Session I: 2023 Compliance Forum Opening

1. **What does SCCE stand for?**

   Society of Corporate Compliance and Ethics

2. **Can you put the 1-pager links into the chat so we can access them sooner?**

   - CMS's Common Types of Health Care Fraud
   - Office of Attorney General of the Commonwealth of Pennsylvania's Medicaid Fraud Control Section Pamphlet

3. **Would the Attorney General (AG) also include Medicaid recipient fraud (suspected)?**

   Straight recipient fraud is investigated by the Office of Inspector General (OIG). Federal regulations require recipient and provider fraud investigations to be conducted by separate agencies. The State's Attorney General (AG) Office occasionally charges recipients if they are involved/conspiring with the provider to commit fraud. There have also been instances where recipients have taken the provider's identity. In those situations, no provider is involved; the provider is the victim. Any complaints to DHS get funneled to the correct place, and if they go to the wrong office, the Inspector General and Attorney General's Offices transfer them to the right place. CBH makes dual referrals to the Bureau of Program Integrity (BPI) and OIG for recipient fraud.

4. **When we submit digital copies of files to audit teams, is there a finite time that auditors are given access? Our audits used to last 1-3 days. The last one in 2021 seemed more open-ended.**

   If access is granted remotely to charts, CBH Compliance expects that, yes, it is a finite time with rare exceptions. The day access is requested is when the analyst sets aside to conduct the audit. The 1- to 3-day window is reasonable unless it is a more extensive audit, but the team lead on our end should be communicating if a longer time is needed. Access should not be open-ended. We are doing more desk audits and will probably continue to do so after COVID. It is more cost-effective as we are not spending taxpayer money on travel to come out and see providers. We will do more if it is possible to tap into electronic medical records (EMRs) remotely or have files submitted. We are working to make those audits feel more like an in-person audit.

Session II: How to Catch a Fraudster

1. **We use work attestations to assess the risk of overlap for multiple providers. Any tips on how to use this info?**

   CBH also does this through the staff roster and assumes some responsibility for the provider network. It's an excellent first step, particularly if they are forthcoming and say, "I work 40 hours at provider X," when they work 40 hours for you and then may have another part-time job you

hear about. You can start to piece it together; is that likely? Even if it's accurate, it leads to concerns about the individual burning out, taking on too much, or if there is a stressor. A stressor where they haven't committed fraud but stress that they need to work three jobs to make ends meet, and if that causes problems down the road, just as a stress level. It's a good way of seeing who needs extra attention, not necessarily negative attention, but just attention. It is a good way if you have a lot of people. For example, CBH has a conflict of interest form where you must report any outside income. One of the things CBH looks at internally is if any department has many different jobs that don't look like passion projects. They don't look like jobs to fulfill a particular interest but are to make ends meet. If so, does that mean we must pay that department more, or are we paying a living wage? It's a significant first step. The utility is a little less as you won't have access to go out to the other providers to ensure there aren't overlapping clock times or dates of service.

2. **For case management services, how should providers differentiate between audio-only telehealth services and those billable telephone calls that were allowed before the expansion of telehealth? Does staff need to get encounter forms for the case management telephone calls that were allowed pre-covid?**

   Per the CBH Claims Department, visual telehealth services are billed as standard without requiring a unique code or modifier. For audio-only telehealth, the submission should include the FQ modifier. When members participate from home, use POS 10; for participation outside their home, submit with POS 02.

3. **Would the place of service codes be the differentiation?**

   Per the CBH Claims Department, when billing for telehealth, POS is determined by where the member participates, POS 10 is used when the member is at home, and POS 02 is used when the member participates anywhere outside the home. They should not be using any other POS for telehealth.

4. **Can providers perform telehealth from their homes?**

   Yes. Either the member or the provider can be in the home setting. The Place of Service code would need to designate where the service was delivered via telehealth.

5. **Can you repeat the name of the statute?**

   62 P.S. §1407 Provider prohibited acts, criminal penalties, and civil remedies

6. **Could you also briefly comment on civil fraud cases under CMP law?**

   Most states have Medicaid Fraud Control Sections and have a civil component looking at false claims. PA is one of potentially seven that do not have civil authority. Any civil authority lies with the Department of Human Services in PA. The more extensive civil fraud cases go to the Department of Health & Human Services (HHS) and the US Attorney, so those cases go federally. It is a lesser burden in a civil case. However, that's where it may come to some of you—the

providers—to turn a blind eye. A criminal case may not be for turning a blind eye, but civil liability may exist. A statute has been pending in various forms since the 1990s for a Pennsylvania False Claims Statute. So, civil false claims cases are handled by one of Pennsylvania's three US Attorney's offices.

7. **I don't know if you can speak to this, but hasn't CMS been much more vocal about citing and punishment for errors or not acting on information that you should have known?**

   Yes, they are looking at those things. There are regulatory and civil violations. Pennsylvania's Attorney General only looks at criminal fraud. The CBH Provider Agreement says that if you determine that a claim is inaccurate for any reason, it needs to be backed out. From a criminal aspect, it is different because it takes away people's livelihoods and potential for their liberty. And there are a lot of serious consequences with that.

