guidelines webpage**.

8.1.1. Disease Treatment-Focused

➡ CPG: Alcohol Use Disorder (AUD)

➡ CPG: Opioid Use Disorder (OUD)

➡ CPG: Pharmacologic Treatment of Attention Deficit and Hyperactivity Disorder (ADHD) in Children and Adolescents

➡ CPG: Pharmacologic Treatment of Schizophrenia

➡ CPG: Treatment of Adults with Major Depressive Disorder

➡ CPG: Treatment of Tobacco Use Disorder

8.1.2. Prescribing Practices-Focused

➡ CPG: Prescribing and Monitoring of Antipsychotic Medications for Youth

➡ CPG: Prescribing and Monitoring of Benzodiazepines and Related Medications

8.1.3. HEDIS® Integrated Care and Prevention Tip Sheets

Several CPGs utilize the **Healthcare Effectiveness Data and Information Set (HEDIS®)**, a widely used set of performance measures in the managed care industry. CBH developed HEDIS tip sheets in partnership with collaborating providers and the Southeastern Pennsylvania Medicaid MCOs that participate in the HealthChoices and Community HealthChoices programs as a resource for providers to summarize HEDIS metrics and parameters.

Please see the **CBH Clinical Practice Guideline webpage** for the most up-to-date versions of these tip sheets.

➡ Adherence to Antipsychotic Medications for Individuals with Schizophrenia

➡ Antidepressant Medication Management

➡ Cardiovascular Monitoring for People with Cardiovascular Disease and Serious Mental Illness

➡ Comprehensive Diabetes Care for People with Serious Mental Illness (SMI): Hemoglobin A1c (HbA1c) Poor Control (>9/0%)

➡ Diabetes Monitoring for People with Schizophrenia and Diabetes

➡ Diabetes Screening for People with Serious Mental Illness Who Are Using Antipsychotic Medications

➡ Provider Lab Tip Sheet

8.2. Clinical Performance Standards

For the most up-to-date versions of the below CPSs, visit the Clinical Performance Standards section of the **CBH Provider Manual webpage**.

➡ CPS: Acute Inpatient Psychiatric (AIP)

➡ CPS: Acute Partial Hospital Program (APHP) – Child, Adolescent, and Adults

➡ CPS: Applied Behavior Analysis (ABA)

➡ CPS: Applied Behavior Analysis – Early Childhood Programs (ABA–EC)

➡ CPS: Behavioral Health Case Management

➡ CPS: Children's Community-Based Services, Family-Based Mental Health Services

➡ CPS: Crisis Response Center Services for Children and Adults

➡ CPS: Federally Qualified Health Center

➡ CPS: Intensive Behavioral Health Services (IBHS)

➡ CPS: Mobile Crisis Response Services

➡ CPS: Opioid Centers of Excellence (COE)

➡ CPS: Psychiatric Residential Treatment Facility

➡ CPS: Tobacco Use Disorder

8.3. Provider Communications

➡ **CBH Provider Bulletins and Notices**

➡ **CBH Provider News Blast eNewsletter Signup**

8.4. Provider Resources

Please see the **CBH Provider Resources** section of our website for the most up-to-date resources.

➡ **Alcohol Use Disorder: A CBH Network Best Practices Guide**

➡ **ASAM 3.7 Medically Monitored Intensive Inpatient Services Wound Care Reference Guide**

➡ **Spravato® (Esketamine): Protocol and Procedures for Behavioral Health Provider Implementation of the Two-Hour Monitoring Period**

➡ **Telehealth Best Practice Guidelines**

8.5. Provider Personnel

➡ **Manual for Review of Provider Personnel Files (MRPPF) 2.8**

➡ **NPAU Provider Personnel Roster Template, 2024 (.xlsx)**

8.6. Exclusion Lists

Neither a provider nor its staff, contractors, subcontractors, or vendors may be on any of the Excluded Individuals and Entities lists:

➡ U.S. Department of Health and Human Services: **List of Excluded Individuals/Entities (LEIE)**

➡ **System for Award Management (SAM)** *(FKA Excluded Parties List System [EPLS])*

➡ PA Department of Human Services: **Medicheck (Precluded Providers) List**

➡ Center for Medicaid and Medicare Services (CMS): **National Plan and Provider Enumeration System (NPPES)**

➡ National Technical Information Service (NTIS): **Social Security Death Master File**

8.7. Miscellaneous

➡ **CBH Acronym and Initialism Guide**

9. REVISION LOG

Date	Changes
2025-07-10	➡ **2. Credentialing** 　» Updated: MRPPF (Version 2.8, Section 2.2.1.) 　» Section 2.1. revised 　» Section 2.2.6. revised 　» Section 2.5.13.6. revised ➡ **3. Authorizations** 　» Updated: Authorization Guidelines (Section 3.10.) 　» Updated: Utilization Review Care Coordination Grid (Section 3.11.) 　» Updated: IBHS Written Order Form updated (Section 3.11.) ➡ **5. Program Integrity** 　» Updated: Provider Self-Auditing Form (Section 5.13.2.) 　» Updated: Claims Overpayment Spreadsheet (Section 5.13.2.) ➡ **8. Additional Documents and Links** 　» Subsections reorganized and renamed 　» Updated: CPG: Prescribing and Monitoring of Benzodiazepines and Related Medications (Section 8.1.) 　» Added: ASAM 3.7 Medically Monitored Intensive Inpatient Services Wound Care Reference Guide (Section 8.4.) 　» Added: Alcohol Use Disorder: A CBH Network Best Practices Guide (Section 8.4.) 　» Updated: CBH Acronym and Initialism Guide (Section 8.7.) ➡ **Appendices** 　» Added: Request/Concurrent Review Template for SUD Bed-Based Levels of Care Appendix (Appendix P) 　» Updated: Policy Requirements Checklist – Initial And Recredentaling, Facilities (Appendix L, subsection 4) 　» Appendix title letters updated
2025-04-25	➡ **2. Credentialing** 　» Various updates throughout section 　» MRPPF updated (Version 2.7, Section 2.2.1.) ➡ **3. Authorizations** 　» Updates to Authorization Guidelines (Section 3.10.) 　» Utilization Review Care Coordination Grid updated (Section 3.11.) 　» CBH Continua of Services added (Section 3.11.) 　» IBHS Written Order Form updated (Section 3.11.) 　» Children's Community-Based Services MST Referral Form updated (Section 3.11.) ➡ **5. Program Integrity**

Date	Changes

» Various updates throughout section

» Program Integrity Treatment Planning Guide updated (Section 5.18.3.)

» Program Integrity Clinical Documentation Requirements: Specific Levels of Care added (Section 5.18.5.)

➡ **8. Additional Documents and Links**

» Spravato® (Esketamine): Protocol and Procedures for Behavioral Health Provider Implementation of the Two-Hour Monitoring Period added (Section 8.4.)

» CBH Acronym and Initialism Guide updated (Section 8.8.)

➡ **Appendices**

» Definitions Appendix updated

» Example Letter appendices removed (previous appendix title letters listed):

   » Appendix D: Initial Credentialing Letter – Independent/Group Practitioners

   » Appendix F: Initial Credentialing Approval Letter – New Provider

   » Appendix H: Recredentialing Letter – Independent/Group Practitioners

   » Appendix L: Initial Credentialing Introduction Letter – Facilities

   » Appendix N: Initial Credentialing Approval Letter – Facilities

   » Appendix O: Initial Credentialing Approval Letter – Independent/Group Practitioners

   » Appendix P: Initial Credentialing Exit Letter – Facilities

   » Appendix Q: Tracking Spreadsheet for Initial Credentialing – Facilities

   » Appendix S: Network Improvement and Accountability Collaborative (NIAC) Credentialing Process (Recredentialing: Facilities)

   » Appendix T: Provider Preparations for the NIAC Site Review (Recredentialing: Facilities)

» Appendix title letters updated

➡ Language updates throughout Manual to differentiate CBH Provider Portal from other secure file servers

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2024-12-31

➡ **2. Credentialing**

» Various updates throughout section

» NPAU Provider Personnel Roster Template updated (Section 8.4.)

➡ **3. Authorizations**

» Updates to Authorization Guidelines (Section 3.10.)

» Utilization Review Care Coordination Grid updated (Section 3.11.)

➡ **4. Quality**

» P4P Operational Definitions Master Document updated (Section 4.11.)

» Minor updates to Fair Hearing procedures (Section 4.5.1.)

» Minor updates to Clinical Appeals (Section 4.8.)

➡ **5. Program Integrity**

» Updates to Prepayment Review Audits (Section 5.5.1.2.)

