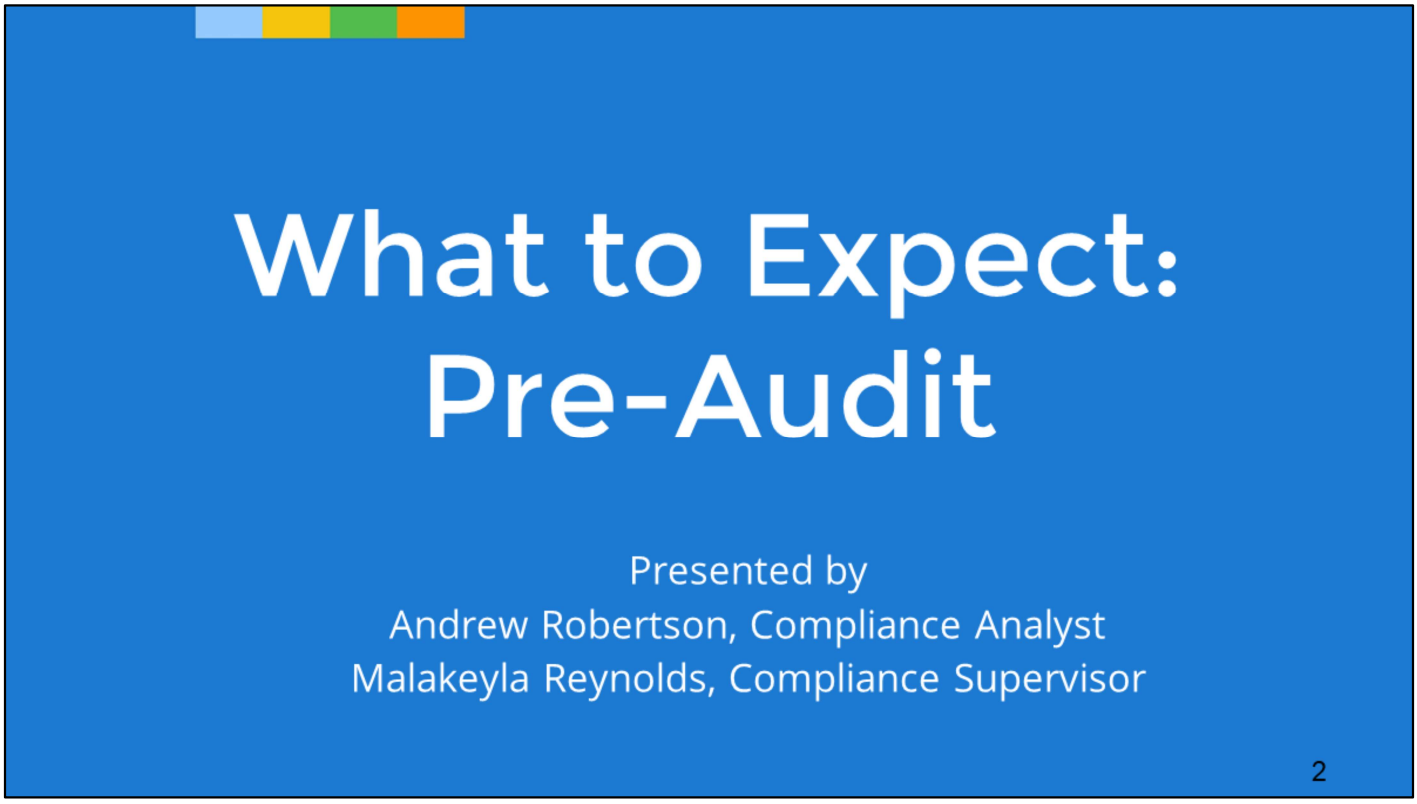
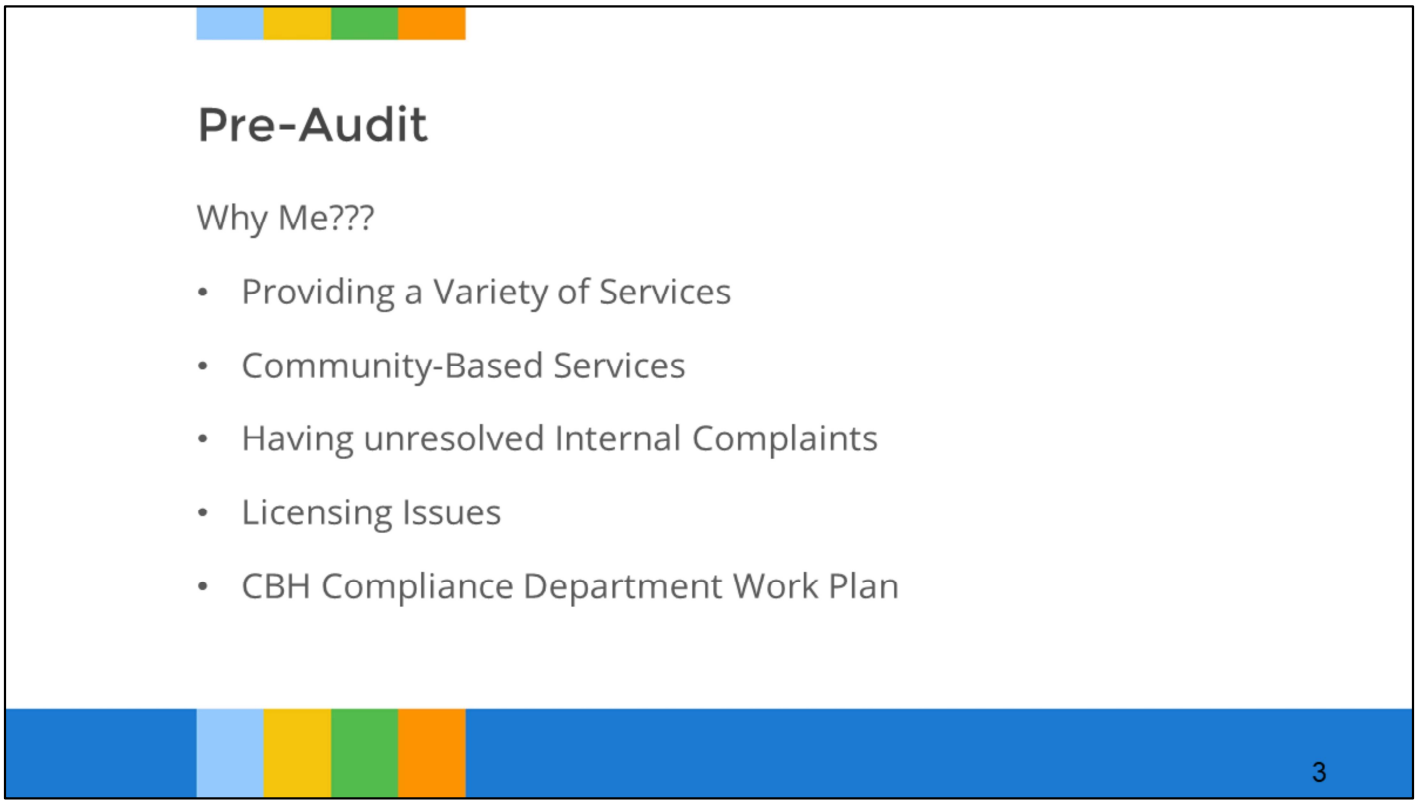
Welcome & Introductions

Information contained in this presentation should not be used as legal advice, please consult with qualified counsel and/or subject matter experts for your information on your specific situation



Intro:
Good Morning , I'm Andrew Robertson, Compliance Analyst in CBH's Compliance department and I'm here to present to you with my colleague Malakeyla Reynolds what to Expect Pre-Audit. We realize that for most providers, a compliance visit is a stressful occurrence. We recognize that what is for us, a rather routine day, may be the most stressful day of your month. However, we hope to provide information that will help in alleviating stress surrounding an audit.

When we arrive or request records, we can assure you, it has been vetted as being necessary. And we will provide any possible information to your agency as to why it is necessary to the extent possible based on the open investigation.



So you may be asking yourself Why me?

Providing a wide variety of services (Do you provide a wide variety of services?)
If you are an agency that sees a large number of our members and/or offer a varied array of services, your agency likely has an increased chance of a compliance visit. So, the more services you provide, the higher the chance that one of those services will be flagged, either through data mining or by a complaint or hotline tip.

Community Based Services (Do you provide Community Based Services?)
Services like IBHS, Case Management, or Telehealth, are provided outside of the office setting, Those services have long been viewed as having an increased risk for FWA.

