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Community Behavioral Health

COMPLIANCE *MATTERS* NEWSLETTER

Fall 2022 Edition

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Aadam Muhammad

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Deadlines

by Angela Brown & Malakeyla Reynolds

In this article we explore a word that can often provoke a bit of anxiety for some of us: Deadlines. We are all tasked with meeting deadlines in one way or another in our busy lives. While some deadlines can sometimes shift and change, there are some that are particularly important to meet on time. For the purposes of this article, we will discuss some CBH Compliance deadlines that are currently in place for providers and why they are so important to meet.

Requests for Information

Providers will be notified of requests by email, letter, and/or by phone. The provider will have 7 days to respond to CBH Compliance requests for information. Some types of information requested include:

- Provider Personnel (i.e., dates of employment, caseloads, hours worked, etc.): In addition to annual Staff Roster submission, CBH Compliance often requests information on personnel to follow up on referrals and/or prepare for audits.

- Programming Information (i.e., schedules, policies & procedures, program descriptions, etc.): CBH Compliance expects providers to have their Compliance Plan, Policies and Procedures relevant to programming readily available.

Chart Requests

CBH Compliance may request medical records for audit, including complete medical records and clinical notes from for a specified period of time. Requests may include admission/ discharge summaries, psychiatric evaluations, encounter forms, physician orders, treatment plan(s), individual progress notes, group therapy notes, and lab/ consultation reports. All treatment plans that cover services for the requested time period are to be submitted to CBH.

Providers will be notified of chart requests by email or in a letter. The provider will have 7 days to respond to CBH Compliance requests for chart documentation. Failure to submit the requested documentation within one week will result in related claims being considered overpayment and subject to recoupment.

Records can be sent via encrypted email to CBH Compliance staff requestor. If you have an electronic health record (EHR) you can also coordinate remote access. If you are unable to submit records via encrypted email or grant remote access to your agency's EHR, Providers must contact the CBH Compliance staff requestor to coordinate submission of records via secure fax, mail, or in-person delivery.

Self-Audits

Provider self-audits are either initiated by Providers or by third parties such as CBH. **Provider Bulletin 18-17: Self-Auditing Process for CBH Providers** requires Providers to contact CBH Compliance when the need to initiate a self-audit is identified

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by the Provider.

Providers may also be required by CBH Compliance to complete self-audits due to results from CBH Compliance audits, or allegations/tips received by the CBH Compliance department. Whether self-audits are initiated by Providers or requested by CBH Compliance, CBH Compliance expects providers to complete their self-audits within 60 days of initiating self-audits to align with the Health Care Fraud Self-Disclosure Protocol HHS OIG Amended 11/8/2021.

For self-audits requested by CBH Compliance, a due date will be established in audit results letters, or via a meeting with the Provider when allegations are received by CBH Compliance. When Providers do not submit self-audit information by the due date or inform CBH Compliance when initiating a self-audit due to potential fraud, waste, or abuse, CBH Compliance reserves the right to conduct an audit of the allegations and/or to recover the payments associated with the allegations, potentially resulting in a financial impact to Providers.

Provider Responses

CBH Compliance completed an audit of your program. Your Executive Director receives a results letter which includes information about the audit, when it occurred, CBH Compliance staff who conducted the review, program(s) audited, error rate(s), and the amount of overpayment due, if any, to CBH. Providers have until the date in the results letter (typically 21 days) to submit a response to audit findings and any supporting documentation. If no response is received by the deadline in the letter, CBH Compliance will proceed and initiate recoupment. If you respond to the audit results letter and submit supporting documentation, the CBH Compliance will review your response and inform you of the outcome of the dispute along with final overpayment amount in a resolution letter. While it is not necessary to respond if no challenges are being made, it is helpful when we receive notification that no challenges are being made.

CBH Compliance aims to be transparent with our providers. When we request information or documentation, please respond. Don't wait until you receive a resolution letter stating that we are recouping payment to respond. By then, it is too late. We appreciate your diligence. Now you know or are reminded of what the expectation is. It's time. Will your agency meet the deadline?