Date	Changes
	» Program Integrity Audit Codes updated (Section 5.8.)
	» Program Integrity Treatment Planning Guide updated (Section 5.18.3.)
	➡ 6. Finance
	» CBH 5010 Institutional Companion Guide (Now V1.12) and CBH 5010 Professional Companion Guide (Now V1.9) updated (Section 6.2.3.1.)
	➡ 8. Additional Documents and Links
	» Telehealth Best Practice Guidelines added (Section 8.3.)
	➡ Appendices
	» Initial Credentialing Approval Letter – Facilities (now Appendix N) and Initial Credentialing Approval Letter – Independent/Group Practitioners (now Appendix O) updated
	» CBH Attestation – Independent/Group Practitioners, FQHC BHCs; FQHC BHC Approval Letter; FQHC BHC Credentialing Letter (formerly Appendices S, T, and U) removed
	» Appendix title letters updated accordingly
2024-07-24	➡ Updated Credentialing Sections 2.2.1 and 2.5.13.6
	➡ Updated Authorization Sections 3.4.2, 3.4.3, 3.9.4, 3.9.5, and 3.10
	➡ Updated Quality Sections 4.3, 4.4, 4.8, 4.9, and 4.11
	➡ Section 5: "Compliance" has been renamed "Program Integrity" (section and department)
	➡ Treatment Planning Guide (Section 5.18.3) has been updated and renamed "Program Integrity Treatment Planning Guide"
	➡ Updated Appendices:
	» C: Credentialing Summary
	» D: Initial Credentialing Letter – Independent/Group Practitioners
	» E: Practitioner Credentialing Attestation
	» H: Recredentialing Letter – Independent/Group Practitioners
	» R: Credentialing Approval Letter –Independent/Group Practitioners
	» AB: Concurrent Review Template
2024-03-15	➡ Added new covered services, updated wording in Authorizations Section 3.10.2.
	➡ Updated Authorizations Section 3.9.1.
	➡ Concurrent Review Template Appendix AB added
2024-01-04	➡ Updated 2023 P4P Operational Definitions Master document added to Section 4.11.
2023-12-18	➡ Complaints and Grievances text updates (4.3., 4.5., 4.5.1.)
	➡ Updated entry for *Non-Hospital EAC* in Section 3.10.2.3.
2023-11-30	➡ Added new covered services, updated referral forms in Section 3.10.
	➡ Updated MHOP, Group Services Clinical Documentation Requirements in Section 5.18.
	➡ Added IBHS Billing Guide, Section 5.19.

Date	Changes
	➡ Section 8.2. Clinical Performance Standards updated
	➡ Miscellaneous minor updates/edits
2023-05-05	➡ Request to Secure Exchange for Provider Access form added to Section 7.2.2.
	➡ Claims Section 6 renamed "Finance," with Claims moved to subsection 6.2. Value-Based Programs added as Section 6.1.
	➡ Updates in Section 6.2.5.3.2. Appealing Rejected Claims for "Recipient not Eligible"
	➡ Various Section 3 Authorizations updates, including addition of Utilization Review Care Coordination Grid
	➡ Section 8.1. Clinical Practice Guidelines updated
	➡ Section 4.11. P4P and VBP Performance Measures added to Quality
	➡ Miscellaneous minor updates/edits
2022-12-30	➡ Complete Design and Organizational Overhaul
	➡ Added full **Compliance section** to Manual
2022-11-30	Added updated Clinical Guidelines in Section 7.2.
2022-08-31	Added updated Clinical Guidelines in Section 7.2.
2021-07-26	Updated Section 3.9.2 and added Section 3.9.6 (EAC)
2021-07-22	Updated Clinical Guidelines for OUD and Benzos
2021-07-19	Updated MRPPF link to V 2.5
2021-06-25	Updated section 3.6
2021-05-13	Updated ABA Performance Standards link to 3.0
2021-03-31	Updated 2.5.11 Credentialing and Recredentialing
2021-02-25	Updated MRPPF link to 2.4
2021-01-26	Updated Provider Personnel Roster link – Section 7.4
2020-12-30	Updates to the Complaint and Grievance section, Clinical Appeals and Significant Incidents - Section 4
2020-12-10	Updated PRTF Performance Standards

Date	Changes
2020-12-07	Added Independent Practitioner Documentation Guidelines to section 7.1
2020-12-01	Added Clinical Guidelines for Alcohol Use Disorder (AUD)
2020-11-19	Removed expired Clinical Guidelines
2020-11-18	Updated links in Section 3.9.2.3
2020-10-20	Updated Section 5.2.3
2020-10-19	Changed effective date for Clinical Guidelines for Major Depressive Disorder
2020-10-13	Added Clinical Guidelines for Major Depressive Disorder
2020-09-29	MRPPF 2.3 added
2020-09-23	Added IBHS Performance Standards
2020-09-21	Updated SIR 3.8.2 to indicate must be completed in 24 hours
2020-09-01	Updated Medicare/Medicaid Exclusions and Updated Exclusion list links
2020-08-06	➡ Added new Clinical Guidelines in Section 7.2. ➡ Added expiration for old Clinical Guidelines in Section 7.2. ➡ Added language about providers informing members about prior authorization outcomes in 3.4.3. ➡ Removed "draft" watermark from PRTF Standards ➡ Updated list of exclusion sources in 2.5.12.7.1.
2020-07-12	➡ Updated "Types of Providers" (2.3.3. in this revision), including new FQHC and BHC definitions ➡ Updated credentialing tables (1.4.2.1. "Initial Credentialing" and 1.4.2.2. "Recredentialing" in this revision) ➡ Added BHC and FQHC language to 1.4.2.2. ➡ Updated language in "Drug Enforcement Administration certification (Physicians and Nurse Practitioners Only)" (2.5.12.2. in this revision) ➡ Added FQHC and BHC definitions to definitions appendix; updated MRPPF definition (Appendix A in this revision) ➡ Updated "PSV by" fields in "Initial and Recredentialing Summary Template for Independent and Group Practitioners" (Appendix C in this revision) ➡ Replaced "Initial Credentialing Letter: Independent and Group Practitioners" (Appendix D in this revision)

Date	Changes
	➡ Replaced "Recredentialing Letter: Independent and Group Practitioners" (Appendix E in this revision)
	➡ Added 09-103, "CRNP – Family and Adult Psychiatric Mental Health," to "Provider Types and Specialty Codes: Independent and Group Practitioners" (Appendix E in this revision)
	➡ Corrected formatting in authorization guideline tables
	➡ Corrected CBH Program Integrity Hotline hours
	➡ Added information about IBHS authorization Bulletins
	➡ Corrected appendices listed Authorization Applicable Appendices
2020-06-30	➡ Added Quality subsection "Provider Participation in Quality Improvement Activities"
	➡ Changed Provider Hotline hours
	➡ Normalized time format
	➡ Updated Member Handbook link
2020-04-22	Updated MRPPF link to 2.2 in Compliance section
2020-03-05	Updated MRPPF link to 2.2 in Additional Documents and Links section
2020-03-04	Updated MRPPF link to 2.1 in Additional Documents and Links section
2020-02-27	➡ Updated Exclusion List links
	➡ Updated MRPPF link to 2.0 in Additional Documents and Links section
	➡ Updated NPAU Personnel Roster link
2019-12-20	Initial publication of new combined document

APPENDIX A: DEFINITIONS

Active Provider

Any provider who:

➡ Is contracted with CBH to provide services to CBH members at the time a decision is made, OR

➡ Has been contracted with CBH to provide services to CBH members within the last 30 days

Adverse Events

Any event occurring during the course of treatment that may place the safety or wellbeing of a member in jeopardy. All adverse events will be reported and tracked through Quality Management as described in the CBH Procedures for Response, Reporting, and Monitoring of Significant Incident Policy.

Applications Not Meeting Threshold Requirements

Any application missing required documents or having documents that do not reflect good standing. Any applicant appearing on an applicable exclusion or sanction list (see Appendices D and E) will also be considered as not meeting threshold requirements.

Behavioral Health Consultant (BHC)

A psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapist working in a Federally Qualified Health Center (FQHC).

Blanket Authorization Number (BAN)

A provider-specific authorization number assigned to services that do not require a prior authorization, used during claims submission, and found on the Provider Schedule A.

Clean Application

An application that meets full threshold criteria; all applicable documentation and screening requirements have been met.

Concurrent Request

A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed, or altered.

Credentials Verification Organization (CVO)

An organization that verifies credentials of practitioners. The findings are presented to the CMO and/or Credentialing Committee for purposes of credentialing independent and group practitioners, as well as FQHC BHCs.