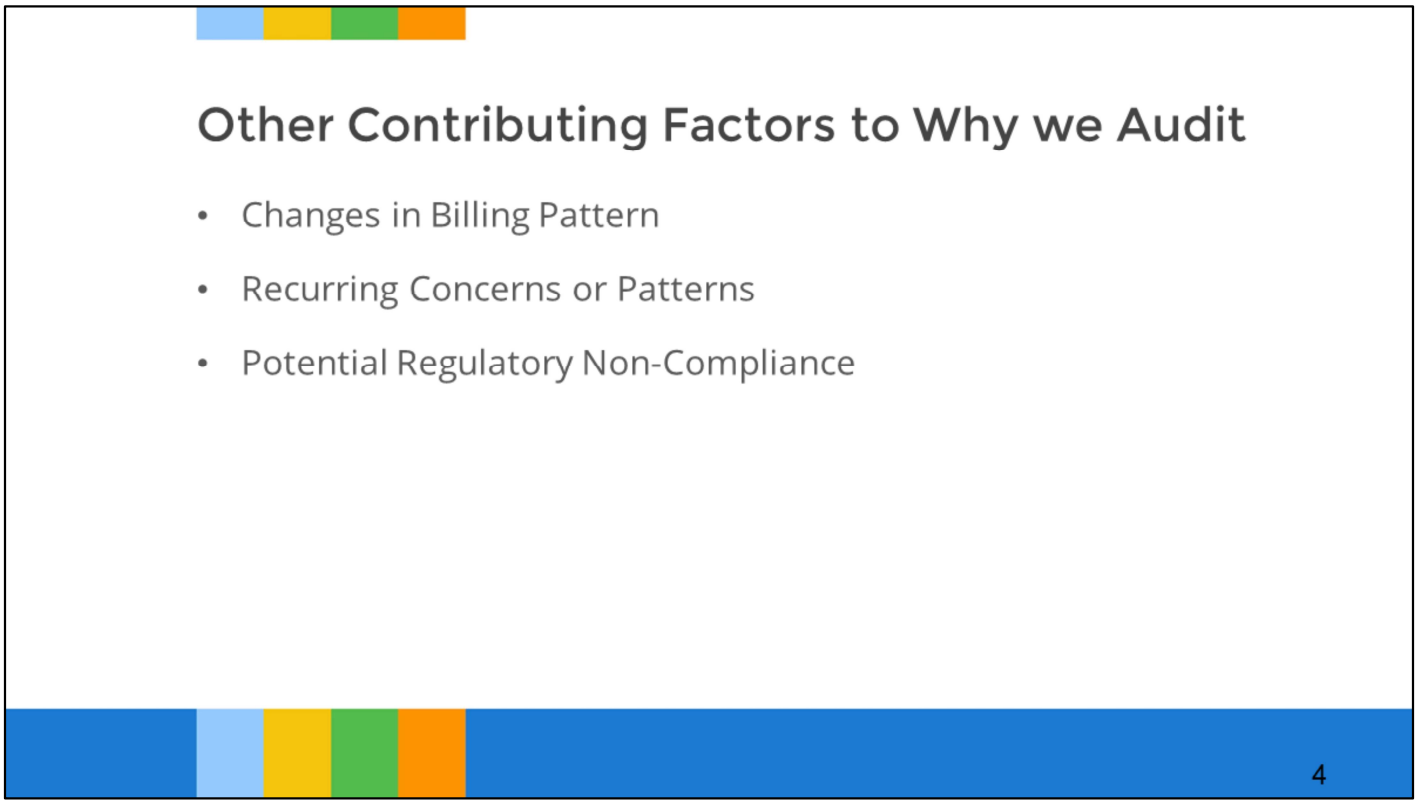
Having unresolved internal complaints
As we have mentioned in Compliance Matters articles in the past, making whistleblowers your friend is an effective way of avoiding our visits. Typically, individuals who feel that their concerns have not been heard and acted on, are more likely to reach out to us or other payors/regulators to provide “tips” on FWA.

Licensing Issues
If your agency is given a provisional license and the issues leading to the provisional status include those that could be tied to compliance concerns, chances are we will

be coming out for an unannounced audit.In many instances, this offers you, as the provider, an opportunity to showcase changes made since the licensing visit. Again, as I mentioned earlier, If you are completing regular self-audits to ensure that relevant state requirements are met, you should be in good shape when your licensing visit comes around.

CBH Compliance Work Plan

Within our annual work plan, there are times where a need to conduct Level of Care specific tours like most recently IOP and CIRC tours have been identified. If you provide a service in the Level of Care selected for review that year, you can expect that we will be coming out for a visit.



Changes in Billing Pattern, These include

- Significant changes (# claims/claim lines) in billing compared to previous years
- The Allegation received includes a high number of service dates and/ or seems wide-spread

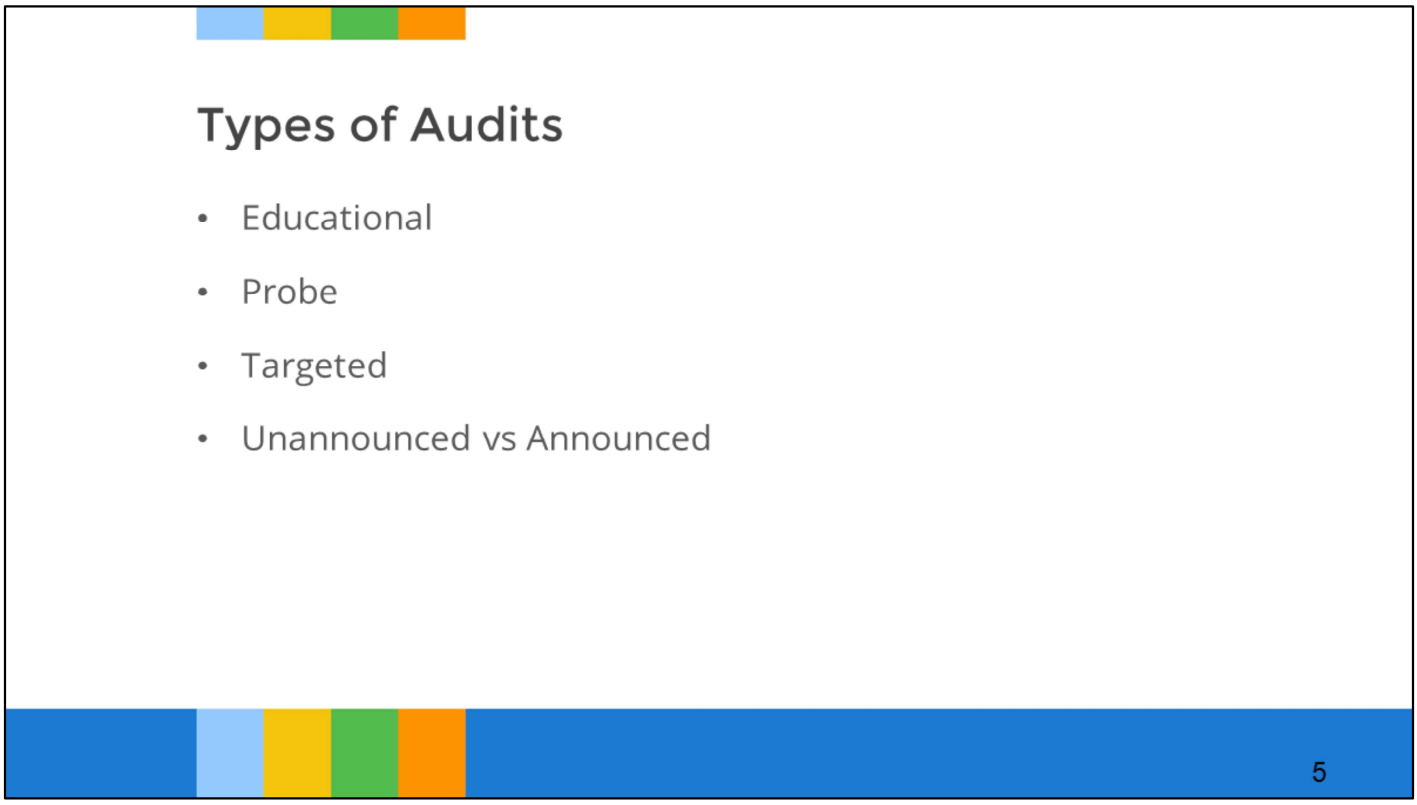
Recurring Concerns or Patterns

Allegations that contain concerns that we have identified in the past that may still be occurring. (a couple of examples of this : certain types of errors, and staff that has been referred to BPI and are working at other locations)

Examples of Potential Regulatory Non-Compliance are

- Evidence of impossible days/impossible scenarios is a clear indication of regulatory non-compliance
- Another example, When we receive a report or allegation to our hotline, when we receive supporting documentation tied to a report or allegation related to a Fraud, Waste and Abuse concern, is also a potential regulatory non-compliance which would necessitate an audit.

Next Malakeyla Reynolds is going to talk to you all about the kinds of Audit we conduct and how we go about requesting information.