Staffing Summer Quick-Takes

We've not seen it officially named as a part of long COVID but staffing challenges that exploded into 2022 seem to be lingering well into our summer. Most industries, including healthcare, are struggling with staff shortages. Below are some reminders/pointers from our team related to staffing.

Waivers

Two basic things must be remembered when it comes to waivers:

1. Waivers are a proactive ask, not reactive.
2. We cannot waive Commonwealth or Federal rules/requirements.

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Waivers Must Be Proactive

In baseball, waivers are usually reactive. Batting average under .200 and a recent trade addition that needs a spot on the roster, you may be getting waived as a result. But, for our purposes waivers of CBH staffing rules/requirements must be asked for in advance. All too often though, we have experienced an audit citing concerns around the qualifications of a staff person and then have the waiver request come in afterwards. Have a candidate for a position but they seem to be missing X, consider seeing if a waiver is possible.

Is it possible?

Speaking of that, is it possible, if it is a CBH requirement that is higher than that of the relevant Commonwealth/Federal requirement, we can consider it. If it is a Commonwealth or Federal requirement, we are not able to waive those requirements.

Finally, waivers are not something that the Compliance Department approves or rejects. We assist in gathering the information related to the request, comparing it to relevant requirements/regulations, review precedent, and then make the request to the CBH Credentialing Committee. For that reason, it can often take several weeks to turn around a waiver request. Please also consider this when making the request and include any time pressures as part of the request.

Required Clearances for Providers Working with Children

Providers are reminded that all individuals working with children are required the have the following three clearances:

- Criminal History Report from the Pennsylvania State Police
- Child Abuse History Clearance from Pennsylvania Department of Human Services
- Fingerprint-based federal criminal history submitted through the Pennsylvania State Police / FBI

How do you determine if you need a clearance? Check out the Pennsylvania Department of Human Services FAQ, **Employees Working with Children, Frequently Asked Questions**, for this and more information on obtaining clearances. Instructions for obtaining clearances can also be found on the **PA DHS website**.

Please note that as of December 2019, provisional clearances are no longer permitted. Employees must have valid clearances before seeing children.

Staff Credentialing (Facilities)

As a reminder, for most facilities, CBH continues to delegate the credentialing of individual staff members to our providers. That means our providers are responsible for the hiring and retention of staff that meet all applicable requirements for their position. Our Manual for Review of Provider Personnel Files (MRPPF) can assist your agency in determining the CBH requirements for clinical positions. You should also always review the qualification requirements for any other payers with whom you contract,

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and applicable State and Federal requirements. If after reviewing source material, you have specific questions, please reach out to us at **CBH.ComplianceContact@phila.gov**. As a reminder, our MRPPF should always be accessed via our online **Provider Manual**. "Bookmarking" a link to the manual may result in missing an updated version.

Junk Drawer

- It's Forum planning time again! We are working on another virtual event this year and are eager to hear suggestions from our providers. So, reach out to **CBH.ComplianceContact@phila.gov** with your preferences on anything from topics, format (one day vs. multiple days, etc), to tie vs. no tie for me (add in color choice too if you are a pro tie voter if you want).

- Congratulations are in order for several on our team! Malakeyla Reynolds has been promoted to Compliance Supervisor and Emily Junod to Compliance Team Leader! In addition, Leann Hanisco has earned her Certified Fraud Examiner (CFE) status!

- Be on the lookout for a notice coming soon that unannounced audits from your Compliance friends will be resuming shortly.

- The Health and Human Services Office of Inspector General (OIG) posted a **special fraud alert**. The alert asks that practitioners use caution when entering business relationships with telehealth agencies. The OIG issued the alert following several investigations showed a concerning number of schemes, many utilizing kickbacks, related to the growth of telemedicine.

