Provider Relations

Provider Relations currently is the public relations arm, for providers, of the Provider Operations Department. Provider Relations consists of a group of Provider Relations Representatives. Provider Relations also works very closely with the CBH Claims Department, Member Services, and the other units within Provider Operations.

Provider Relations Representative are a resource for providers. The Provider Relations Representatives are available to provide information to the providers and the DBHIDS about levels of care offered, locations, provider leadership, billing history, claims issues, patterns of quality concerns, provider contact information, and contract status. In addition, the Provider Relations Representative are the conduit of information for the provider as they attempt to navigate the Department of Behavioral Health (DBHIDS). As a result, they are often called upon the provider to answer questions by clinical management, claims, finance, or network development.

In general, providers will direct any question that falls outside their normal practice (i.e. concurrent reviews for billers, claims submissions for clinicians) to the Provider Relations Representatives.

Provider Relations interacts with the different departments as follows:

CLINICAL CARE MANAGEMENT

The most common interaction between the two departments involve the out-of-network (OON) process. Once the necessary information for an OON provider has been entered into the CBH computer system, the Provider Relations Representative may ask on behalf of the provider for the authorization number in order to process payment. They may also require further clarification, from a Clinical Care Manager, regarding the authorization of services. For clinical meetings, the Provider Relations Representative is present in order to stay on top of issues that affect the provider, but also to address any claims/payment questions that may arise.

CLAIMS

Provider Relations is in nearly constant contact with the Claims Department to assist in resolving claims issues related to payment. Additionally, they offer claims trainings for providers to ensure that all information is relayed.

OPERATIONS SUPPORT SERVICES (OSS)

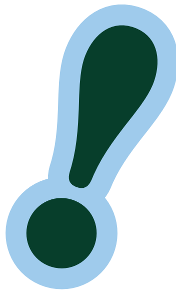
Provider Relations will contact OSS if a provider is having difficulty around case open request or requests for authorizations. There is also an expectation that OSS may bring issues involving providers' submissions of the same to our attention, particularly if clinical care management is not active in the management of the service (i.e. outpatient).

INFORMATION SERVICES

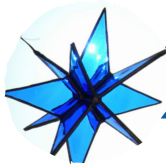
Provider Relations is the conduit.

INTAKE/MEMBER SERVICES

Frequent contact will likely continue as questions arise about contracted services that are provided by facilities. Also, there may be an initial point of contact with the Provider Relations Representatives surrounding consumer complaints before being sent to Quality Management for completion.



The focus of Provider Relations is to be effective and supportive partners facilitating the provision of services for the people we serve.



Network Development

The Network Development Department is a component of Provider Operations. Its primary responsibility is to ensure that there are quality resources in the provider network to sufficiently meet the behavioral health needs of CBH's members. In collaboration with Clinical Care Management, Member Services, Credentialing, and Compliance, Network Development staff systematically identifies gaps and needs in services and develops strategies to address such gaps and needs. Accordingly, the Network Development Department is the single point of contact on activities related to resource development and support. All resource development/reconfiguration is completed through a Request for Proposal (RFP), Request for Qualification (RFQ), or Request for Interest (RFI) process.

Network Development activities include the following:

- Administers the Request For Proposal (RFP) and Request For Qualifications (RFQ).
- Responds to inquiries from providers interested in entering the CBH network.
- Conducts all initial credentialing audits.
- Works with providers newly entering the CBH network to ensure compliance with CBH requirements.
- Responds to inquiries from in-network providers regarding expansions, relocations, and other changes in services.
- Conducts trainings and provides technical assistance to providers to ensure quality clinical care.

Contracting Opportunities (RFP/RFQ)

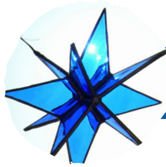
Unsolicited requests for new programs or program expansions are not be accepted for Community Behavioral Health (CBH) services. The Philadelphia Department of Behavioral Health and Intellectual disAbility Services utilizes Requests for Proposals (RFP) and Requests for Qualifications (RFQ) to acquire new services or to add providers to the CBH network. Requests for the relocation of existing services may still be submitted for consideration outside of the competitive bidding process.

The DBHIDS website will be the *only* guaranteed method of notice for DBH-related RFP and RFQ. RFP and RFQ are issued in accordance with the City of Philadelphia contracting requirements as outlined in Philadelphia Code Chapter 17-1400. We encourage all current and prospective providers to monitor the DBHIDS website regularly for new contracting opportunities.