Educational Audits: Educational audits provide valuable insight into the comprehensiveness and sufficiency of clinical documentation as it relates to supporting the service provided. CBH providers may request an educational audit for the agency, program(s), or specific level(s) of care. CBH Compliance or other departments may recommend educational audits for new providers or programs to mitigate documentation challenges. In educational audits, most observed errors will be reported as “non-variance.” Non-variance concerns are those noted by the CBH Compliance Department as concerning that could have financial impacts as part of future audits but carry no financial impact for the current audit. Overpayment concerns are those concerns that carry an immediate financial impact to the provider. The following error types will always be considered “overpayment” and the financial impact calculated accordingly:

- Missing documentation
- Services provided by unqualified staff
- Services not rendered

In addition, when the auditor observes indication of potential fraud, the auditor will note the errors as variance and calculate the financial impact accordingly.

A probe or targeted audit may be scheduled when an educational audit identifies significant non-variance and/or overpayment 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.

Probe Audits: Smaller samples used to “take a peek” or get a sense of what is occurring in the documentation. The results of a probe audit will indicate whether additional auditing is warranted. Also, probe audits are used in educational audits and level of care reviews or “tours.”

Targeted Audits: Targeted audits are “targeted” because we are following up on a specific referral, tip, or allegation. Targeted audits usually involve a specific timeframe, claims for specific members or service types, and/or services provided by a specific staff person.

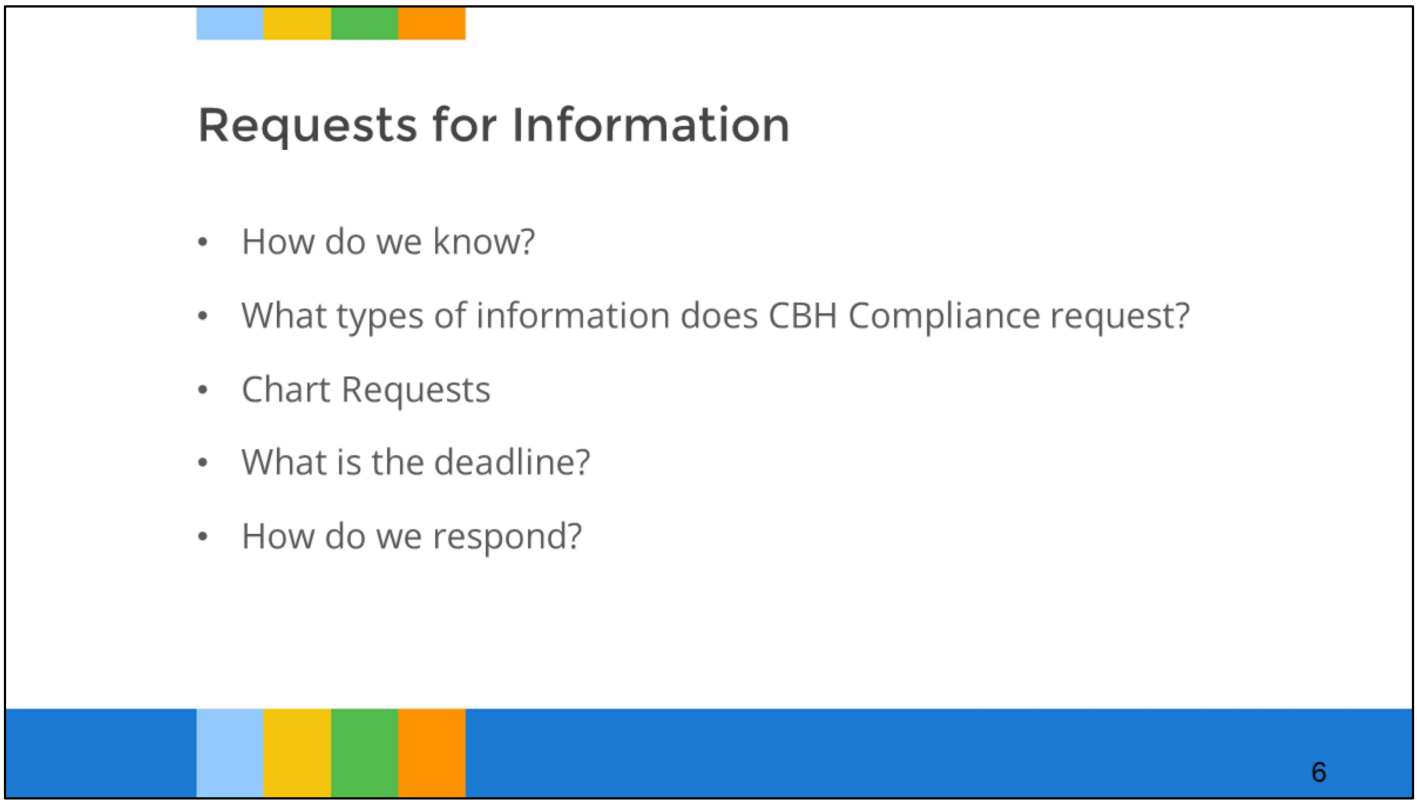
Unannounced vs. Announced: Conducting unannounced visits to review and assess potential fraud, waste, and abuse is a widely accepted practice for Special Investigation/Compliance Units across the country. In general, the notice provided will be determined, at least in part, by the type of audit being conducted; For example:

Type of Audit	***Typical Notice***
Educational	One week minimum
Probe	24-48 hours
Targeted (including extrapolation)	No notice

CBH reserves the right to amend these guidelines based on the precipitating circumstances of the review.

Unannounced 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.



Notification:
Providers will be notified of requests by email, in a letter, and/or by phone.

Types of requests:

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 time period. 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. Please note that neither CBH nor Medical Assistance will reimburse the provider for this cost.

Deadlines:
Typically, providers will have 7 days to respond to CBH Compliance requests for information.

For Chart requests, 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.

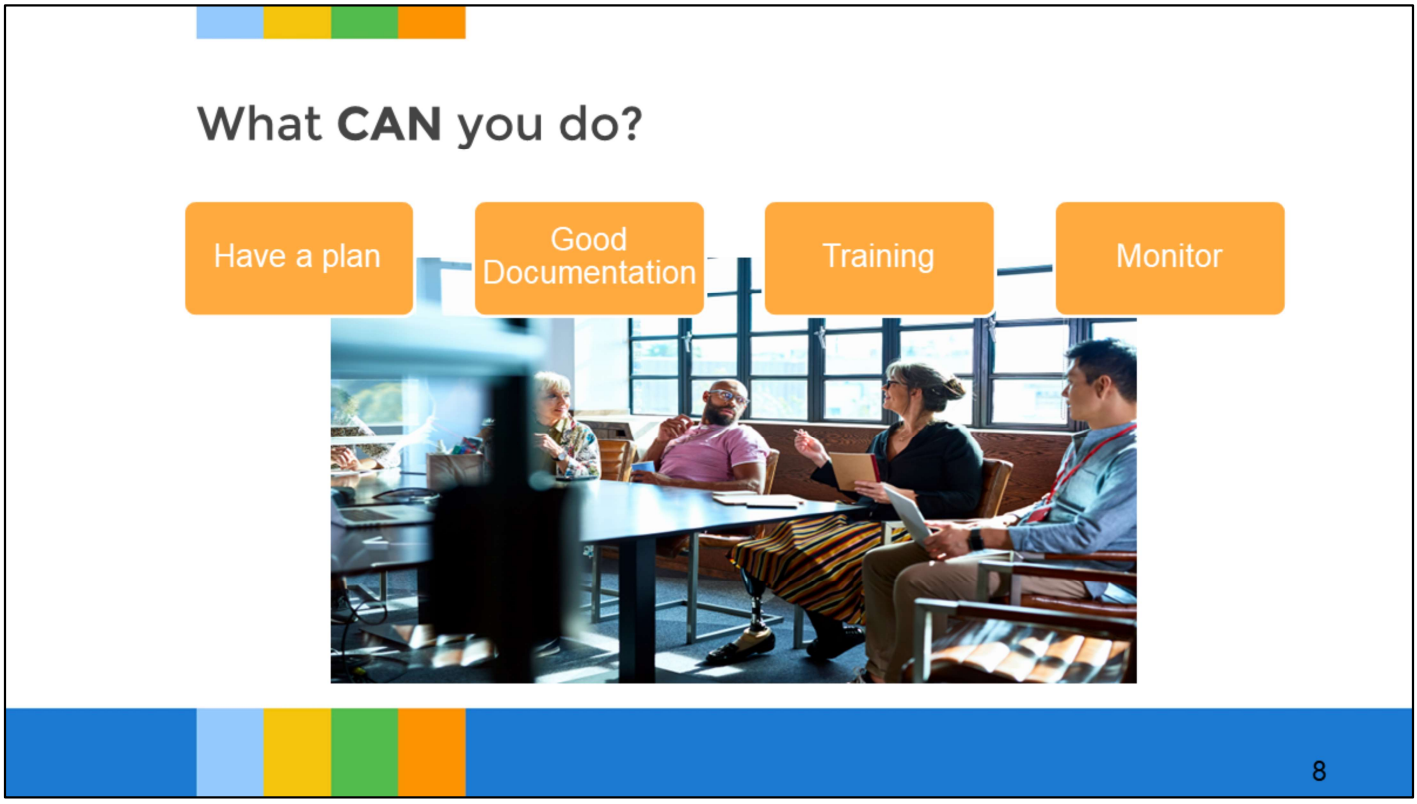
Responding to the request:
Information should be submitted to the CBH Compliance staff requesting the information. The type of information needed, deadline, method of submission, and contact information will be provided in the request. At times, CBH Compliance staff may provide a formatted template to be used for your submission.