   There are still civil and regulatory ramifications to providing any false information. We all make mistakes, so if an error is made, and you find out there's a mistake, document it. Notify whoever needs to be notified of that mistake, document it, and document it at the time of what you did.

   The Yates Memo is now several years old. Over the last several years, I have heard that the Federal Government, particularly in enforcing false claims act cases that may involve treble damages and monetary penalties, is more interested in figuring out if you are a provider who had an effective compliance plan and you caught it. The intent is to clean up the system by going after what they call the bad actor and getting the exclusion. The exclusion keeps that person from reentering and billing the network or the federal system again. So, in that case, having a compliance plan is essential. Have your compliance plan be placed, be effective, and report it when you find it. Do not just take care of the individual alone; do not report it. You can't clean up the system until you exclude those who have nefarious reasons for doing it.

8. **Is POS where the member or provider is?**

   The place of service is where the member is located. OMHSAS Bulletin 21-09 says, "The originating site is the setting at which an individual receives behavioral health services using telehealth delivery."

9. **What is the best practice for signing encounter forms when telehealth is used?**

   The best practice is one that you can implement and that is effective. Be cognizant, saying all other things are equal, and you have an unlimited funding source. You would get an electronic capture system where the member can access it remotely. There is a substantial upfront cost for implementing and supporting it moving forward. It may not be an option for smaller providers, or even large providers, who are working on a smaller profit margin. It is whatever you can put in place that's effective. OMHSAS's **March 30, 2023 memo regarding interim telehealth guidance** leaves you with an audit trail where you can definitively say, "Yes, that person signed that encounter form, and here's how I know."

Elizabeth Madigan from Pennsylvania's Attorney General's office mentioned many documents to sign for the US. Attorney's office for the Federal Government for certain State aspects, and a program within Adobe exists. I have a password in this program, and when I put in my signature, it timestamps and authenticates my signature each time. So that might be an option as the Adobe system might be a little bit less expensive than some of these others where you're just putting a signature on a PDF. It gives you a timestamp of when that person signed it. It also can't be altered later, so I can't change the document or reuse that signature.

That's probably relatively low cost, and things like DocuSign are probably low cost. I don't know if they meet the HIPAA security requirements. That would be something you would want to look into as an agency. For example, CBH Compliance has DocuSign for non-PHI documents. The little per envelope charges that they charge don't seem like a lot at first, but they add up very quickly. It's going to depend on your situation.

10. **I heard CMS wants the provider's address listed for credentialing if providing services from home. Will this take effect in 2024?**

I'm not. I'm not sure; I'm not aware of it.

11. **Is compliance mandatory for MA providers (under ACA)?**

If you are a contracted CBH Provider, under our provider agreement, it is required. I am unsure whether the Federal Government strongly suggests or requires that I can remember.

Outlined by provisions in the Patient Protection and Affordable Care Act 42 U.S.C. § 18001 (2010)

Section 6401 of the Patient Protection and Affordable Care Act states that all providers "of medical or other items or services" shall establish a compliance program as a condition of enrollment in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Session III: Compliance Plans

1. **Can the links be placed in the chat?**

   - **CBH Provider Manual**
   - **Office of Inspector General (OIG) and Department of Health & Human Services (HHS) General Compliance Program Guidance**

2. **When will agencies receive feedback on their plan and the scoring rubric used by CBH?**

CBH Compliance is reporting out quarterly to the CBH Compliance Committee. It is aggregate-level data that was presented earlier in the presentation. We don't anticipate sending something back to providers regarding the individual results unless requested. It was not a qualitative look. For example, we are not looking deep into the plans to say your committee minutes or structure

could be done differently. It was not that kind of review this time around. We were looking for the plans to be in place for our provider community and that they are touching on it. Our feedback would go to providers who did not respond, leading CBH to believe there was no compliance plan. Our feedback would also go to providers whose plans did not include all or most of the seven elements. CBH Compliance can revisit providing individual feedback. However, that was not the scope of the review this time.

3. **Did I understand correctly that Compliance Officers should report directly to the COE or the Board? Is it acceptable for a Compliance Officer to report directly to the COO?**

   The link on the slide to the **HHS OIG General Compliance Program Guidance** strongly suggests that the Compliance Officer report directly to the CEO or the Board. It is common for the Compliance Officer to report through General Counsel offices, for example, or through the Operations/ Chief Operations Officer less commonly. If you are going to do that, there is some inherent risk of potential conflict. The General Counsel's job is to protect the organization, whereas the Compliance Officer's job may sometimes contradict that. The Chief Operations Officer may be at odds with the Compliance Officer's position at times, as the Chief Operations Officer's job is to ensure things run smoothly. If you are going to do that, there needs to be a clear dotted line so the Compliance Officer can report directly to the Board. You want to make sure that person is in a position to feel comfortable reporting directly to the Board and that there is a mechanism to do so. If the Board meets quarterly, ensure they have time set aside, not just a few minutes, but sufficient time to report concerns. The Board should be taking that responsibility themselves as well.