One Ringy Dingy, Two Ringy Dingy

The rapid expansion of telehealth in Pennsylvania and nationwide may well go down as the most lasting regulatory impact of COVID for healthcare. The Commonwealth set out early to get feedback from members and providers on the telehealth experience and thoughts about its use moving forward. **Their study** found that three quarters of members wanted to continue to utilize telehealth moving forward, and providers also found the flexibility that telehealth offers appealing, with 86% in favor of continuing its use to engage new members.

A crossroads approached this summer as COVID-related waivers were expiring, threatening some of that flexibility. The Commonwealth published a revised set of guidelines via an **OMHSAS bulletin** on July 1st of this year. The bulletin establishes new requirements for the delivery of telehealth in behavioral health that in many ways are in line with the COVID related expansion and waivers but does so free of being tied to an emergency declaration. OMHSAS also placed clearer expectations and requirements for how these services should be utilized, documented, billed. Some of the highlights of the bulletin include:

- Expansion of telehealth to non-licensed agency staff and substance use disorder treatment staff

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- Guidance on delivery of services for PA residents temporarily out of state
- Expectations regarding policies, signatures, consent, and appropriate use
- Requirements for out of state practitioners

While we in the compliance world appreciate the flexibility expanded use of telehealth gives to our members and providers, we are also cognizant of the risks that telehealth can bring.

One of the favorite phrases that you will hear used in any presentation or article from me is the adage "Follow the money". Whenever and wherever we see large increases in spending and dollars available, a small but persistent group of individuals will seek to exploit that flow of money for their advantage. We've seen it in relation to the opioid epidemic and most recently COVID. It seems clear that the Federal government is also aware of some of the risks related to telehealth as a July 22 search of the **HHS OIG Workplan** returned 9 different workplan items. This list includes one titled **"Medicaid – Telehealth Expansion During Covid-19 Emergency"** that outlines a desire to review whether the States were able to adequately cope with the rapid rise of telehealth use by complying with relevant Federal guidance and in providing adequate information to providers. Services delivered via telehealth often are occurring outside of an office setting. Staff are delivering services without oversight of agency leadership and without the support of peers and other clinical staff to handle difficult situations. These raise both concerns related to fraud, waste, and abuse and quality/safety.

So where does that leave us? Well, nothing worthwhile comes easily, right? There is little question that telehealth was vital in the Commonwealth's and nationwide response to COVID. As we move to a "new normal" that ostensibly involves telehealth remaining, what needs to be done to mitigate the risks that may come with it? We will spend more time in upcoming issues talking in some more detail about the following, but I suggest these broad categories as focal points for making telehealth safe, efficient, fraud-free, and sustainable:

- Clear, well-publicized, and accessible provider policies on the use of telehealth
- Implementation of a charting system that allows for both original notes/signatures to be seen by auditing and oversight entities, and shared among members of the treatment team
- Strengthening of compliance plans to include monitoring for fraud related to telehealth
- Clear assignments for specific staff/departments to check relevant websites for changes to billing codes, documentation requirements, service delivery expectations, etc.

Stay tuned as we dig deeper into the above points in order to hopefully ensure that telehealth remains an effective tool in our treatment toolbox.

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When Less Is More: The Art Of Progress Notes

One of the most common questions we get asked in Compliance, both directly and indirectly boils down to "What on Earth do you want to see in a clinical note?". We are asked so often, in fact, that it's already been addressed in a **2019 Compliance Matters** article.

In addition, it is a frequent topic of discussion in meetings, LOC specific guidance, trainings, etc. So maybe it's time for a quick refresh.

The simple, quick answer from 2019 is still the same. And it does not change with payment models, levels of care, etc. That is we need to see a concise and accurate representation of what happened in the session/service that provides a clear picture of the service provided by the staff. That 2019 article contained more details about dos and don'ts, and those are still accurate as well.