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

Confidentiality:
For mental health services: If you have concerns about confidentiality, please refer to the PA. Mental Health Procedures Act (5100.32) concerning non-consensual release of information. (See: PA code, Title 55 Public Welfare, ch. 5100. 32, MH Procedures, nonconsensual release of information.)

For substance abuse 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. All member identifying information copied and removed will be destroyed upon completion of the audit and evaluation. Information disclosed may be disclosed only back to the program from which it was obtained and may be used only to carry out the purpose of the audit and evaluation.

How do we **prepare** for a CBH Compliance Audit?



Plan:
Earlier we discussed types of audits. Any audit, especially unannounced or audits requiring large numbers of charts, can put significant strain on medical records departments.
We encourage provider agencies to have a plan in place for the retrieval of significant numbers of charts with no prior notice, and available for review in a timely manner. These policies and procedures must also address the prompt retrieval of records that may be housed off-site.

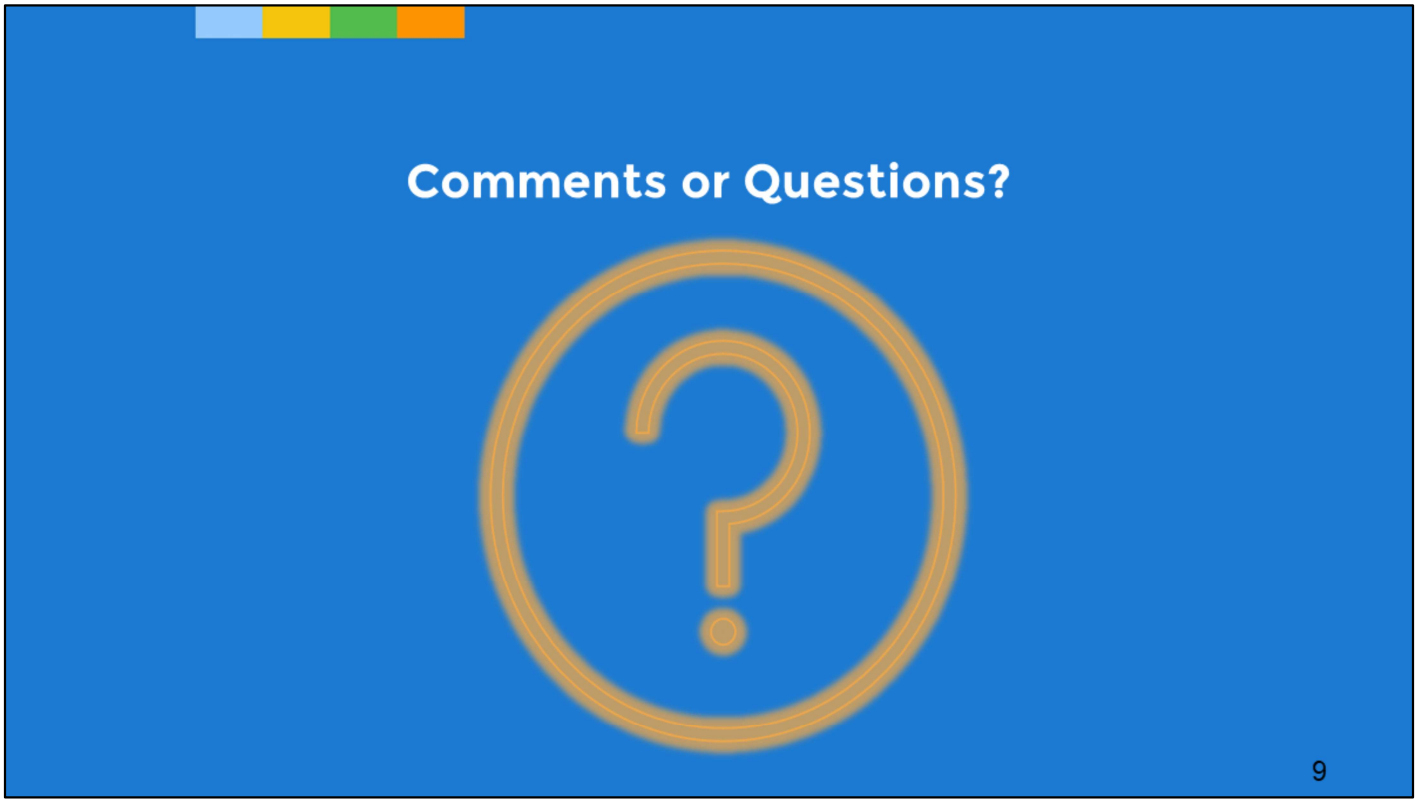
Documentation practices:
It is vital that charts are complete and easily accessible in the event of an audit but the primary reason for good documentation is to capture the care provided to our members. Good documentation ensures continuity of care.

Training:
Training is an essential aspect of a strong compliance program. Officers, employees, any third-party individuals, essentially everyone that works at a provider and/or Supports your business, needs to be informed about compliance. These individuals need to be aware of laws, regulations, and standards relevant to the services you provide, inclusive of agency policies, and what actions are barred or not allowed.

Monitoring:
Complete internal reviews of documentation, check for discrepancies, content,

interventions, copied content, missing documentation, etc. Conduct service verification with members and families. Review issues in supervision and monitor progress. Report compliance concerns & overpayments to CBH and to BPI.

These are things that providers can do to be proactive in preventing and detecting Fraud, Waste, & Abuse.



This concludes this portion of the training.

What to Expect: Audit Day

Presented by
Emily Junod, MSW, LCSW – Compliance Team Leader
Leann Hanisco, MS, CFE – Compliance Data Leader

Audit Day

Audits typically begin around 8:45am-9:00am
- analysts arrive on-site
- coordinate EMR access

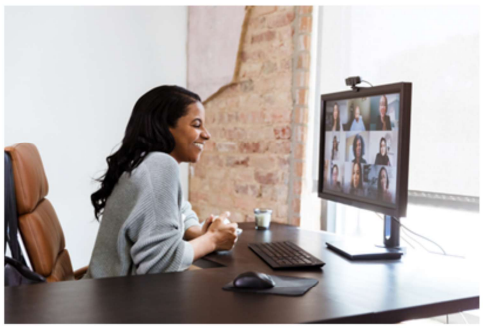
Potential Morning Meeting

Introductions

Reason for Audit

Housekeeping

Provider Contact Person



Documentation Requests

Chart Lists:

- On-site & Remote Audits

- Multi-Day Audit

For announced audits, providers must provide access to paper charts beginning no later than 9:30 AM, and for unannounced audits no later than 10:00 AM, and continue in a constant flow until all charts are presented. The audit team lead will communicate to the provider the time the last charts are required to be presented; this time will vary based on the number of charts requested.

For providers with electronic health records, access to all charts in announced audits must be available by 9:30 AM and by 10:00 AM for unannounced audits.

For announced audits, if the provider requires the chart list the day prior to the audit (i.e., to allow the provider's IT department to create auditor accounts), charts are to be made available upon Analysts' arrival at 9:00 AM.

For providers with multiple programs requiring multi-day visits, lists will be presented each morning for each program to be audited that day. The same timeframes described above are followed.

Missing Documentation

- Completed documentation should be present in chart at time claim is submitted

- Documentation much be located during the audit in presence of audit team

CBH Provider Bulletin #18-02

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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. The CBH Compliance Department has historically allowed providers to submit missing documentation as part of the provider's response to the audit. Previously, providers have had until 10:00AM of the business day after the daily on-site audit to submit progress note and treatment plan documentation listed as missing at the audit. Providers will now be required to locate the documentation during the audit in the event CBH Compliance Analysts are unable to locate documentation related to a paid claim.

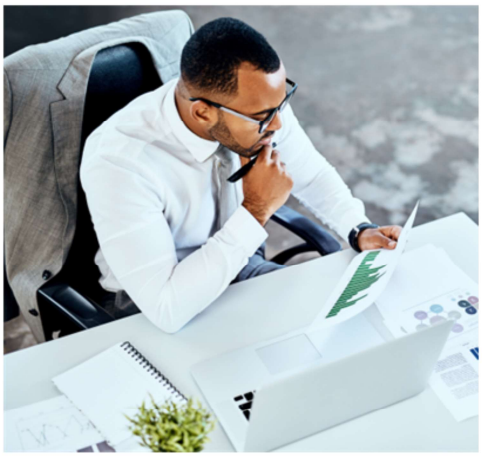
Procedure: The CBH Compliance Audit Team Lead, or designee, will communicate with the provider representative periodically throughout the audit day when an analyst is unable to locate required documentation in the record. The provider representative will be asked to review the member record in the presence of the CBH auditing team to determine if the documentation is present. Documentation not filed in the record at the time of the audit, i.e. 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.