Session IV: Fraud, Waste, and Abuse

1. **Can the compliance officer be the CEO?**

   It can be a potential conflict.

2. **For self-audit, do you have a template for me to use, and can you add the link for the tools?**

   The template is titled Provider Self-Auditing form and can be found on the CBH webpage for **Oversight and Monitoring Audit Tools**. That site also includes the 2018 forum self-audit presentation.

   There is also the Claims Overpayment Spreadsheet. That form is to report claims information, but it may be difficult for providers to fully complete, such as invoice number or invoice line. If a provider does not know all the requested information, they can fill it out to the best of their ability or request a paid claims report from CBH Compliance. The provider could then review the paid claims report to identify which claims are part of the self-audit overpayment. It may take a little back and forth, but requesting a paid claims report may be an easier option for providers.

   You don't necessarily have to fill out claim adjustment forms if they are compliance-related. If you need to check beforehand, let CBH Compliance and Claims know. Both departments work together to help determine when it is compliance-related.

3. **What are the specific regulations governing the work of independent practitioners and small group practices? So much of CBH's manual content and compliance regulations seem to have been written for outpatient psychiatric practices. Group and independent practitioners seem almost to be an afterthought.**

   It is certainly not an afterthought, but we can understand the feeling. Historically, CBH has felt different than our peers as our system is clinic and facility-heavy. Provider Operations has tried to address this by bringing in more independent practitioners and group practices in recent years. Unfortunately, the level of guidance has not kept up with that effort. There is an Independent Practitioner Documentation Guideline on the CBH webpage: Independent Practitioner Guidelines are section 5.18.10. of the **CBH Provider Manual**.

   The Independent Practitioner Guidelines 2020 Forum presentation can be found on the CBH webpage for **Oversight and Monitoring Audit Tools**.

   The difference between independent practitioners and group practices is that we typically ask them if they are providing services like an outpatient clinic, and we ask them to operate like an outpatient clinic regarding treatment plan rules and documentation requirements. This should be reinforced in the Independent Practitioner Documentation Guidelines. There is no regulatory backing, so the regulations for independent practitioners and group practices fall to the general documentation guidelines. Where records are required to have member identifiers on each page, they must be legible.

   The credentialing process for independent practitioners and group practices differs, but Mark's team does an excellent job explaining the difference and keeping the CBH Provider Manual updated. Independent practitioners and group practices have to be first before they can be paid in the system and before they can be contracted. We use the Council for Affordable Quality Healthcare (CAQH) to help with primary source verification. It all goes through the Chief Medical Officer (CMO), Credentialing Committee, or both for the sign-off. Let us know if there are specific areas of guidance that the Independent Practitioners Guidelines do not cover, and we can put something together. We want to do anything to encourage more independent practitioners in our network. Hence, our members have various kinds of feels of providers they can go to.

4. **Can you share the regulations for the use of CRNPs in outpatient and inpatient services?**

   » **CBH Provider Bulletin 21-16: Certified Registered Nurse Practitioner (CRNP) Requirements for Psychiatric Outpatient Services**

5. **What are the proportions of independent practitioners and group practices compared to outpatient psychiatric facilities?**

   It feels minimal, as many of our group practices are consult-driven. Our member services department could not direct someone to these for outpatient treatment as these practices conduct inpatient consultations.

6. **Thank you for the CRNP outpatient guidance. Is there any guidance for inpatient locations?**

Not at this time. CBH Compliance does not have specific guidance for inpatients. From a utilization review standpoint, for continued stay, a mental status from a psychiatrist is required. We are looking for daily contact with a psychiatrist for acute inpatient, but CRNP could run other groups or provide other services.

7. **Is there a time standard for supervisor co-signatures on Treatment Plans and Biopsychosocial completed by unlicensed staff?**

   For the CBE-MD & NON-MD, the requirement for co-signature if it's a psychologist, the licensed staff has to do all of it. The co-signature is the person assuming responsibility for it, so the timeframe would be for the CBE NON-MD licensed person to finish it. For other things that the licensed staff person might not be needed for the services to be billable, I don't think there is a timeframe. We ask that the note be completed within seven days or by the time the claim is dropped. So, if you don't consider a note complete until the supervisor reviews it, it would fall under that seven days or claim drop.

   See the **CBH Treatment Planning Guide** for more information.

8. **What are you most excited about from all the developments over the last two years?**

   I am most excited about value-based and the transition to that. It feels like it only happens in Pennsylvania, as it doesn't seem like anyone else is talking about it during webinars or conferences. However, AI can potentially cause some serious compliance problems for CBH and providers, but we're only scratching the surface. Another exciting development is the increase in data analytics.