Emergency Services

Services needed to evaluate or stabilize an emergency psychiatric medical condition delivered by a provider qualified under the Medical Assistance Program. CBH does not require prior authorization for emergency services, which include services through a crisis response center, a substance use assessment center, or mobile crisis teams.

Facility (Organizational Provider)

An organization that employs or contracts with staff to provide behavioral health services under an appropriate facility license. Examples of facilities may include, but are not limited to:

➡ Inpatient Hospitals

➡ Free Standing Substance Use Treatment Facilities

➡ Residential Treatment Facilities

➡ Outpatient Clinics

➡ Laboratories

➡ Partial Hospital Programs

Federally Qualified Health Center (FQHC)

A community-based health care provider that receives funds from the Health Resources and Service Administration (HRSA). Behavioral health services are provided by a Behavioral Health Consultant (BHC).

Group Practice (Group)

A professional corporation or partnership of individual practitioners of the same discipline and license type. The group is the entity to which payments will be made. A group must be enrolled in PROMISe as a group provider, and each individual practitioner who performs services for which payment will be made via the group must also be enrolled in PROMISe. The group may not bill for services as a rendering provider.

High-Volume Provider

Any practitioner or group practice seeing 500 or more unique CBH members in a calendar year.

Independent Practitioner

Practitioners who are licensed, certified, or registered by the State to practice independently and have an independent contractual relationship with CBH. An independent practitioner is enrolled in PROMISe under their own Social Security Number (SSN) and/or Federal Employee Identification Number (FEIN).

Level of Care

Refers to the services a provider is approved to deliver. Levels of care appear on the Schedule A along with billing codes and rates.

Manual for Review of Provider Personnel Files (MRPPF)

CBH-published document that provides minimum standards for all clinical staff positions within the CBH Provider Network. The MRPPF is updated at least annually and is available to the public through the CBH Provider Manual at CBHPhilly.org.

Medical Necessity Criteria (MNC)

Detailed criteria to assist providers and CBH in determining the most clinically appropriate type, amount, extent, duration, and site of behavioral health services for the member's specific needs. Medical Necessity Criteria for state-wide available mental health services are issued by the State and found in the **HealthChoices Program Services and Requirements** Appendices S and T. MNC for CBH-specific services are written by CBH and approved by the State. MNC for all substance use treatment services is found in the ASAM.

Member Portal

A web-based platform serving as a primary point for CBH members to access claim information, view coverage and eligibility status, receive shared content from CBH (e.g., documents), and link to other pertinent information.

Negative Decision

A recommendation by the Credentialing Committee for either termination from the network or inability to enter the network.

Non-urgent Services

Non-acute services when the decision-making timeframe does not adversely impact the health of the member or the member's ability to regain maximum functioning and would not subject the member to severe distress or decompensation. Non-urgent services do not require a prior authorization.

Parent Organization

An entity that controls, owns, or overseas an organization and retains the Federal Tax Identification number for all service locations (CBH Child) attached to the Parent Organization. The Parent Organization is always the contract holder and is always the receiver of payment. A Parent Organization can be a single entity at one service location. or have two or more service locations.

Primary Source Verification

Verification from the original source of a specific credential (education, training, licensure) to determine the accuracy of the qualifications of an individual healthcare practitioner.

Prior Authorization

A determination made by a Primary Contractor or its BH-MCO to approve or deny a provider's request to provide a service for a specific duration and scope to a member *prior* to the provider initiating provision of the requested service.

Protected Health Information (PHI)

Health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations, and payment for healthcare services. PHI includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify an individual or provide healthcare services or healthcare coverage.

Provider

A term used interchangeably to describe independent practitioners and facilities.

Provider Portal

A web-based platform serving as a primary point for providers to view the status of authorization requests, submit requests for (a limited number of) service authorizations, and create templates for frequently submitted authorizations. Provider staff can also use the portal for secure messaging and file-sharing with CBH staff to access resources.

Registration Number

A member-specific authorization number assigned to services that do not require a prior authorization but do require submission of a service request form to obtain an authorization number.

Schedule A

A document issued by CBH which allows the provider to submit claims for the services provided at the newly credentialed facility. All approved services or levels of care offered by the parent organization or facility are listed on document along with billing codes and rates.

Urgent Services

Acute services to address a member's psychological state, which, without services, could jeopardize the life, health, or safety of the member or others. Under reasonable standards, a determination for care is made within a 24-hour period and, if left untreated, could rapidly become a crisis or emergency. An urgent request also includes when a member's discharge from a hospital will be delayed until services are approved, or a member's ability to avoid hospitalization depends upon prompt approval of services.

APPENDIX B: NONDISCRIMINATION AND CONFIDENTIALITY AGREEMENT

(Signed by Members of the CBH Credentialing Committee)

Nondiscrimination and Confidentiality Statement

As a member of the Community Behavioral Health Credentialing Committee, involved in the evaluation and improvement of quality of care and services, I recognize that confidentiality is vital to the credentialing process. Therefore, I agree to respect and maintain the confidentiality of all discussions, records, and information generated in connection with Credentialing Committee activities, and to make no voluntary disclosure of such information except to persons authorized to receive it.

As a member of the Credentialing Committee, I will ensure credentialing and recredentialing decisions will be made in a non-discriminatory manner and will not be made based on an applicant's race, ethic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Signature: _____   Date: _____

Print Name: _____

APPENDIX C: CREDENTIALING SUMMARY

Parent Name:	Name of Reviewer and Review Date(s):
Parent Address:	

Provider/ Provider Type	CBH Child #	PROMISe #	License #	Practice Location (Child Address)	Recommended Status
Practitioner Name					

Specific Services to be Delivered

Credentialing Status:	*Complete/Clean or Incomplete/Unclean*

NCQA Element	NCQA Factor	Verification	PSV by	Date of Verification
Credentials	A.1	License	CAQH	
Credentials	A.2	DEA	CAQH	
Credentials	A.3	Education	CAQH	
Credentials	A.3	Residency	CAQH	
Credentials	A.3	Fellowship	CAQH	

NCQA Element	NCQA Factor	Verification	PSV by	Date of Verification
Credentials	A.3 & 4	Board certification	CAQH	
Credentials	A.5	Work history (5 years starting with licensure date)	CAQH	
Credentials	A.6	Malpractice history	CAQH	
Sanctions	B.1	License	CAQH	
Sanctions	B.2	Medicare / Medicaid	CAQH	
Application	C.1	Inability to perform essential functions	CAQH	
Application	C.2	Illegal drug use	CAQH	
Application	C.3	History of loss of license	CAQH	
Application	C.3	History of felony convictions	CAQH	
Application	C.4	Limitation of privileges, disciplinary actions	CAQH	
Application	C.5	Malpractice coverage	CAQH	
Application	C.6	Correctness & completeness of application (CAQH attestation)	CAQH	
CBH Requirement		CRNP Psychiatry Mental Health Specialty / LSW Clinical Practicum	CBH	
CBH Attestation		Mandatory Trainings, LOC Requirements, Clearances, Covered Services in the Medicaid or Medicare Program or any other state or federal assistance program, Exclusion List	CBH	

CBH Reviewer Signature: _____ Date: _____

CBH Reviewer Printed Name: _____

Director of Credentialing Signature: _____ Date: _____

Director of Credentialing Printed
Name:

_____

Chief Medical Officer Signature: _____   Date: _____

Chief Medical Officer Printed
Name:

_____

APPENDIX D: PRACTITIONER CREDENTIALING – ATTESTATION

Practitioner Name (Individual):	
Provider Name (Organization or Group):	
Individual Practitioner Email:	
Additional Designated Email:	
License Number:	
NPI:	
Individual PROMISe (MAID) Number:	
CAQH Number:	
Physical Address (where services will be provided):	

I, **[Practitioner]**, attest that I have met each of the following requirements:

➡ Completed all CBH mandatory trainings (or will complete within 90 days of contracting, and ongoing as required)

➡ Completed all level of care specific required trainings (or will complete within respective time frames at contracting and ongoing)

➡ Obtained and maintain a valid PA Criminal History Report

➡ Obtained and maintain a valid PA Child Abuse Clearance (for staff likely to have contact with children per Commonwealth definition)

➡ Obtained and maintain a valid FBI Clearance (for staff likely to have contact with children per Commonwealth definition, and for staff who live or have lived outside of Pennsylvania within the past two years)

➡ Reported directly to CBH any history of arrest or allegation that appears on the PA Criminal History Report, PA Child Abuse Clearance, or FBI Clearance.