CONTRACTS CHECKLIST FOR NEW IN-NETWORK PROVIDERS

Documents Needed for New Provider/Program:

- ☐ Proof of MA enrollment (PROMISe #)
- ☐ Certificate of Licensure
- ☐ NPI and Taxonomy Code
- ☐ Licenses and DEA Certificates of Physicians
- ☐ Licenses of Psychologist, Nurses, and Social Workers if being licensed is a job requirement
- ☐ Proof of Tax I.D. Number: copy of TIN Label, IRS Confirmation of TIN, or copy of Social Security Card
- ☐ W-9
- ☐ CBH Provider Information Form
- ☐ Program Description
- ☐ Insurance Information
- ☐ Staff Roster and Confirmation of use or non-use of temporary staffing
- ☐ Organizational Chart - which includes structure of Board of Directors
- ☐ Board of Directors Membership - which specifies the gender and ethnicity of each member
- ☐ Article of Incorporation
- ☐ Proof of JCAHO/COA/CARF Accreditation, if applicable
- ☐ Please check, if applicable
  - ☐ Minority-Owned Business Enterprise (MBE)
  - ☐ Woman-Owned Business Enterprise (WBE)
  - ☐ Disable Owned Business Enterprise (DSBE)



Credentialing Department

WE ARE CURRENTLY RE-DESIGNING THIS PROCESS AND WILL BE AMENDING THIS CHAPTER AS CHANGES ARE MADE.

Community Behavioral Health (CBH) utilizes a delegated credentialing model. This model allows providers to function with a high degree of autonomy while ensuring that minimum standards in both personnel files and clinical documentation are met. The Credentialing Department focuses primarily on re-credentialing of providers. For specific information on initial credentialing, the Request for Proposal (RFP) process, or entering the CBH Network of Providers, please consult the Network Development section.

Teams conduct re-credentialing audits that focus on reviews of clinical documentation and personnel files. Audit teams utilize published scoring tools to generate objective results in the form or a numerical score. These scores then lead to one of three credentialing statuses (one year, two years, and three years). Copies of all scoring tools in use are always available at the DBH website (www.DBHIDS.org/credentialing-manual).

The re-credentialing audit process is mandated by the State to ensure that our network of providers are able to provide the services for which they are contracted. CBH has built on the most basic of requirements to review, in some detail, clinical documentation. This is done to provide our providers with specific feedback as to the strengths of their documentation and clinical practice and to address areas in need for further growth. CBH auditors view this process as highly collaborative and at its core educational. Auditors are given the rare opportunity to review clinical documentation with little outside distraction, a gift not afforded to the majority of clinicians. Feedback provided is meant to serve as a new or fresh perspective for the providers.

Preparing for Re-Credentialing

The delegated credentialing model, when implemented correctly, leads to a near constant state of readiness for re-credentialing audits. Delegated credentialing requires that providers have in place clear systems to ensure that minimum standards are met in both areas. In general, providers can expect a scheduling letter outlining the date(s) that the audit team will be present on site for their review at least 3 weeks in advance of the audit. Within a week of the audit, the assigned team leader for the credentialing audit will contact the assigned staff person at the agency to provide additional information which may include a client list for charts to be reviewed.

The presentation of requested charts may happen as late as 24 hours prior to the audit.

Credentialing teams will arrive on-site by 9AM and begin each day with a brief introduction that allows for quesitons/answers and for the provider to present unique strengths and challenges of the program(s) to be reviewed. Auditors will then review clinical charts and all human resource files for staff hired since the last CBH credentialing audit. During the day on-site, audit team members may bring specific questions to provider staff for clarification or assistance in navigating files.

Typically, a brief verbal exit will be provided at the conclusion of the audit. Providers may invite staff as they determine appropriate for the exit. Each verbal exit will focus on general themes seen in the clinical documentation encompassing areas of strength and those in need of growth. Specific cases/examples are often not provided in the verbal exit as it relates to clinical documentation. Specific concerns will be shared in the verbal exit as they relate to staff that are not able to be credentialed and/or who lack appropriate background checks or clearances. This is done to not only allow the provider to begin addressing the concerns as soon as possible, but also to ensure that corrective measures are taken immediately to ensure the safety of CBH members and compliance. Again, for specific requirements related to staff and clinical documentation, please refer to the CBH Credentialing Manual.

Audits may last several hours over the course of one day to a week or more depending on the size of the provider, number of new hires, and CBH members served. Following the conclusion of the audit, a written exit summary will be sent to the provider. This will expand on the general themes identified in the verbal exit. Specific case examples will be given in order to assist the provider in identifying strengths and areas for growth. In general, each exit summary will also outline areas that are required to be addressed in a Quality Improvement Plan (QIP).

Finally, scores obtained, agency themes, and information from other sources such as clinical management, quality management, etc are presented to the CBH Board of Directors. The Board of Directors ultimately makes the final decision on as to the credentialing status conferred to the provider. This decision is relayed to the provider in the form of a letter from the CBH Chief Medical Officer and the President of the CBH Board of Directors.