Mid-Day Check in

Around 12:00pm providers are to check in with the Audit Leader to see how far along the analysts are in their review

Please ensure to provide a contact point-person and their contact information

Audit Findings



Three types of results:

Overpayments: Take back money for improperly paid claims (Note APA & Units)

Non-Variance: No monetary impact this audit

Additional Information: Clinical / Quality / Billing Concerns

Audit Follow-up: Self-Audit requests

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After the audit, the audit findings are compiled into the preliminary internal report which becomes the compliance report upon approval of the Compliance Committee.

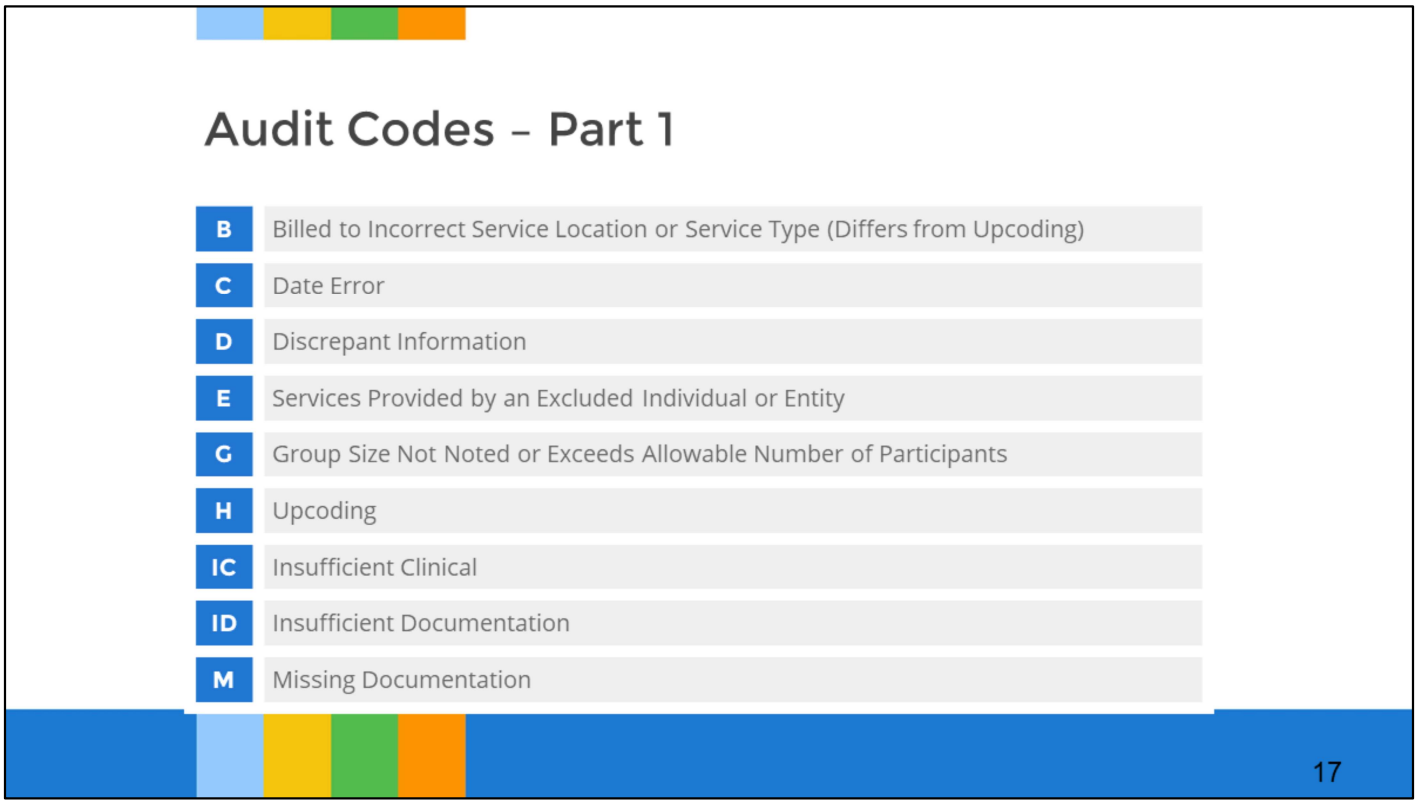
The audit results are divided into 3 categories if applicable:

The Overpayment are errors broken down by audit codes as to why a claim needs to be repaid to CBH.

Non-variance concerns are also broken down by error code but at the time of the audit does not need to be repaid to CBH. These errors are used as guidance to a provider that at a future audit these errors will need to be repaid.

There is also an Additional Information category for concerns observed during the audit that may not be related to compliance.

Audit finding may include follow up steps for a provider such as completing a self-audit.



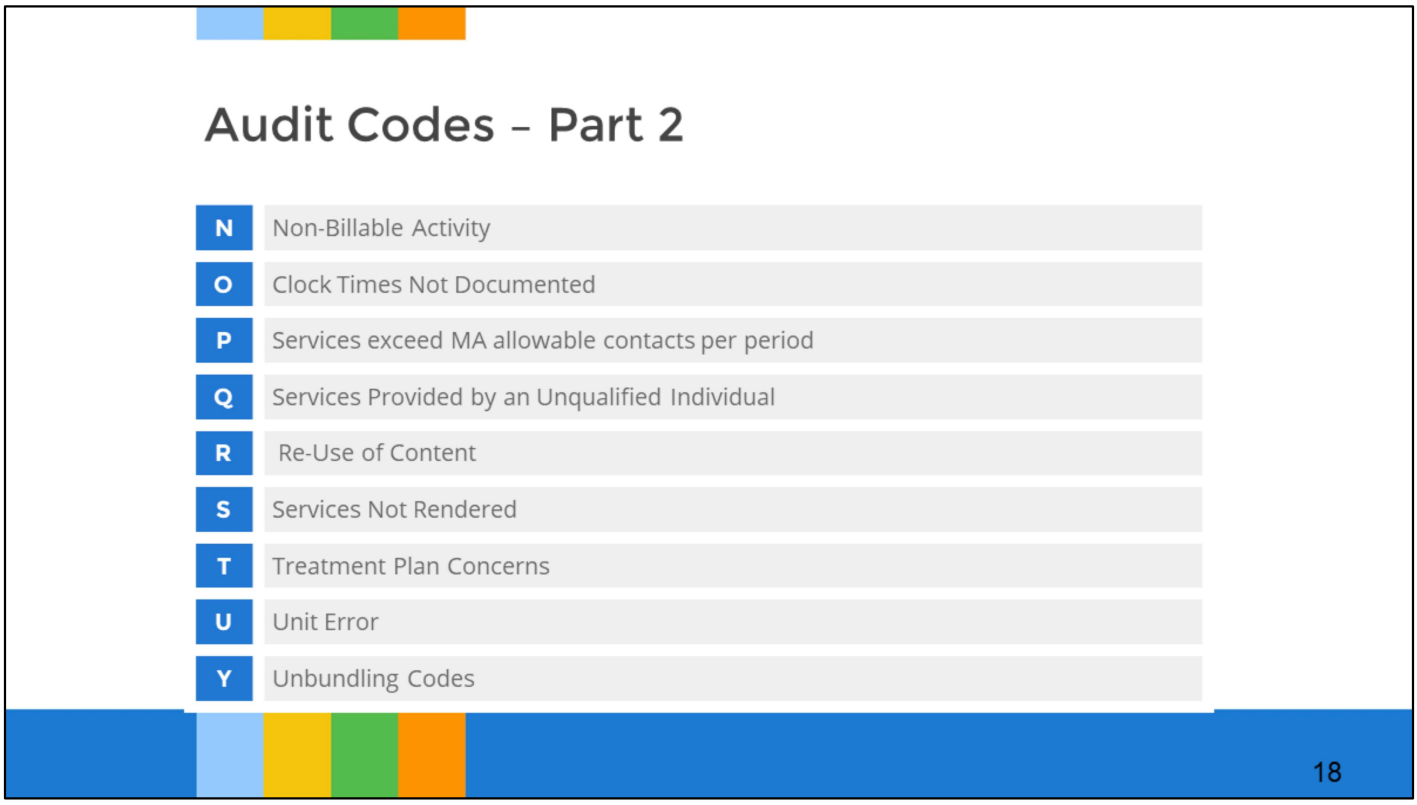
During an audit, the CBH Compliance Analysts review a provider's medical or staff record against the claim paid by or seeking payment by CBH.

If there is a problem with the documentation for the claim, it will be labeled with one or more of these error codes.
This slide and the next contain a list of codes used during an audit, this list can also be found on the CBH website. Some of the more frequent error codes include:

Insufficient Clinical -Content of the note must contain clinician interventions, client response, plan for future sessions, and must support duration of time billed. All billed dates of service must have adequate documentation that reflects the treatment rendered.