➡ Created a CAQH profile, attested or re-attested to the content, and authorized CBH to access my profile and documentation on CAQH.

I am aware that under the CBH Provider Agreement, I am not permitted to provide Covered Services in the Medicaid or Medicare Program or any other state or federal assistance program, if I am found ineligible as confirmed by my review of the following federal and Commonwealth resources on a monthly basis: List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM) (formerly Excluded Parties List System (EPLS)), and PA DHS Medicheck List. I am able to provide proof of monthly review of these databases upon request from CBH. If I become aware I have been named in any of the aforementioned lists, I shall cease proving services to CBH members and notify CBH (via email to **CBH.CredentialingContact@phila.gov**) within three business days of becoming aware that I have been excluded from participation in any state or federal program.

Signature: _____   Date: _____

Print Name: _____

APPENDIX E: INITIAL CREDENTIALING BOARD SUMMARY

Parent Name and CBH Parent #:	Name of Reviewer and Review Date(s):

Parent Address:	Date Exit Letter Mailed (if applicable):

Population Served:	Schedule A Effective Date:

Provider /Provider Type	CBH Child #	PROMISe #	Address	Recommended Status

Status Legend

➡ 1 = One Year   2 = Two Years   3 = Three Years   4 = Pended

Current Provider Agency Status

➡ System Involvement: Provider history of providing services within the DBHIDS system

➡ CBH Contracted Services: Current contracted services by service category (i.e., OP MH, Residential Rehab, etc.)

Specific Services to be Delivered

➡ Program Overview: Brief description of newly credentialed service, including target population, practice model or EBP, etc.

➡ Specific Levels of Care: Specific LOCs to be provided, including LOC 1&2 descriptions

Program Review

➡ Business Documents: Brief description of all the business documents submitted (i.e., PROMISe enrollment, service description, Provider application)

➡ Staff File Review: Any significant findings or omissions from staff file review

➡ Policy and Procedure Review: Findings from policy and procedure review for both required core policies and ancillary policies

➡ Site Visit: General impressions from CBH site visit conducted for initial credentialing

Miscellaneous

➡ Other items not addressed above, i.e., pending litigation

APPENDIX F: PROVIDER TYPES AND SPECIALTY CODES – INDEPENDENT/GROUP PRACTITIONERS

CBH contracted providers who are considered independent providers or group practices will be licensed as such by the Commonwealth of Pennsylvania. They will be assigned the following provider types and specialty codes by the Commonwealth. All other provider types and specialty code combinations that are eligible for reimbursement by CBH are considered facilities.

Provider Type	Specialty Code(s)	Description
09	103	CRNP – Family and Adult Psychiatric Mental Health
11	112	Outpatient Practitioner – (LCSW, LSW, LPC, LMFT)
17	171	Occupational Therapist
17	174	Art Therapist
17	175	Music Therapist
19	190	General Psychologist
31	339	Psychiatry

APPENDIX G: BUSINESS DOCUMENTS FOR INITIAL CREDENTIALING – FACILITIES

Agency/Parent Organization

➡ CBH Provider Application

➡ Verification of corporate status (i.e., profit/non-profit)

➡ IRS Treasury Letter

➡ Completed W-9

➡ Board of Directors membership

➡ Table of Organization/Organizational Chart

➡ Proof of Accreditation – Joint Commission/CARF/COA

➡ Minority Status

➡ Insurance Information

Facility

➡ CBH Provider Application

➡ Certificate of Licensure or Approval Letter

➡ Accreditation Certificate or Letter – Joint Commission/CARF/COA

➡ Proof of PA Medicaid (i.e., PROMISe) enrollment

➡ NPPES Verification of NPI and taxonomy

➡ Program/Service description

APPENDIX H: STAFF DOCUMENTS FOR INITIAL CREDENTIALING: FACILITIES

Submission to CBH Required:

➡ Completed Network Personnel Analysis Unit (NPAU) staff roster, including notations for all vacant positions

➡ Job descriptions for each position included on staff roster

Providers must maintain the following individual staff documents on file and provide copies to CBH upon request:

➡ Licenses (Physicians, CRNPs, Physician Assistants, RN, LPN, Psychologists, Behavior Specialist, LSW, LCSW, LPC, LMFT) or certificates (Certified Peer Specialist, Certified Recovery Specialist, Certified Psychiatric Rehabilitation Practitioner)

➡ Resume/Curriculum Vitae

➡ Verification of previous employment or performance evaluation

➡ Degree, diploma, or copy of transcript. For foreign-trained staff, degree verification from a National Association of Credential Evaluation Services (NACES)

➡ Pennsylvania State Criminal History Report

➡ Pennsylvania Child Abuse Clearance (if applicable)

➡ FBI Criminal History Report (if applicable)

➡ Evidence of completion of CBH Mandatory trainings (if present)

APPENDIX I: INITIAL CREDENTIALING REQUIREMENTS FOR STAFF FILES – ATTESTATION, FACILITIES

I, **[CEO or Executive Director]**, attest that **[Provider Agency Name]** staff members serving Community Behavioral Health (CBH) members have each met the following requirements for their individual staff files. Consistent with the parameters outlined in the CBH Manual for Review of Provider Personnel Files (MRPPF) and the CBH Credentialing Handbook, Appendix H, each staff file includes the following documents:

➡ Licenses (Physicians, CRNPs, Physician Assistants, RN, LPN, Psychologists, LSW, LCSW, LPC, LMFT) or certificates (Certified Peer Specialist, Certified Recovery Specialist, Certified Psychiatric Rehabilitation Practitioner)

➡ Resume/curriculum vitae

➡ Signed job description

➡ Verification of previous employment or performance evaluation

➡ Degree, diploma, or copy of transcript. For foreign-trained staff, degree verification from a National Association of Credential Evaluation Services (NACES) is required

➡ Pennsylvania State Criminal History Report

➡ Pennsylvania Child Abuse Clearance (if applicable)

➡ FBI Criminal History Report (if applicable)

➡ Evidence of completion of CBH mandatory trainings (if present)

Facilities must maintain complete and up-to-date staff files for each staff person on the roster consistent with the above requirements. CBH reserves the right to request and review staff files as part of the initial credentialing review or for compliance or quality monitoring purposes.

I am aware that under the CBH Provider Agreement, I am not permitted to employ or engage any individual who is ineligible to provide Covered Services in the Medicaid or Medicare Program or any other state or federal assistance program, as confirmed by my review of the List of Excluded Individuals and Entities ("LEIE"), the Medicheck List, and System for Award Management ("SAM") on a monthly basis. I am able to provide proof of monthly review of all personnel in these databases upon request from CBH.

If **[Provider Agency Name]** becomes aware that an employee has been named in any of the aforementioned lists, **[Provider Agency Name]** shall issue notice of termination to the employee or Subcontractor and notify CBH (via email to CBH.ComplianceContact@phila.gov) within three business days of becoming aware that an employee or subcontractor has been excluded from participation in any state or federal program.

Signature: _____   Print Name: _____

Title: _____   Date: _____

APPENDIX J: INITIAL CREDENTIALING AND RECREDENTIALING SITE VISIT CHECKLIST – FACILITIES

Date of Site Visit: _____ CBH Reviewer(s): _____

Parent Facility Name and Address: _____

Facility Contact Person: _____

Section 1: Facility Site Information

Item	Criteria	Met Y/N	Comments
1	Facility identified by visible signage		
2	Accessible by public transportation		
3	On-Site parking available		
4	Handicapped parking		
5	Wheelchair/Handicapped accessible		

Section 2: Waiting/Reception Area

Item	Criteria	Met Y/N	Comments
6	Office hours and emergency contact information posted in reception area		
7	State and local licenses posted		
8	CBH Member Rights information posted		

Item	Criteria	Met Y/N	Comments
9	CBH Program Integrity Hotline information posted		
10	Notice of Privacy Practices/HIPPA information posted		
11	Resource information posted		
12	Reception area clean and well-lit w/ sufficient space for members		
13	Adequate privacy for member registration		

Section 3: Facility/Therapy Room/Medication Management

Item	Criteria	Met Y/N	Comments
14	Clean, identified bathrooms accessible to both staff and members		
15	Facility is clean, well-maintained and free from hazards		
16	Treatment rooms provide for adequate privacy		
17	Adequate office and meeting space for staff		
18	Secure area for record storage		
19	Secure area for medication storage		

Summary of Findings:

APPENDIX K: POLICIES AND PROCEDURES FOR INITIAL AND RECREDENTIALING – FACILITIES

The following policies are required by CBH for all parent organizations and facilities at the time of initial credentialing. Additionally, these policies must be maintained and provided to CBH upon request during recredentialing and oversight and monitoring processes. Some policies may not apply depending on type of services provided (e.g., Medication Management Policy will not apply to providers who do not deliver medication services). These policy requirements are in addition to all policies required by the licensing entity.