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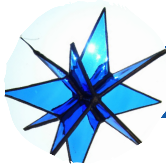
Utilization and Supervision of Graduate Students in Field Placements

All DBHIDS agencies that have graduate students who deliver outpatient client care in field placements, practicum or internships are reimbursed at regular DBH/CBH non-psychiatric rates. However, only students who have completed at least one year in a behavioral health-related graduate program qualify for reimbursement. All clinical documentation completed by graduate students needs to be cosigned by a staff member that meets the credentialing requirements for a Mental Health Professional or a Clinical Supervisor in order for the services to be reimbursable. It should be noted that supervision requirements are more stringent to insure that the interns provide quality care and fully inform clients of their training status. At any point during a Network Accountability and Improvement Collaborative site visit, the clinical supervision policy may be requested for review to ensure

that it captures language around supervision for interns. Please refer to the CBH Provider Bulletin entitled "Receiving Reimbursement for Graduate Students in Field Placements and Assuring Standards of Student Supervision" dated for September 1, 2000 for additional details.



Compliance Department

Under the HealthChoices Behavioral Health Program, DBHIDS/CBH receives state and federal Medicaid funding for payment of services for eligible Medicaid clients. DBHIDS/CBH has the responsibility to ensure that Medicaid funding is spent according to federal and state rules. Both DBHIDS/CBH and the providers have the responsibility to have systems in place to prevent fraud and abuse of these funds.

Definitions

FRAUD - as defined by the Center for Medicare and Medicaid Programs (CMS), **"Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting."**

ABUSE - as defined by CMS, **"Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the MA program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Provider Agreement, and the requirements of the state or federal regulations) for health care in a managed care setting."**

WASTE - **as defined by CBH, is the unintentional misuse of funds through inadvertent error, most frequently incorrect coding and billing.**

Statute Title 42, Section 1320 Medicare/Medicaid Fraud is specifically designed to control and prevent fraud in connection with claims under the Medicare or Medicaid programs. Providers found to be non-compliant could face hefty fines (e.g. up to $10,000 for each claim plus treble damages), 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 to those who deliberately ignore or recklessly disregard their legal obligations, but also to those who deliberately ignore or recklessly disregard their legal obligations or endanger the health and/or welfare of a member.

REPORT FRAUD, WASTE & ABUSE

CBH Hotline: 1-800-229-3050

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
- 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

Provider's Responsibility

PROVIDER COMPLIANCE PLAN

Providers are required to have a corporate compliance program that is designed to minimize an organization's risk of violating federal and state statutes and regulations related to the Medicare and Medicaid programs. The Office of the Inspector General (OIG) of the United States has published guidance for various types of healthcare providers in developing compliance programs. In addition to the U.S. Sentencing Commission has published the areas which should be included in a comprehensive corporate compliance program. The seven areas are as follows:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards
2. Designation of a compliance officer and compliance committee accountable to senior management
3. Effective training and education for compliance officer and organization's employees
4. Effective lines of communication between compliance officer and organization's employees
5. Enforcement of standards through well publicized disciplinary guidelines
6. Provision for internal monitoring and auditing
7. Provisions for prompt response to detect offenses and the development of corrective action initiatives

PROVIDERS, AS PARTICIPANTS IN THE MEDICAL ASSISTANCE (MA) PROGRAM MUST:

- Follow all state MA regulations and ensure that all services for which they have received payment follow all the appropriate rules
- Have a system to ensure that employees know, understand, and comply with the legal requirements that apply to the business. These include rules and regulations for clinical documentation, physical plant requirements and those related to claims submission.

- Be able to prove that they have provided all the services for which they have submitted a claim.
- Have documentation to support that services billed were rendered.
- Have mechanisms to identify, investigate, and take corrective action for suspected or substantiated fraud and abuse activities.
- Notify the DBHIDS/CBH Compliance Department of suspected program or client fraud and abuse within 24 hours of discovery.
- Participate in announced and unannounced Compliance audits.
- Display the DBHIDS/CBH Compliance Hotline posting in all clinical areas.

Monitoring of Fraud and Abuse by DBHIDS/CBH

The Compliance Department of DBHIDS/CBH has been charged with the responsibility to:

- Monitor compliance with Medicaid regulations
- Perform routine and special audits of providers
- Report activities to the Compliance Committee, the CBH Board of Directors and the other components of DBHIDS
- Provide education and training for employees and providers
- Develop and monitor corrective actions taken by providers as a result of audit activities
- Maintain a fraud and abuse hotline
- Maintain a cooperative relationship with governmental oversight agencies and fully cooperate in any investigation of suspected fraud and abuse

In addition, special features have been and continue to be incorporated into the Claims Payment System at CBH to automatically scan and prevent payment of services that may potentially constitute fraud or abuse. These features or "edits," as they are called, include, but are not limited to, the prevention of payments for services that have:

- Not been authorized
- Been previously paid
- Been provided to persons who were ineligible for treatment

Reports have been and continue to be developed in the Claims Payment System to monitor provider activity relating to services billed, including both payment and rejections, for purposes of identifying potential fraud and abuse.