Insufficient Documentation- Documentation must contain required elements such as: date of service; client identification on each page; original non-photocopied signature; legible documentation; note must be completed, signed, and/or entered into the clinical record within seven days or before the claim was submitted to CBH, whichever occurred first; and contain all required signatures.

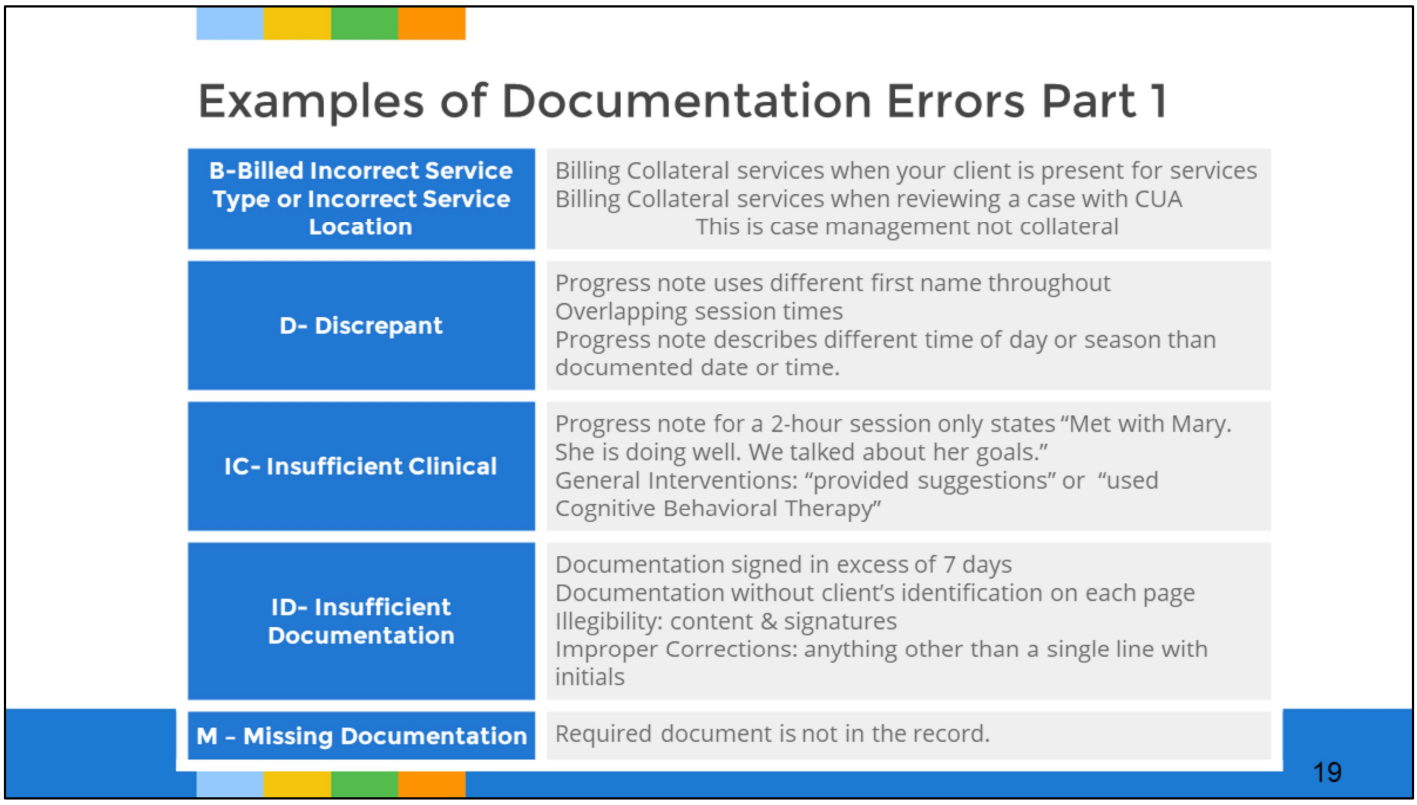
Missing documentation -The clinical record must be complete and accurate. Treatment progress notes, signed and dated by the individual providing the service, shall be completed for each service provided.



Again, some of the more frequent error codes include:

Re-use of identical content- Documentation must be original and accurately describe the individual's treatment experience for the billed service.

Treatment Plan Concerns- Treatment plans must be developed, updated, and signed by all appropriate persons as required for each level of care. Services provided shall be consistent with goals and interventions identified in the current recovery/resilience plan. The Treatment Planning guide can be found within the CBH Provider Manual.



CBH Compliance utilizes audit codes when reviewing clinical records for stated expectations. These are examples of typical errors observed during audits.

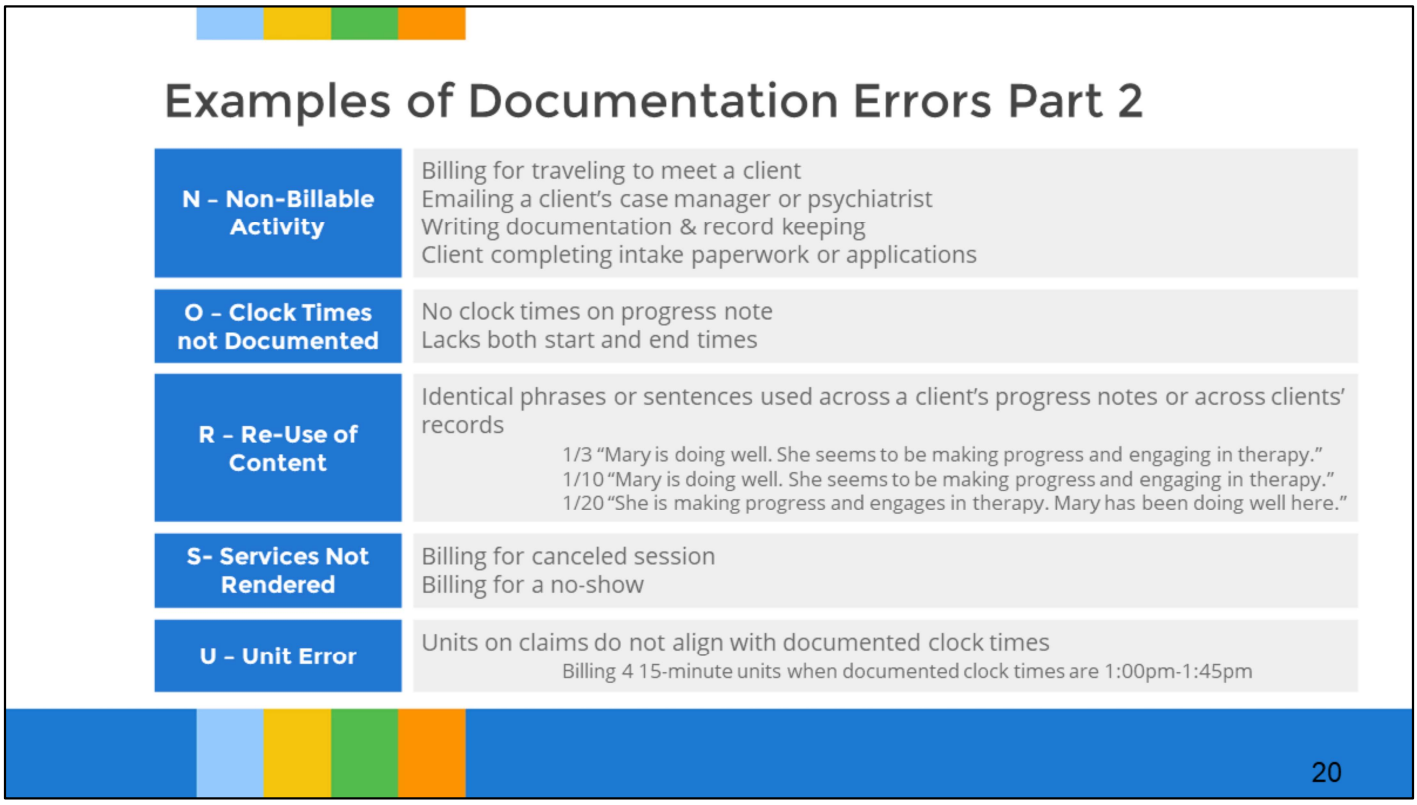
Audit code B for Billed Incorrect Service Type or Incorrect Service Location. Billing Collateral services when your client is present for those services; or Billing Collateral services when conducting a case review with CUA. This is case management not collateral services.

Audit code D for Discrepant. Progress note uses a different first name than the client's name; overlapping session times; or progress note describes different time of day or season than documented date or time.

Audit code IC for Insufficient Clinical. Progress note for a 2-hour session only states "Met with Mary. She is doing well. We talked about her goals." Or progress notes lists general interventions "provided suggestions" or "used Cognitive Behavioral Therapy"

Audit code ID for Insufficient Documentation. Documentation signed in excess of 7 days, documentation without the client's identification on each page, illegible content and or signatures as documentation, or improper corrections of documentation which is any correction other than a single line through the error with staff initials.