1. Employee Screening and Sanction Policy

2. Incident Management Policy

3. On-call/Emergency Protocol Policy

4. Comprehensive Medication Management Policy:

    a. Use of Psychotropic Medications in Children and Adolescents (FDA-approved and Off-Label)

    b. Use of Antipsychotic Medications in Children and Youth

    c. Screening for and Treatment of the Components of Metabolic Syndrome

    d. Policy on the Full Range of Treatment Services Provided by Methadone Treatment Centers

    e. Policy Related to On-site Maintenance, Administration, and Prescription of Naloxone

    f. Prescribing of Benzodiazepines policy

5. Staff Development Policy (applies to full-time/ benefit-eligible employees only)

    a. Clinical Supervision

    b. Performance Evaluation

6. Quality Assurance Policy:

    a. Feedback from Participants, Families, Allies, and Program Alumni Policy

    b. Measuring the Effectiveness of Services Policy

7. Completion of High-Risk Behavioral Assessments Policy

8. Peer and Family Inclusion Policy

9. Preventative and Diagnostic Healthcare Policy

10. SCA Monitoring Policy:

      a. Confidentiality Policy

      b. Sexual Harassment Policy

      c. Review of Interim Services Policy

      d. Priority Populations Policy

      e. Single County Authority (SCA) Grievance and Appeal Procedures Policy

      f. Treating Injection Drug Users (IDU) Policy

11. Tobacco Use Disorder Treatment Policy

12. Evidence-based Treatment Linkage Policy

13. Language Access Policy

14. Telehealth Policy

APPENDIX L: POLICY REQUIREMENTS CHECKLIST – INITIAL AND RECREDENTALING, FACILITIES

1. Employee Screening and Sanctions Policy

Required Levels of Care: All Levels of Care

Description: The provider will establish a policy describing the mechanism for reporting criminal convictions, reports of child abuse, and/or license/certification suspension/revocation to the provider, pre-employment and throughout the term of hire. Areas to be identified include criminal history, child abuse clearance, and employee sanctions.

Minimum Elements of the Policy:

�→ The policy includes language that discusses the duty of staff members to report sanctions (e.g., criminal arrests, convictions, license suspensions/revocations, child abuse reports) taken against them to the provider agency or affiliate.

➥ The policy includes language that discusses the duty of all staff members to inform the provider about criminal convictions, child abuse reports, and license suspensions and/or revocations at the time of hire as well as throughout the entire duration of employment.

➥ The policy includes language that addresses the process the provider will use to inform staff members when information received during credentialing contradicts with information provided by the employee.

➥ The policy includes language including mandates that staff members will be given an opportunity to explain or correct misinformation in the file, subject to clearly delineated sanctions explained in the provider policy and addresses in great specificity the procedure the staff member will use to respond to the conflicting information.

➥ The policy includes language that discusses the provider's disciplinary action(s) for an employee's failure to report the aforementioned events.

2. Incident Management Policy

Required Levels of Care: All Levels of Care

Description: The provider will have a policy that addresses the provider's efforts towards identification, reporting, management, and investigation of all reportable significant incidents involving a Community Behavioral Health (CBH) member.

Please refer to **Bulletin 18-13** and **its attachment**.

Minimum Elements of the Policy:

➥ The policy includes language defining an unusual or significant incident

➡ The policy includes language indicating that this policy is applicable whenever a provider reports a significant incident involving an adult or child member of mental health and drug and alcohol services, whether they are: CBH members receiving in-plan services, or County-funded individuals receiving supplemental funding through the Office of Mental Health, or the Coordinating Office of Drug and Alcohol Programs, including those served by the Behavioral Health Special Initiative (BHSI).

➡ The policy details the provider's reporting process; see CBH Bulletin for requirements for reporting on the following:

» Death

» Where to fax reportable incidents

» An internal investigation process

» Process for reporting incidents involving alleged physical abuse, sexual abuse, and/or neglect of children

» Process for reporting incidents involving alleged physical abuse, sexual abuse, and/or neglect of an adult 18 years and older, who has a physical or mental impairment

» A missing person who may be at-risk

➡ The policy includes a list of where to send Significant Incident Reports.

3. On-Call/Emergency Procedures

Required Levels of Care: Outpatient Level of Care

Description: The provider will have an on-call emergency protocol that addresses the member's ability to access the agency/independent practitioner during non-business hours (outpatient services only)

Legal Reference: 55 Pa. Code § 5221.23(a)

Minimum Elements of the Policy:

➡ The policy includes language that discusses the member's ability to access the treatment provider during non-business hours (e.g., text, answering system).

➡ The policy includes language that discusses how the member is informed about the provider's on-call emergency procedure. Note: this should be a part of the member's initial orientation to the program.

➡ The policy includes language that identifies the names of providers/agencies utilized for emergency services. Addresses and phone numbers should be included within the policy.

4. Comprehensive Medication Management Policy

Required Levels of Care: All Levels of Care as applicable

Description: The provider will establish a Comprehensive Medication Management Policy, incorporating the following:

➡ Screening for and Treatment of the Components of Metabolic Syndrome

➡ Naloxone Policy

➡ Benzodiazepine Prescribing

➡ Use of Psychotropic Medications in Children and Adolescents (FDA-approved and Off-label)

➡ Use of Antipsychotic Medications in Children and Youth

➡ Full Range of Treatment Services Provided by Methadone Centers Policy

Screening for and Treatment of the Components of Metabolic Syndrome

CBH providers who prescribe medications are required to have a policy addressing the screening and treatment of Metabolic Syndrome in patients prescribed antipsychotic medications.

Individuals with psychotic disorders are at an elevated risk of developing obesity, hyperlipidemia, and diabetes, which is further increased by the use of antipsychotic medications. It is imperative to ensure that all individuals receiving behavioral health treatment services in Philadelphia receive treatment that aligns with best practice standards. Therefore, monitoring for Metabolic Syndrome should be included as part of a comprehensive treatment plan.

The policy should, at a minimum, include or address the following components:

1. Patient, family, and/or care giver education

2. Initial and ongoing monitoring includes the following items (The frequency of monitoring should reflect current clinical guidelines and standards. For more information, please see the resources below):

   » Fasting plasma glucose or hemoglobin A1c

   » Lipid panel

   » Blood pressure

   » Weight/BMI or waist circumference

   » Personal and family history of diabetes, hyperlipidemia, metabolic syndrome, cardiac risk factors, and obesity

3. Notification of abnormal results to primary care provider and patient/caregivers

   » Abnormal results require review of psychotropic regimens. Such reviews can trigger alteration of dosage or change of medication.

4. Referral for definitive diagnosis

5. Treatment and coordination between the psychiatrist and the source of primary care

For additional information, providers should review the **Clinical Practice Guidelines for the Pharmacologic Treatment of Schizophrenia**.

Naloxone Policy

Philadelphia was, and remains, significantly impacted by the opioid epidemic. Beginning in 2016, CBH and DBHIDS sought to ensure that all persons receiving any level of behavioral health treatment services in Philadelphia would have immediate access to emergency treatment for an opioid overdose and access to appropriate medical and behavioral health treatment. To that end, providers are required to develop a policy related to onsite maintenance, administration, and prescription of naloxone.

The policy should include or address the following components:

1. Maintain naloxone kits on-site in all programs, at all times.

2. Ensure that there are staff present on all shifts who are trained to administer naloxone to individuals who are known to be or suspected of experiencing an overdose.

3. Follow established provider policy emergency procedures to immediately administer naloxone as indicated and ensure immediate emergency medical attention following administration.

4. Offer naloxone (through prescription, use of the standing order, or direct dispensation) to all clients for their personal use through a written prescription by a program physician or the standing order.

5. Educate and train clients on the availability and use of naloxone.

6. Enable staff to identify persons in need of and to promptly administer naloxone as indicated.

7. Assure safe acquisition, storage, monitoring, and administration of naloxone, as well as safe disposal of used or expired naloxone.

For additional information, providers should review the **Clinical Practice Guidelines for Opioid Use Disorder**.

Benzodiazepine Prescribing

CBH requires all providers who prescribe medications to have a policy related to the safe prescribing and monitoring of benzodiazepines. Providers should review the **Clinical Practice Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications**.

The policy should include or address the following components:

1. Benzodiazepines should not be initiated as monotherapy for the treatment of anxiety disorders.

2. Benzodiazepines should not be used for the treatment of insomnia without appropriate evaluation and should not be used chronically.

