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Compliance Forum 2024: 'Clean Claims'

Thursday November 7th, 2024

PRESENTED BY:

Maria Perkins, MS, LPC

Business Rules Leader

Leann Hanisco, MS, CFE

Program Integrity Data Leader

Nil Gok

Director of Claims Management

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Topics to be Covered

COMMUNITY BEHAVIORAL HEALTH

- Claim Accuracy Provider Notice
- False Claims Act
- Importance of Correct Billing
- Place of Service Codes
- Diagnosis Codes
- Current Procedural Terminology (CPT) Codes
- Modifiers
- Telehealth Billing
- Tips/More Information
- Claims Q&A with Director of Claims Management – Nil Gok

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Claim Accuracy Provider Notice

COMMUNITY BEHAVIORAL HEALTH

Claim Accuracy

Providers are reminded that all components or sections of a claim must accurately reflect the service rendered. As a Medicaid payer, all services paid by CBH are subject to the Federal False Claims Act (FCA). The FCA states, in part, that any person or entity who submits or who causes to submit a false claim is subject to damage recoveries. The following are common areas where errors can be made, identified either through prepayment claim edits or post payment reviews.

Place of Service Code

Providers are required to utilize the most appropriate place of service code on the claim to accurately reflect the service provided. Available codes for each service are listed on your agency's Schedule A. In some cases, a level of care may have several potential billing sentences. Please take care to ensure that the place of service code is appropriate for the specific sentence.

Please note that providers must ensure that the place of service code best matches the service location and is allowable under current Commonwealth guidance. If you have questions about the most appropriate place of service code to use and/or believe that a code(s) may be missing from your Schedule A, please contact your Provider Relations Representative. Please do not 'guess' the best code to use.

Incorrect/Discrepant Diagnosis

Claims must contain an accurate diagnosis. Providers are asked to denote the primary diagnosis 'treated' as part of the service in the first diagnosis field on the claim. For professional services, this can be completed by designating the diagnosis "pointer" (24.E on 1500 form) to designate the primary diagnosis treated. For institutional claims, this is accomplished by ensuring that the diagnosis treated is listed in the first field on line 66 of a UB-04. In general, care should be taken to ensure that the service provided was appropriate for the members and their diagnoses. For instance, a claim submitted for detoxification but lacking an appropriate AOD diagnosis may be rejected, or payment may be recouped via audit. Current available diagnosis codes are attached to this notice. Commonwealth defined permissible codes can change. Please ensure that you are aware of changes to current coding.

Incorrect/Discrepant Billing Code

Each claim requires an appropriate CPT or revenue code for each service billed. Care should be given to ensure that the code used accurately reflects the service provided. During a CBH record review, should the code billed appear to not match the service provided, the amount paid will be recouped with no ability to rebill for the accurate service.

False Claims Act

- **False Claims Act [31 U.S.C. § § 3729-3733]**
- The civil FCA protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law.
- Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or ex-business partners, hospital or office staff, patients, or competitors.
- There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Physicians have gone to prison for submitting false health care claims. OIG also may impose administrative civil monetary penalties for false or fraudulent claims, as discussed below.
- Fraud & Abuse Laws | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

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Importance of Correct Billing

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Timely Payment

- Providers who submit correct claims in a timely manner are more likely to receive payment for services rendered sooner than those who submit claims with errors or claims submitted outside of the 90 day window

Correct Payment

- Providers who submit claims with inaccurate information or information that needs to be adjusted after submission may be subject to fines and/or delayed payment

Accurate Reporting

- CBH reports cost-avoidance and claims information to outside agencies for monitoring. Inaccurate reporting can cause delays or misrepresentation of services provided

Member Safety/Harm Reduction

- Inaccurate information could have a significant influence on the member and their care. Submitting correct information significantly decreases the likelihood of harm due to inaccurate information in systems

Correct Place of Service Codes

- **Available codes for each service are listed on your agency's Schedule A**
- https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

Incorrect/Discrepant Diagnosis

Valid ICD-10 List

https://www.cms.gov/files/document/valid-icd-10-list.xlsx

Valid ICD-9 List

https://www.cms.gov/files/document/valid-icd-9-list.xlsx

Current Procedural Terminology (CPT) Codes

What is a CPT® code?

The Current Procedural Terminology (CPT®) codes offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency.

CPT codes are also used for administrative management purposes such as claims processing and developing guidelines for medical care review.

The CPT terminology is the most widely accepted medical nomenclature used across the country to report medical, surgical, radiology, laboratory, anesthesiology, genomic sequencing, evaluation and management (E/M) services under public and private health insurance programs.

The development and management of the CPT code set rely on a rigorous, transparent and open process led by the CPT® Editorial Panel. Created more than 50 years ago, this AMA-convened process ensures clinically valid codes are issued, update

https://www.cms.gov/license/ama?file=/files/zip/updated-list-codes-effective-january-1-2024-published-march-1-2024.zip

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Modifiers

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- Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. They are used to add information or change the description of service to improve accuracy or specificity. Modifiers can be alphabetic, numeric or a combination of both, but will always be two digits

- https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00003604

Telehealth Billing

CPT & Place of Service Codes

Use the correct CPT Place of Service codes (based on the client's location – not the provider's location)

Modifiers

Telehealth via video or phone

Documentation

Document which platform used (phone, Zoom, Teams, etc.) – Just ensure it is HIPAA-compliant

Tips/More Information

- Do not submit claims you don't think will get paid – submitting any/all claims and "seeing what will pay" can result in financial consequences and/or member harm
- Make sure to submit correct place of service codes, diagnosis codes, and modifiers
- When submitting both paper and electronic claims, make sure there is no duplication and that claims are accurate
- Do not try to re-submit claims that have already been rejected for a certain reason
- Do not try to re-submit claims that CBH has already recouped

Tips/More Information (cont'd)

Ensure there is justification for re-submitting claims for more units or $ - we monitor those re-submissions and they are subject to auditing/reporting

Make sure to communicate with CBH if you have any claims questions

Note that submitting incorrect claims information can cause member harm as well as delay financial/business processes

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Claims Questions

Disclaimer Provider-specific questions will not be addressed in this Forum, just general questions. For specific questions, please contact your claims representative

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Fraud, Waste, and Abuse Hotline

1-800-229-3050
cbh.compliancehotline@phila.gov

Messages can be left 24/7
Answered Live Weekdays 9-11am and 2-4pm

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Compliance Matters

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Thank you