Audit code M for Missing Documentation. Record does not contain required documentation for claim paid by or seeking payment by CBH.



Audit code N for Non-Billable Activity. Billing for traveling to meet a client, emailing a client's case manager or psychiatrist, writing documentation or record keeping activities, or a client completing intake paperwork or applications in session.

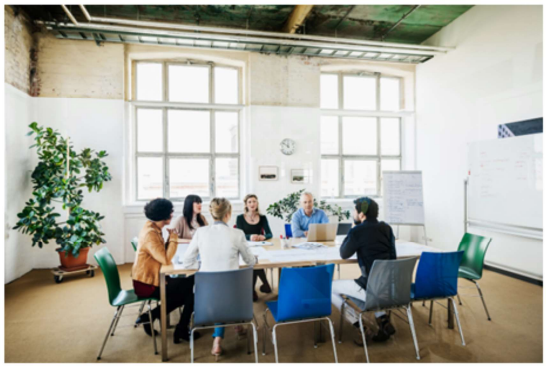
Audit code O for Clock Times not Documented. Clock times not present on progress note or progress note lacking both start and end times.

Audit code R for Re-Use of Content. Identical phrases or sentences used across a client's progress notes or across clients' records. For example on 1/3 "Mary is doing well. She seems to be making progress and engaging in therapy." 1/10 "Mary is doing well. She seems to be making progress and engaging in therapy." 1/20 "She is making progress and engages in therapy. Mary has been doing well here."

Audit code S for Services Not Rendered. Billing for a canceled session or for a session when the client is a no-show.

Audit code U for Unit Error. Units on claims do not align with documented clock times. For example billing 4 15-minute units when documented clock times are 1:00pm-1:45pm

Potential Exit Meeting



- For in-person and virtual audits, an exit meeting may take place. It is then that we go over any results we may have found
- For desk audits, an exit meeting may be requested by either the provider or Audit Leader. This does not always occur but can if it is necessary
- It is here that the Audit Leader will usually describe the process moving forward (timeframe for report & opportunity for response). The next section will detail this process

Comments or Questions?

What to Expect: Post-Audit

Presented By:

Aadam Muhammad, MPH, MSW, LSW - Operations Specialist
Malakeyla Reynolds, M.Ed., CHC - Compliance Supervisor

Overview

The purpose of this presentation is to provide clarity on the processes of the CBH Compliance Department after an audit has been completed at your organization.

This presentation will review:

1. Audit Related Correspondences & Communications
2. Compliance Audit Documents
3. Submitting a Response to a Compliance Audit's Findings
4. Resolution of Audits
5. Overpayment Recovery Process
6. Questions & Closing Remarks

Compliance Audit Correspondence

- Correspondence containing Audit Documentation is now sent to Providers via the Box Application.
- A CBH Provider Notice issued March 18, 2022, contains directions for CBH Providers to use Box: https://cbhphilly.org/wp-content/uploads/2022/03/CBH_Provider-Notice_Box-App_2022-03-18.pdf
- Recipients of Audit Documentation is defaulted to Executive Staff (e.g., CEO, Executive Director), unless otherwise identified by the Provider.
- To Update Audit Documentation Recipients – A Formal Request must be Submitted by Executive Staff in writing to your Designated Provider Relations Representative.

Audit Documentation

The following documents are generally included in Audit Correspondences:

- Audit Results Letter
- Audit Compliance Report
- Audit Attachment
- *Self-Audit Resolution Letter

Note: *Self-Audit Correspondences will not contain an Audit Attachment, Results Letter, or Compliance Report, as the Provider has self-reported the impacted claims.

There may be additional documentation included with the audit findings, as relevant to the audit scope.

Audit Results Letter

The Audit Results Letter will Contain Summary Information Including:

- Date of Audit
- Program(s) Audited
- Error Rate(s), & Identified Overpayment(s)
- Deadline to Respond if Disputing Audit Findings (**21 Calendar Days**)
- A Meeting may be Requested with Compliance to Review the Audit.
- Responses are Submitted to the CBH Compliance Operations Specialist
- *When Applicable*: Requests for Self-Audit
- *When Possible:* Notification that a Referral has been made to the Pennsylvania Bureau of Program Integrity (BPI) & Office of the Attorney General (OAG)

C·B·H
Community Behavioral Health

Month Day, 202X

NAME OF ED/CEO
TITLE
NAME OF PROVIDER
STREET ADDRESS OF PROVIDER
CITY, STATE, ZIP

Dear Mr./Ms.:

On (Month Day, 202_), CBH Compliance Analyst audited # clinical records for the following program(s) and compared them to payments CBH made to your agency:

Program	Type of Program	Error Rate
		XX.XX%

CBH Compliance has identified billing problems that are summarized in Attachment A. Please see the corresponding Compliance Report for specific details.

The total financial impact for the billing issues is $XX. XX. As a result, CBH will initiate and process claims adjustments for unsubstantiated services on Month Day, 202_. You have until this date to refute the findings by submitting an encrypted email containing a written response and any supporting documents to Compliance Operations Specialist, Aadam Muhammad at aadam.muhammad@Phila.Gov (reference Case #X_-2022).

All information pertaining to the compliance audit identified in this letter, including the total financial impact, has been reviewed and agreed upon by the CBH Compliance Committee.

Sincerely,

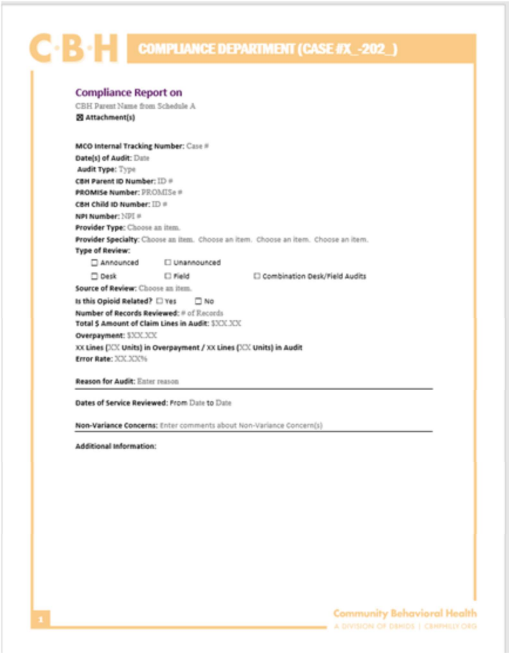
Kenneth Inness, MA, AHFI, CFE, CHC
Senior Director of Compliance & Compliance Officer

Community Behavioral Health
801 Market Street, 7th Floor | Philadelphia, PA 19107
Phone: 215-413-3100 | Fax: 215-413-3280 | www.cbhphilly.org
A division of the Department of Behavioral Health and Intellectual disAbility Services

Audit Compliance Report

The Audit Compliance Report will Contain Information Including:

- Why the Audit was Conducted
- Results of the Audit in Narrative Form
- Types of Services Reviewed/Levels of Care
- Compliance Issue(s) Observed
- Detailed Examples of Observed Errors
- Additional Information on Compliance Issue(s) not in Audit Scope which could become Overpayment Concerns in Future Audits



C·B·H COMPLIANCE DEPARTMENT (CASE #X_-202_)

Compliance Report on
CBH Parent Name from Schedule A
☒ **Attachment(s)**

MCO Internal Tracking Number: Case #
Date(s) of Audit: Date
Audit Type: Type
CBH Parent ID Number: ID #
PROMISe Number: PROMISe #
CBH Child ID Number: ID #
NPI Number: NPI #
Provider Type: Choose an item.
Provider Specialty: Choose an item. Choose an item. Choose an item. Choose an item.
Type of Review:
☐ Announced ☐ Unannounced
☐ Desk ☐ Field ☐ Combination Desk/Field Audits
Source of Review: Choose an item.
Is this Opioid Related? ☐ Yes ☐ No
Number of Records Reviewed: # of Records
Total $ Amount of Claim Lines in Audit: $XX.XX
Overpayment: $XX.XX
XX Lines (XX Units) in Overpayment / XX Lines (XX Units) in Audit
Error Rate: XX.XX%

Reason for Audit: Enter reason

Dates of Service Reviewed: From Date to Date

Non-Variance Concerns: Enter comments about Non-Variance Concern(s)