3. Benzodiazepines should not be prescribed to individuals with substance use disorders.

4. Benzodiazepines should not be prescribed to individuals enrolled in medication-assisted therapy (MAT) for opioid use disorders or to individuals who are prescribed chronic opioid medications for pain.

5. Benzodiazepines should generally not be prescribed to children and adolescents, pregnant/lactating individuals, or the elderly.

6. Benzodiazepines and other controlled substances will be prescribed in accordance with state requirements related to the **Prescription Drug Monitoring Program (PDMP)**.

Use of Psychotropic Medications in Children and Adolescents (FDA-approved and Off-label)

CBH members, including children and adolescents, should receive medication management interventions, including the use of psychotropic medications, in a manner consistent with evidence-based and best practices. Youth who are prescribed psychotropic medication, both FDA-approved and off-label, and their guardians, should participate in a comprehensive and collaborative informed consent process.

Off-label drug use is defined as the use of a drug to treat a condition, target symptoms or a population of patients even though the drug is not specifically approved for an indication by the FDA. The use of non-FDA-approved medications requires a higher standard of informed consent and closer clinical monitoring.

When medication is being considered as part of the treatment plan, there should be a collaborative discussion with the member and their caregiver regarding:

1. The rationale for an initial prescription of medication, including the condition or targeted symptoms

2. The risks specifically associated with the proposed use

3. If the selected medication is off-label, the nature of off-label use and the reasons for choosing a non–FDA-approved medication

4. If the medication also has a black box warning about its use, the prescriber must discuss the nature of the black box warning as well as the regulatory requirements and monitoring schedules set forth by the FDA for these uses.

5. Proposed strategy for tapering and or discontinuing the prescribed medication

Documentation of the discussion, the informed consent document with required signatures, and any written materials provided to the patient must be included in the chart. Psychoeducation materials regarding psychotropic medications can be found on the **American Academy of Child and Adolescent Psychiatry's (AACAP) "Families/Youth" website section**.

Contracted providers are required to develop and implement a policy and procedure to monitor adverse events for each class of psychotropic medication prescribed. These policies and procedures should be informed by evidence-based guidelines.

Use of Antipsychotic Medications in Children and Youth

The **Children's Hospital of Philadelphia (CHOP) Policy Lab**'s 2015 study, *Antipsychotic Prescribing to Children in Pennsylvania*, showed that children and adolescents enrolled in the Medicaid program have been disproportionately prescribed antipsychotics compared to children who are commercially insured.

To ensure CBH members receive the safest and highest quality psychiatric care available, CBH has published **Clinical Practice Guidelines for the Prescribing and Monitoring of Antipsychotic Medications for Youth**. These guidelines are based on several nationally recognized prescribing guidelines and practice parameters. In particular, AACAP's *Practice Parameter on the Use of Atypical Antipsychotic Medications in Children and Adolescents* informs the requirements outlined in the CPG.

All CBH network providers who treat and care for youth (ages 0-17) are required to develop policies and procedures to ensure that prescribing adheres to these guidelines.

The policy should include or address the following components:

1. A psychiatric evaluation providing a comprehensive overview of clinical formulation and subsequent treatment recommendations must be conducted prior to prescribing antipsychotics.

2. When selecting any antipsychotic for use in a child or adolescent, a provider should follow the most current available evidence in scientific literature.

3. Although the use of antipsychotics off-label is not contraindicated, regular monitoring is critical to detect adverse effects, as well as to ensure that the medication is effective.

4. The long-term simultaneous use of multiple antipsychotics has not been studied rigorously and generally should be avoided.

5. Body weight, BMI, liver function tests, vital signs, fasting blood glucose and/or Hemoglobin A1C, and a lipid panel should be obtained at baseline and monitored at regular intervals during treatment with an atypical antipsychotic.

6. Clinicians should routinely monitor patients for components of metabolic syndrome given the risk of developing metabolic syndrome with long-term use of antipsychotics.

7. The dosing of antipsychotics should follow the "start low and go slow" approach with the goal of finding the lowest effective dose.

8. Psychotropic medication should be used as part of a multimodal treatment plan that also includes effective behavioral health therapy and other psychosocial interventions as determined by the psychiatrist and treatment team leader.

9. Providers must document the use (at baseline and every six months) of a standardized rating scale such as the Abnormal Involuntary Movement Scale (AIMS) or the Neurological Rating Scale (NRS) to monitor movement disorders as a possible side effect.

Full Range of Treatment Services Provided by Methadone Treatment Centers Policy

➡ The policy indicates methadone treatment centers provide, or be able to refer to, a full range of services including vocational, educational, legal, and health. Note: this does not apply to Suboxone.

➡ The policy language includes that treatment centers will comply with all state and federal licensing regulations.

➡ The policy includes language about how the agency offers an integrated and holistic treatment approach that provides psychosocial treatment, in addition to the provision of methadone, and that adequately screens for and treats co-occurring psychiatric conditions.

5. Staff Development

Required Levels of Care: All Levels of Care

Description: The provider will establish a staff development policy to apply to full-time, benefit-eligible employees that incorporates the following:

➡ Clinical Supervision Policy

➡ Performance Evaluation Policy

Minimum Elements of the Clinical Supervision Policy:

➡ The policy indicates all clinical and direct care staff members receive recovery/resilience-oriented supervision.

➡ The policy describes how supervision is focused on improving outcomes for people receiving services as well as addressing staff strengths and challenges.

➡ The policy must also describe how supervision sessions support the individualized learning plan for each staff member. Please reference Appendices for the Network Inclusion Criteria (NIC) within this document for further specifications around supervision.

Minimum Elements of the Performance Evaluation Policy:

➡ The policy indicates the requirement of performance evaluations occurring for all staff.

➡ The policy indicates that after the staff person's probationary period ends, performance evaluations are conducted on an annual basis, at a minimum.

➡ Further, the policy provides language about the areas for staff improvement that are identified as part of the performance evaluation and that are linked to the individual's ongoing learning plan or yearly goals.

6. Quality Assurance

Required Levels of Care: All Levels of Care

Description: The provider will establish a quality assurance policy that incorporates the following:

➡ Feedback from Participants, Families, Allies, and Program Alumni Policy

➡ Measuring the Effectiveness of Services Policy

Minimum Elements of the Feedback from Participants, Families, Allies and Program Alumni Policy:

➡ A policy must be in place to ensure that there is ongoing feedback from participants (to include children, youth, and adults), families, allies, and program alumni.

➡ The feedback obtained should be both quantitative and qualitative.

➡ The policy must include language about the findings from the data collection and feedback from a sampling of participants, families, allies, and program alumni that are analyzed on a quarterly basis.

Minimum Elements of the Effectives of Services Policy:

➡ A policy must be in place that indicates that agencies measure the effectiveness of the services provided.

➡ This policy must include language about how disparities concerning access, engagement, service quality, and outcomes are routinely assessed and monitored.

7. Completion of High-Risk Assessment Policy

Required Levels of Care: All Levels of Care

Description: The provider will have a policy that addresses the need for high-risk behavioral assessments to be completed, including the screening for suicidality, homicidality, and any bio-medical/physical concerns which may require a medical evaluation and assessment of withdrawal-symptom severity.

Minimum Elements of the High-Risk Assessment Policy:

➡ The policy includes language that indicates the screening for suicidality and should include the history of prior attempts, assessment of potential lethality of these attempts, needed medical interventions as a result of the attempts, confirmation of self-reports from ancillary sources, current plan, means to carry out the plan, and potential lethality of the current plan.

➡ The policy indicates that the agency has measures in place for high-risk screens, to include possible referrals for an emergent evaluation.

➡ The policy includes language about incident reporting, which occurs at the state and CBH level if a suicidal/homicidal attempt is made.

➡ All providers offering substance use services funded through DDAP have answered the specified emergent care questions as identified in the DDAP Case Management and Clinical Services Manual.

8. Peer and Family Inclusion

Required Levels of Care: All Levels of Care

Description: The provider will establish a Peer and Family Inclusion policy that incorporates how peer support and a more vibrant peer culture will contribute to the overall culture of the program. Questions that should be taken into consideration when developing the policy include the following:

➡ How is the power of peer culture/peer support being recognized?

➡ Define roles of Peer Support Staff vs. Peer Volunteers?

➡ What are the supervision and training requirements of Peer Support Staff and Peer Volunteers?

➡ What opportunities are created for peers to support each other?

➡ What opportunities do peers have to engage in active leadership roles at all levels of the program?