Provider Screening for Exclusion from Participation in Federal Health Care Programs

All 3 lists should be checked monthly for every employee (newly hired and current employees/contractors); checked prior to hiring an employee or contractor; and because one might contain information that the others do not:

PENNSYLVANIA MEDICHECK LIST: an on-line data base maintained by the Department that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program: http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedprovidersist/S_001152.

It is necessary to examine the Medicheck list to assure that an order for a service or a prescription is not initiated by individuals who are no longer permitted to participate in the MA Program. Under applicable law, the Department and managed care organizations will not pay for any services prescribed, ordered, or rendered by the providers or individuals listed on the Medicheck List, including services performed in an inpatient hospital or long-term care setting. In addition, subsequent to the effective date of the termination or preclusion, any entity of which five percent (5%) or more is owned by a sanctioned provider or individual will not be reimbursed for any items or services rendered to MA recipients.

LIST OF EXCLUDED INDIVIDUALS/ENTITIES (LEIE): a data base maintained by HHS-OIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. Pursuant to federal and state law, an individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although the Department makes best efforts to include on the Medicheck List all federally excluded individuals/entities that practice in Pennsylvania, providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program. The LEIE can be searched and downloaded from the OIG's web site at http://oig.hhs.gov/fraud/exclusions.asp.

EXCLUDED PARTIES LIST SYSTEM (EPLS):
A world wide data base maintained by the General Services Administration (GSA) that provides information about parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits. Whereas the LEIE contains only exclusion actions taken by the HHS-OIG, the EPLS contains debarment actions taken by various Federal agencies, including exclusion actions taken by the HHS-OIG. The EPLS may be accessed at: http://epls.arnet.gov

Immediately self report any discovered exclusion of an employee or contractor to BPI:

- Via e-mail through the MA Provider Compliance form at the following link: http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm.

- by U.S. mail at the following address:
  Bureau of Program Integrity Commonwealth of Pennsylvania
  P.O. Box 2675
  Harrisburg, PA 17105-2675

- by fax at: 1-717-772-4655 or 1-717-772-4638

DPW FRAUD AND ABUSE HOTLINE:

The Department of Public Welfare has a hotline if you want to report a medical provider (for example a doctor, dentist, therapist, hospital) or business (medical supplier) for suspected fraud or abuse for services provided to anyone with an ACCESS card. The hotline number is 1-866-DPW-TIPS (1-866-379-8477).

Some common examples of fraud and abuse are:

- Billing or charging you for services that your health plan covers
- Offering you gifts or money to receive treatment or services
- Offering you free services, equipment, or supplies in exchange for your ACCESS number
- Giving you treatment or services that you don't need
- Physical, mental, or sexual abuse by medical staff

You can call the Hotline and speak to someone Monday through Friday, 8:30AM to 3:30PM. You may leave a voice mail message at other times. If you don't speak English an interpreter will be made available. If you are hearing impaired you can call the hotline using your TTY device. You do not have to give your name and if you do, the provider will not be told you called. You can also report suspected fraud and abuse by using the website: http://www.dpw.state.pa.us/omap or email mailto:omaptips@state.pa.us. This has been set up so you do not have to give your name also.

CBH FRAUD AND ABUSE HOTLINE:

CBH also has a Fraud and Abuse hotline you may call, but this is only for behavioral health concerns. The hotline number is 1-800-229-3050.This hotline is staffed Monday through Friday from 9:00 AM - 11:00AM and 2:00 PM - 4:00PM. You will be given the option to speak to someone or to leave a message if you call during those hours. You can leave a message if you call at any other time. You do not have to give your name.

You can call either of these hotlines to report any suspected fraud and abuse issues.

Do You Suspect Fraud And/Or Abuse?

If you are

- ✧ a behavioral health provider for Medicaid enrollees of Community Behavioral Health (CBH)

~ or ~

- ✧ a user of behavioral health services

and suspect any type of fraud and/or abuse, as defined on page 2.8, you may ANONYMOUSLY call the CBH Fraud and Abuse Hotline and make a report.

CBH Hotline: 1-800-229-3050

Standard Hours:

Monday thru Friday
9:00 AM - 11:00 AM
and
2:00 PM - 4:00 PM

REMEMBER YOUR CALL WILL BE ANONYMOUS