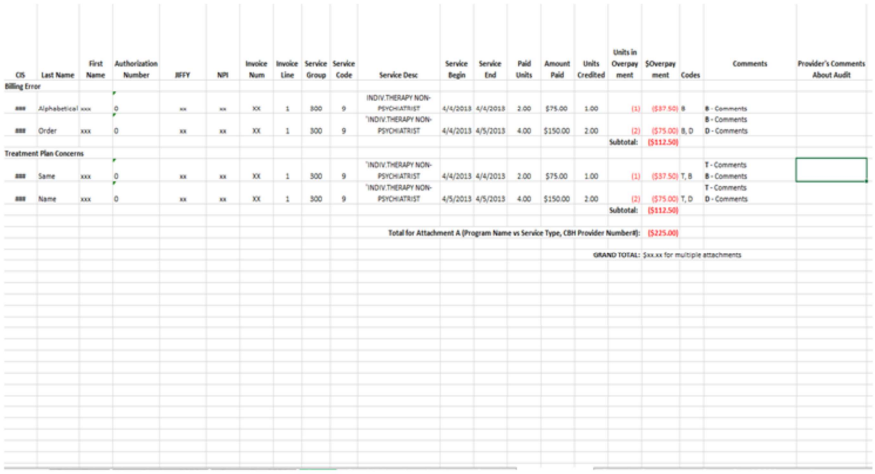
Additional Information:

1 Community Behavioral Health

Audit Attachment

The Audit Attachment Spreadsheet will Contain:

- Itemized Line-by-Line Detail of Claims Reviewed
- Compliance Error Codes with Comments
- Overpayment(s) and Unit(s) in Error
- Column for Provider Response to Dispute Findings by Claim
- Attachments may have Multiple Tabs
- You will only receive an Attachment if Compliance Issues were identified



CIS	Last Name	First Name	Authorization Number	JIFFY	NPI	Invoice Num	Invoice Line	Service Group	Service Code	Service Desc	Service Begin	Service End	Paid Units	Amount Paid	Units Credited	Units in Overpayment	$Overpayment	Codes	Comments	Provider's Comments About Audit
Billing Error																				
###	Alphabetical	xxx	0	xx	xx	XX	1	300	9	INDIV.THERAPY NON-PSYCHIATRIST	4/4/2013	4/4/2013	2.00	$75.00	1.00	(1)	($37.50)	B	B - Comments	
###	Order	xxx	0	xx	xx	XX	1	300	9	INDIV.THERAPY NON-PSYCHIATRIST	4/4/2013	4/5/2013	4.00	$150.00	2.00	(2)	($75.00)	B, D	B - Comments D - Comments	
															Subtotal:		($112.50)			
Treatment Plan Concerns																				
###	Same	xxx	0	xx	xx	XX	1	300	9	INDIV.THERAPY NON-PSYCHIATRIST	4/4/2013	4/4/2013	2.00	$75.00	1.00	(1)	($37.50)	T, B	T - Comments B - Comments	
###	Name	xxx	0	xx	xx	XX	1	300	9	INDIV.THERAPY NON-PSYCHIATRIST	4/5/2013	4/5/2013	4.00	$150.00	2.00	(2)	($75.00)	T, D	T - Comments D - Comments	
															Subtotal:		($112.50)			
										Total for Attachment A (Program Name vs Service Type, CBH Provider Number#):							($225.00)			
										GRAND TOTAL: $xx.xx for multiple attachments										

Self-Audit Resolution Letter

Self-Audit Resolution Letters:

- Summarizes the Provider's Self-Audit Review
- Lists Final Overpayment Information
- When Possible: Notify if a Referral has been made to the Pennsylvania Bureau of Program Integrity (BPI) & the Office of the Attorney General (OAG)
- No Appeals for Self-Audits

Submitting a Response to a Compliance Audit's Findings

- Responses must be submitted by the deadline stated in the Audit Results Letter (**21 Calendar Days**)
- Use Column for Provider Response to Dispute Findings by Claim*
- Must Submit Attachment When Disputing Findings
- Unless previously submitted, Supporting Documentation should be included with your Dispute to Substantiate Disputed Claim(s)
- Response will be reviewed by a member of the Compliance Department who was not involved in the initial review

*Note: There are certain Error Codes can not be disputed.

Resolution of Audits

CBH Compliance Audits are considered "Resolved" under the following conditions:

Self-Audits: Upon Receiving the Self-Audit Resolution Letter

For All Other Audits:

- If No Response was Received in Dispute to the Audit Findings by the Listed Date in the Results Letter, an Audit Resolution Letter will be Sent to the Provider advising that no Response was Received
- If a Provider Disputed the Audit Findings, CBH Compliance will review the Response and inform the Provider of the Outcome along with the final overpayment amount in an Audit Resolution Letter
- If No Compliance Issues were Identified

Once an Audit is considered Resolved, any identified overpayment(s) are considered **final**.

Overpayment Recovery Process

- Resolved Audits are Forwarded to the CBH Finance Department for Processing and Recoupment via Claims Adjustments
- Audit Overpayment Recoupments are Reflected on Payment Statements issued to Providers by CBH
- In the event Claims Adjustments are not possible, the CBH Compliance & Finance Departments will arrange an alternative method to recoup the overpayment(s).

CBH Compliance Offers two Payment Plan Options for Providers Experiencing Financial Hardship:

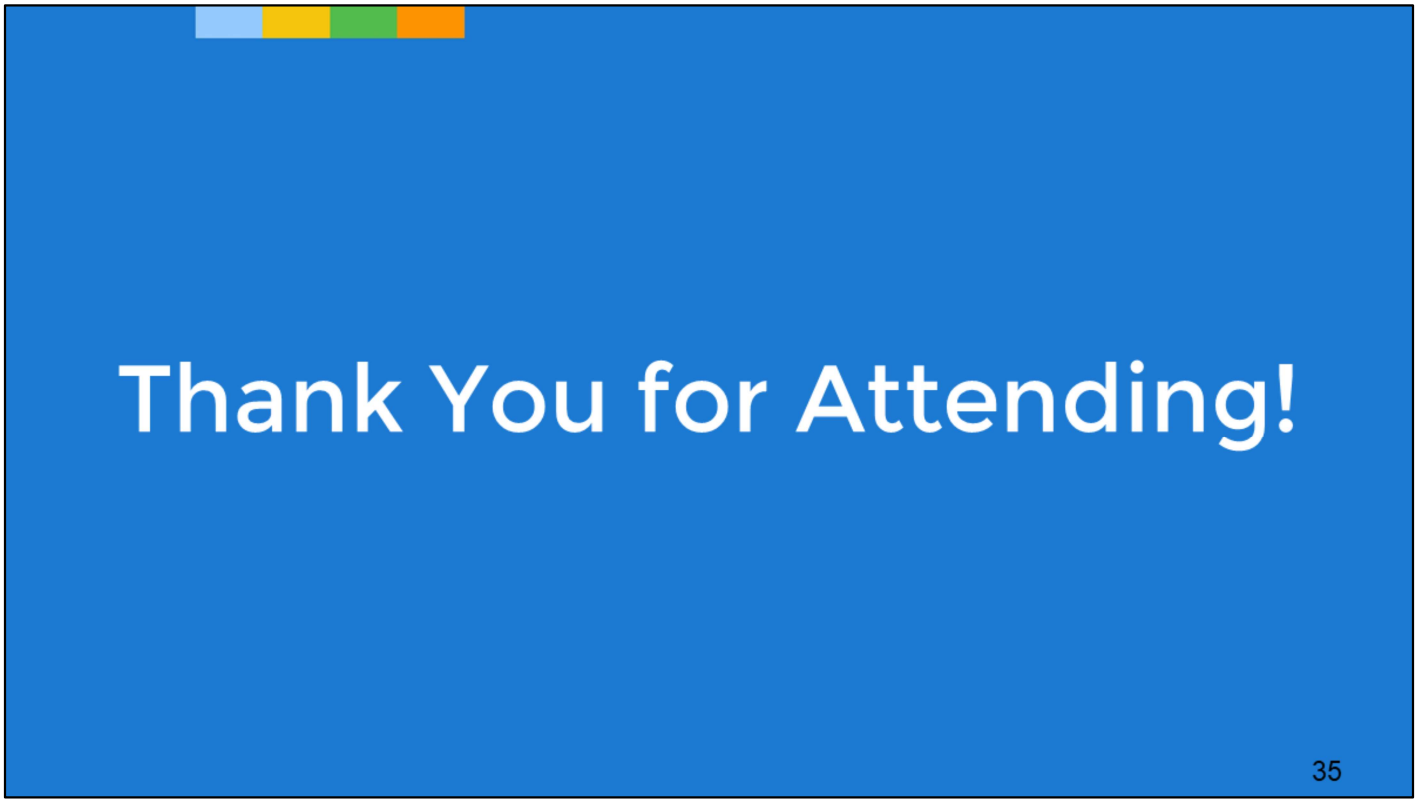
- **Standard 20% Weekly Plan** – Weekly Deductions of 20% of Paid Claims until the Overpayment has been recouped in full.
- **Custom Payment Arrangement** – The Provider proposes a Custom Payment Amount and Schedule to pay the Overpayment in full by no later than one calendar year.

For Payment Arrangements, CBH Compliance may request additional Financial Documents for review, including but not limited to: Pay Statements & Tax Forms, and is subject to approval by the CBH Compliance Committee.

Questions?

If there are any additional questions, you may contact the CBH Compliance Department Directly at the following Email Address:

CBH.ComplianceContact@Phila.Gov


Thank You for Attending!
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