➡ What collaborations or relationships have been established in the community to link individuals to other behavioral health agencies or recovery support groups?

Minimum Elements of the Peer and Family Inclusion Policy:

➡ The policy clearly indicates the purpose of peer culture within the framework of the services offered.

➡ The policy specifies the provider's stance in relation to ensuring peers participate in planning, developing, delivering, and evaluating program content and outcomes. Consider the role and functions of peer support staff and peer volunteers, as well as how their role enhances the program.

➡ The policy defines who is responsible for implementation of the various aspects of the policy and procedures stipulated.

➡ The policy offers step-by-step detail regarding how they will promote and enhance peer support and culture throughout the agency. Some examples to consider include:

» Detail regarding how to create an engaging and welcoming environment for individuals in the program

» Detailing the process of how to orient individuals to program structure and expectations for a successful experience

» Detailing how the agency ensures individuals have input on deciding group topics and other therapeutic supports

» Detailing how the agency is ensuring that peers take the lead in recovery/resilience planning as well as continuing support planning

» Detailing a plan to foster successful integrations of peer support staff into the agency

» Detailing the role of alumni (e.g., Are they serving as mentors?)

➡ Providers should also reference the **DBHIDS Peer Support Toolkit** as a guide to ensure full implementation of Peer Support practices throughout the agency.

9. Preventative and Diagnostic Healthcare Policy

Required Levels of Care: All Levels of Care

Description: The provider will establish a Preventative and Diagnostic Healthcare Policy indicating that holistic care and ensuring continuity of services are provided.

Minimum Elements of the Preventative and Diagnostic Healthcare Policy:

➡ The policy indicates how agencies assist participants in accessing critical preventative and diagnostic healthcare services through referrals or coordination with community healthcare supports.

➡ The policy indicates indicate how education about behavioral health diagnoses, treatment, and trends, as well as education on physical/public health challenges including chronic diseases and community illness trends, are provided to participants.

➡ The policy incorporates how outcomes of the education of, referrals to, and coordination with physical health providers are tracked.

10. Single County Authority (SCA) Monitoring Policy

Required Levels of Care: All Department of Drug and Alcohol Programs (DDAP) funded programs

Description: The provider will establish a SCA Monitoring Policy, incorporating the following:

➡ Confidentiality Policy

➡ Sexual Harassment Policy

➡ Policy Regarding the Review of Interim Services

➡ Policy on Priority Populations

➡ SCA Grievance and Appeal Procedures Policy

➡ Policy on Treating Injection Drug Users (IDU)

Minimum Elements of the Confidentiality Policy:

The policy addresses the following areas:

➡ Releases of individual-identifying information

➡ Storage and security of clinical records

➡ Computer security of clinical records

➡ Staff access to records

➡ Confidentiality training for all applicable staff

➡ Disciplinary protocols for staff violating confidentiality regulations

➡ Revocation of consent

➡ Notification that re-disclosure is prohibited without proper consent

Minimum Elements of the Sexual Harassment Policy:

The policy is required for all DDAP-funded programs as noted in the DDAP Operations Manual.

➡ The policy includes language ensuring that employees are aware of the policy

➡ The policy includes language ensuring that sexual harassment will not be tolerated, and that employees who violate the policy will be disciplined

Minimum Elements of the Review of Interim Services Policy:

This policy must be in place for all DDAP-funded providers who serve both pregnant women and Injection Drug Users (IDU).

➡ The policy clearly details the procedures for ensuring the provision of interim services for the identified individuals if they are not able to be admitted within 14 days after the completion of the level of care assessment.

➡ The policy includes language that interim services are provided and arranged for within 48 hours of the level of care assessment.

Minimum Elements of the Priority Populations Policy:

➡ The policy specifies the provider's priority populations, which should be indicated in the following order:

1. Pregnant Injection Drug Users

2. Pregnant Substance Users

3. Injection Drug Users

4. Overdose Survivors

5. Veterans

➡ The policy includes language stating that all individuals identified as part of the priority population are offered admission to the recommended level of care immediately.

Minimum Elements of the SCA Grievance and Appeal Procedures Policy:

➡ The policy is in place for all DDAP-funded providers as it relates to the SCA.

Minimum Elements of the Treating Injection Drug Users (IDU) Policy:

➡ The policy ensures the SCA is notified within seven days upon reaching 90% capacity for admission of individuals who are identified as IDU.

11. Tobacco Use Disorder Treatment Policy

Required Levels of Care: This policy is required for all Levels of Care. With the shared goal of addressing health disparities in the behavioral health community, we leave it to each provider to make their own decision about implementing a tobacco-free environmental policy in their settings, while ensuring non-punitive, motivational, and harm-reduction strategies for members ambivalent about abstaining from tobacco use.

Description: The provider will establish a Tobacco Use Disorder Treatment policy.

Minimum Elements of the Feedback from Participants, Families, Allies, and Program Alumni Policy:

➡ The policy addresses procedures for integrating tobacco use disorder treatment throughout the workflow, including screening for tobacco use, educating members who use tobacco on treatment options, providing barrier-free access to evidence-based tobacco use disorder treatment (counseling and pharmacotherapy [medication and nicotine replacement therapy]), addressing tobacco-related challenges and goals in treatment planning, and discharge planning.

➡ The policy addresses procedures for staff training on implementing evidence-based tobacco use disorder treatment.

12. Evidence-Based Treatment Linkage Policy

Required Levels of Care:

➡ All licensed drug and alcohol providers

➡ Crisis Response Centers (CRCs)

Minimum Elements of the Policy:

Applicable to: CRCs And Drug And Alcohol Treatment Providers

➡ How programs discuss medication-assisted treatment (MAT) options (to include buprenorphine, methadone, and naltrexone ER) with members for the treatment of opioid use disorder (OUD).

➡ That the provider documents informed consent discussions with the members, to include the risks, benefits, and alternatives of evidence-based treatments, to include MAT.

➡ How members have access to and are quickly linked with evidence-based treatments, particularly medication-assisted treatment (MAT).

➡ The process for tracking and aggregating the number of individuals with OUD who are receiving MAT; this should clearly be defined in the procedure of the policy, to include the platform for tracking this information, the person (title) responsible for tracking this information, and that this data will be submitted to CBH on a quarterly basis.

Applicable to: Outpatient Drug and Alcohol Treatment Providers

➡ Plan to promote access, including enhanced access avenues, including night or weekend hours, or dedicated open access hours.

➡ For providers offering methadone or buprenorphine, the process to track and report time from a member's first appointment (with any staff) to the time of induction.

Applicable to: Residential Drug and Alcohol Providers

➡ How admissions are occurring during night and weekend hours.

➡ How admissions occurring across shifts are tracked, and this data is submitted to CBH quarterly.

Applicable to: CRCs

➡ The process and protocols to promote aftercare linkages for members with substance use disorder (SUD) who are not authorized for residential level of care, including "warm handoff" and a plan to track and follow up.

➡ The tracking process for transition activities for members referred to community drug and alcohol providers, with data submitted to CBH quarterly.

APPENDIX M: SERVICE REQUEST FORM

This form should be faxed to CBH Operational Support Services (OSS) unit at (215) 413-7683 within 90 days of the service start date. This form can be used to submit multiple requests. Questions about this form can be directed to OSS at (267) 602-8580.

Type of Service: _____

Date of Submission: _____

CBH Provider #: _____

Date CBH Received: _____

Client Name	CIS #	Soc Sec #	Living Arrangement Code	Voc Educ Code	Requested Service Code	Initial Service Start Date	Requested Auth Service Start Date	Requested Auth Service End Date	# of Units	Primary Dx	Second Dx	Priority Group Code

APPENDIX N: PES PRIOR AUTHORIZATION TEMPLATE

Providers requesting an initial or concurrent prior authorization (aside from services that require packet submissions) must provide the following details to CBH at the time of the request, as applicable:

- ☐ Caller Name
- ☐ Phone Number/Extension
- ☐ Provider Name
- ☐ Medical Assistance (MA) Number
- ☐ Third Party Insurance (If Applicable)
- ☐ Member's Current Phone Number and Address
- ☐ Arrival Date and Time
- ☐ Mode of Arrival
- ☐ Living Situation
- ☐ Special Needs (None/Visually Impaired/Hearing Impaired/Physically Impaired/Intellectually Impaired)
- ☐ Legal Involvement
- ☐ Treatment History
- ☐ Current Services
- ☐ Presenting Problems
- ☐ Medical History
- ☐ Family Support
- ☐ Employment
- ☐ Trauma History
- ☐ Department of Human Services/Community Umbrella Agency (DHS/CUA) Info
- ☐ Name of School, Grade, Any Special Education Services, Current Grades if Available
- ☐ Precipitating Events
- ☐ Mental Status Exam