It is important to remember that there is no one magic format or set of prompts that will yield perfect notes each time. We continue to be asked from time to time if a new note "template" meets "our requirements". As a rule, we don't endorse any template, format, etc. This is not done in attempt to be contrarian, but rather reflects the belief that the content of the note (and the session) is what determines the appropriateness and completeness of the note. Some other tidbits that don't fit nicely into dos and don'ts but I think are still valuable to remember:

If a service is not billable, no note will be able to substantiate it.

If the service itself is not billable. Let's say the member had a mental health outpatient appointment but no showed. The staff member wrote a beautiful note about the interventions that were to be used, the outreach attempts, etc. All of which are great. BUT, it still does not substantiate billing for the missed appointment.

Now more than ever, clear, complete, and concise documentation is important.

With staffing challenges still present, the ability for new staff to be able to quickly gain an understanding of the clinical picture, successful vs. unsuccessful interventions, strengths, challenges, etc of a member is all the more important.

Good documentation should be the goal; not just a rule.

HHS OIG had a podcast on why documentation matters. For the record, if you listen to HHS OIG podcasts about documentation, you've truly found your home here. Welcome. **Here's a transcript**.

In it, HHS makes the case that there are three main reasons why documentation is important. Those are "to protect the programs, to protect your patients, and to protect you the provider". I would argue it all comes down the to protect our members. Following a rule that has no benefit other than to follow the rule is always a tough

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sell (though we HHS OIG podcasters, we are a different sort). But there is a real benefit for the member. Protecting your agency and the MA system ensure that there is both choice of quality providers and funding to cover those services. Without you our providers or the ability to fund the services, our members are at risk. Don't ask your staff to comply with documentation requirements JUST to meet the CBH (or insert any person/organization) rules, ask and demand quality documentation to benefit our members.

Less really can be more.

One of the most common phrases our team hears is something along the lines of "We spend all day writing notes and there is no time to take care of our members". I always have two thoughts when I hear it:

- Good documentation is part of the care of our members. Breaking them into two separate things is not accurate and may reflect part of the problem.

- If you are spending all day writing notes you are, my opinion, writing too much or seeing too many folks. Nobody wants to read a novel of each sentence exchanged in a session. Right now, you may be thinking "You violated that whole less is more thing about 4 paragraphs ago buddy." To that, touché. I can safely say that none of our staff are looking for pages of documentation for a service, we are looking for that concise accounting of what the participants (staff, member(s), family members) brought to the session.

The same is true now as it was in 2019. If you are left with questions after reading the note and you want the rest of the story, then there is some work to be done.

Quiz

What is the hottest temperature ever recorded in Philadelphia?

Previous Quiz Answers:

Delta airlines has US hubs in nine US Airports across eight cities! They are: Atlanta (main hub/corporate home), New York (JFK and LaGuardia), Los Angeles, Boston, Minneapolis, Detroit, Salt Lake City, and Seattle/Tacoma.

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Puzzling

O F J S M T T G F J K D Q N F S I F L J

H F R H P R T A R J D D A I A U J L W B

E D L A Y R N A E T R T H Q P N C L S C

E K T Q N D I N A F E Y C I G S G I K V

E R S T B K O N U I J R A H X H M R F R

J M O H Y I F H K D M K E L Y I V G X P

B E F H T R I U R L C Z B O R N M S O U

J Q U A S O E U R I E Y W O N E Y N W C

R B C Q X P F W N T X S H P X R J G L E

V A T O E L P C O I E U J I M M I E S L

V L S H N B I I U M M R P H I L L I E S

N L P J G P R B Q I N M S R E U N I O N

K P K H Q E E A D F U W H L A M I X B K

N A Z S A O Q I B O N C A Q C H S Z B J

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S T N V P S M H I Q S L Q Q O M J Z A I

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Word List:

Ballpark
Barbeque
Beach
Fan
Frankfurters
Grill
Humidity
Jimmies
Lawnmower
Phanatic
Phillies
Picnic
Pool
Reunion
Shore
Sprinkles
Sundae
Sunshine
Sweat
Tea
Thunderstorms