- ☐ Staff Who Conducted
- ☐ Date
- ☐ Time
- ☐ Suicidality (History/Current/Unable to Assess)
- ☐ Homicidality (History/Current/Unable to Assess)
- ☐ Other MSE Details
- ☐ Urine Drug Screen (Results/Date/Time)
- ☐ Breathalyzer (Results/Date/Time)
- ☐ Blood Alcohol Level (Results/Date/Time)
- ☐ Withdrawal Symptoms (None Reported or Observed/Headache/Restlessness/Runny Nose/Tremors/Nausea/Vomiting/Irritability/Watery Eyes/Muscle Pain/Fatigue/Other)
- ☐ American Society of Addiction Medicine (ASAM) Criteria
- ☐ Patterns of Substance Use – Complete For Each Substance Used
  - ☐ Amount
  - ☐ Frequency
  - ☐ Onset of First Use
  - ☐ Last Use
  - ☐ Method
- ☐ Medications (Names, Dosages, and Frequency)
- ☐ Vital Signs (Date and Time, Results for Most Recent Set Taken as Follows)
- ☐ Diagnosis
- ☐ Alternative Services Considered
- ☐ Case Conceptualization and Service Requested

APPENDIX O: CONCURRENT REVIEW TEMPLATE

Please Note: Specific programs and services (e.g., Eating Disorder Units and ECT in Acute Psychiatric Inpatient Hospitalization) may require more information than a standard concurrent review. Please contact your assigned clinical care manager (CCM) with any questions about concurrent review requirements.

Demographics

➡ Member Name

➡ Member MA#

➡ Member Address and Phone Number

➡ Member Gender Identity, Sexual Orientation, and Preferred Pronouns

➡ Caller Name and Phone Number/Extension

➡ Provider Name

➡ Date of Review

➡ Service Requested

➡ Commitment Status

➡ Presenting Problem/Primary Treatment Needs

➡ Systems Involved and Name/Contact Information (DHS/CUA/Justice System/IDS/etc.)

➡ Current School/Grade Level and Any Special Education/Accommodations (when applicable)

Current Clinical Presentation

➡ Description of Current Behaviors (Summarize participation/response to individual/group modalities, any behavioral concerns, active or resolved behavioral health symptoms since the start of treatment, activities of daily living (ADLs), special precautions, etc.)

➡ Medical Diagnoses (Vital signs, lab work, height/weight, etc.)

➡ Substance Use Assessment and Urine Drug Screen (UDS) (if applicable)

➡ Medications including dosage, frequency, start/end date, rationale for medication, if member is adherent, side effects, titration plan, and response to date

➡ Mental Status Exam

➡ Structured Tools/Assessment

Clinical Plan/Care Coordination

➡ Provider Treatment Plan

➡ Evidence-Based Practices (EBP) Being Used in Treatment

➡ Protective Factors/Member Strengths

➡ Care Coordination, (including when applicable):

　　» Family/significant others, including dates and outcomes of family sessions

　　» Outpatient and/or community treatment providers

　　» PCP/medical provider

　　» Cross systems

　　» School/early interventions

　　» Natural supports

　　» ISPT needed

➡ Social Determinants/Barriers to Treatment

➡ Disposition and Aftercare Plan (including if referral and/or evaluations are needed)

➡ EBP Recommended in Disposition Plan

➡ For Next Review (CCM will provide follow-up questions to be answered following the Utilization Review)

APPENDIX P: REQUEST/CONCURRENT REVIEW TEMPLATE IN SUD BED-BASED LEVELS OF CARE

Member Information

➡ Member's most current address and phone number

➡ Preferred name, pronouns

➡ Is the member a 30-day readmission?

➡ History of special education/learning disabilities

  » If yes, full-scale IQ and date of assessment

➡ Systems involvement

  » DHS: If yes, DHS committed, DHS supervision, DHS investigation

➡ Protective factors and member strengths

➡ Highest level of education, work history, income, family supports/connections

ASAM Dimensions 1-6 with Level of Risk (LOR)

➡ Date ASAM completed

➡ Person who completed ASAM with credentials/license

➡ Has medication-assisted treatment (MAT) been discussed with the member?

  » Yes, No, N/A. If Yes or No, share specifics.

ASAM Dimension	Information
Dimension 1	➡ Substances used (duration, frequency, method, last use) ➡ Drug testing results ➡ History of withdrawal and/or overdose ➡ Withdrawal symptoms ➡ SUD MAT medications ➡ LOR
Dimension 2	➡ Current medical diagnoses ➡ Medical history ➡ Medications

ASAM Dimension	Information
	➡ Medical appointments ➡ Vitals ➡ Medical provider with contact information ➡ LOR
Dimension 3	➡ Current mental health symptoms/diagnoses ➡ Mental health history ➡ Mental health medications ➡ Last contact/appointment with mental health provider ➡ Trauma history ➡ Suicide risk ➡ Mental health provider with contact information ➡ Issues with sleep, gambling, memory/concentration, risky sex behaviors, physical aggression, self-harm, and/or suicidal ideation ➡ LOR
Dimension 4	➡ Stage of change as it relates to substance use ➡ Any concerns to start or stay in treatment? ➡ LOR
Dimension 5	➡ Treatment history ➡ Longest period without substance use ➡ How was this period accomplished? ➡ What led to return to use in the past? ➡ Triggers/plans for triggers ➡ LOR
Dimension 6	➡ Living situation ➡ Legal involvement or history/PO/Parole/is treatment a stipulation currently? ➡ Family support ➡ Source of income ➡ Spending of free time ➡ Employment/education ➡ Current supports ➡ Strengths ➡ LOR

Provider Treatment Plan and Safety Plan

➡ Treatment Planning

» Short term goals, in member's own words (i.e., What do they want from treatment at this LOC?)

» Measurable objectives with interventions and target complete dates

» Progress towards goals, specifically dimension drivers for that LOC

» Were any evidence-based practices used?

» Protective factors/strengths

➡ Date of last treatment plan

➡ Safety plan

» Was this developed?

» Who are the crisis supports?

Evidence-Based Practices

➡ What EBPs are recommended and used in treatment?

Care Coordination/Aftercare

➡ Current address or housing status

➡ Supports

➡ ICM/contact and current updates

➡ Outpatient treatment/outreach

➡ Legal

➡ PO contact

➡ Interagency and discharge planning meetings with supports

Social Determinants/Barriers to Treatment

➡ Legal barriers, economic stability, access to education, access to health care, physical environment, social and community support, food security, access to transportation, access to housing

➡ Any follow-ups regarding the social determinants of health

Disposition Plan

➡ Housing and treatment recommendations

➡ Barriers to disposition plan

Referral/Evaluation Needed

➡ Date referral completed, if needed?

Clinical Formulation

➡ Treatment recommendations

For Next Review

➡ What goals should be achieved?

➡ Updates, disposition planning, EBPs recommended?

APPENDIX Q: OUT-OF-NETWORK (OON) REQUEST FORM

This form only needs to be completed when there is no active contract for the OON provider.

Provider Name:	
Provider Address:	

Provider Contact			
Clinical Contact Person:		**Phone #:**	
Billing Contact Person:		**Phone #:**	

Recipient's Name:	
Recipient's CIS #:	
Level of Care Description & Code:	
Units/Days Authorized:	
Service Begin Date:	
Service End Date:	
Person Completing this Form:	
Date of Completion of this Form:	
Phone Number/Extension:	
Brief Reason for Utilizing OON Provider:	
Description of Services Needed:	

Upon completion of this form, email to **CBHOON@phila.gov** and cc the assigned OON Clinical Care Manager for this level of care.

APPENDIX R: COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION (CBE) REQUIRED ELEMENTS

- ➡ Referral source

- ➡ Reason for evaluation

- ➡ Identifying data demographics

- ➡ History of presenting challenges/needs – multiple sources and integrate discrepant information

- ➡ Review prior/current treatment- multiple sources

- ➡ Medications – current and past

- ➡ Medical history

- ➡ Family psychiatric

- ➡ Developmental

- ➡ Educational

- ➡ Psychosocial history and current functioning

- ➡ Trauma assessment

- ➡ Aggression/self-harm/risk

- ➡ Substance use assessment

- ➡ MSE

- ➡ Diagnosis/provisional

- ➡ Strengths and protective factors

- ➡ Family Engagement

- ➡ Community supports/preferences

- ➡ Potential barriers/challenges

- ➡ Formulation

- ➡ Comprehensive recommendations/discharge option