



Compliance Matters Autumn 2015

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Call for Submissions

The Compliance Department frequently receives questions about electronic health records (EHR) from providers. We would like to collect information that could help providers exploring EHR systems to publish in the next issue of Compliance Matters. Does your agency use an EHR system? Which one? How did you come to select your system? What are the system's strengths and limitations?

Please submit any relevant information to:

Kathleen.fox@phila.gov

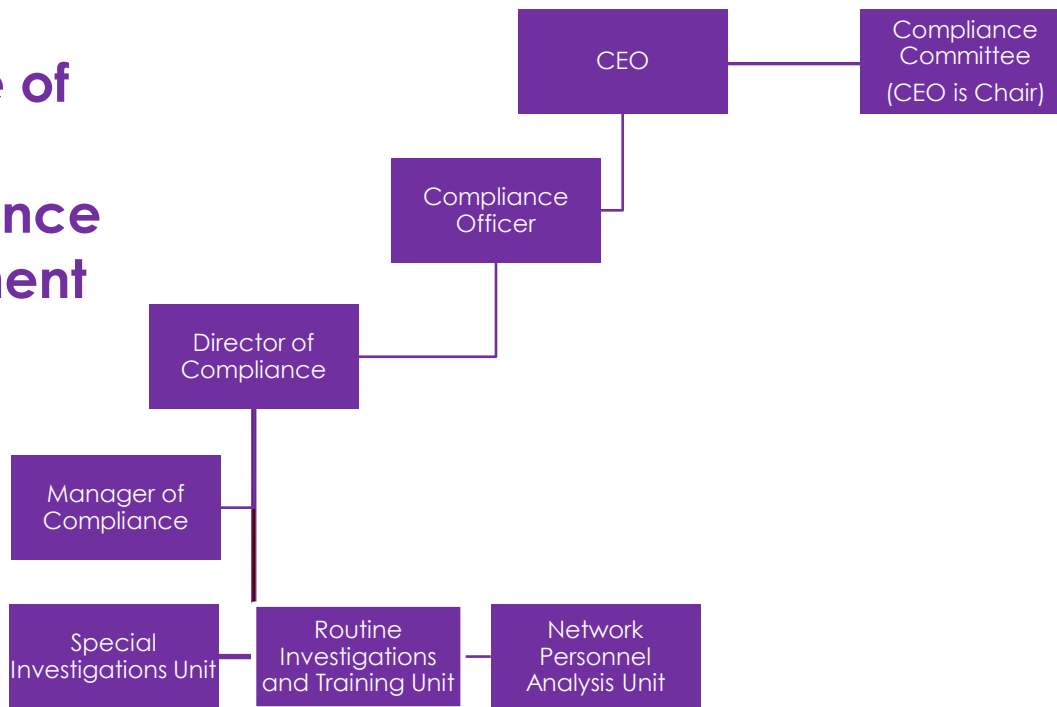
As discussed in the inaugural issue of Compliance Matters, one imperative factor in a successful, effective compliance program is oversight. The CBH Compliance Department, acting on behalf of the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and led by the CBH Compliance Officer, reports directly to the CBH Compliance Committee.

The CBH Compliance Committee meets monthly to provide oversight and direction to the Compliance Department. The responsibilities of the Compliance Committee include, but are not limited to, review and approval of all Compliance policies and procedures; administration of internal compliance measures; review and approval of all audit recommendations and results; and evaluation of the Compliance Department's effectiveness and performance.

The Compliance Officer is directly involved in day-to-day operations of the Compliance Department. The Compliance Committee is comprised of all CBH officers (unless excused by the Compliance Officer) and representation from DBH/IDS. This also includes representation from the CBH Board of Directors, assuring a smooth line of communication with the Board of Directors. The composition of the Committee is meant to be multi-disciplinary with members who have various backgrounds and areas of expertise.

The Compliance Department is composed of three distinct yet integrated units: the Routine Investigative and Training Unit (RITU), the Special Investigative Unit (SIU), and the Network Personnel Analysis Unit (NPAU). The RITU is charged with conducting 'routine audits' on all CBH providers and also for ensuring that effective training related to fraud, waste and abuse is provided to CBH, DBH/IDS, and provider staff. The SIU conducts targeted audits based on tips from a number of sources and assists providers, as needed, with self-audits (see #selfies2015 on page four). The NPAU leads periodic audits of provider staff files to assure that the requirements associated with delegated credentialing are being met. NPAU staff are also responsible to maintaining the MRPPF (page 2) and for analyzing data to identify potential staffing gaps and/or training issues within the system. Future issues of Compliance Matters will delve deeper into the functions of each unit.

Structure of CBH Compliance Department



MRPPF Madness!

What happened to the new revision of the Manual for Review of Provider Personnel Files, affectionately known as 'The MRPPF', you ask?

The CBH Compliance Team is finalizing the revision while ensuring that provider comments to the draft are considered and the latest State regulations and guidelines are being incorporated. The revision will be out in late 2015 or early 2016.

Do we have Clearance, Clarence?

There are changes to the CBH requirements for obtaining Child Abuse Clearances, Criminal History Reports, and FBI Background Checks for those staff who have contact with children. Effective October 15, 2015, these documents will need to be updated every three years. This will replace the requirement that all clearances

and criminal background checks be updated every two years. Changing to a three year renewal will also be in line with the latest State regulations. The new requirements are described in full in Bulletin #15-04, which is available on the CBH Provider section of the [DBHIDS website](#).

State Child Abuse Clearances can now be obtained online. This process, along with instructions for obtaining FBI Checks and PA Criminal History Reports is available here: [Pennsylvania Department of Human Services Website](#)

Avoid lapsed clearances at your agencies by making sure a system is in place to advise your staff well in advance of when clearances are about to expire. Incorporating the clearance protocol into your agency orientation will also communicate the gravity of obtaining these documents as a condition of work.

Foreign Education Credentials

CBH Compliance defines a foreign degree as a degree obtained solely outside of the borders of the United States. Credentials of staff educated outside of the United States must reflect all of the necessary requirements for the position. Only coursework completed outside of the United States is eligible to have a foreign degree equivalency utilized.

Courses and/or degrees completed within the United States must be at an appropriately licensed and accredited institution.

Stay Informed!

To receive the latest updates from CBH, sign up for e-mail notifications!

For assistance, please contact your Provider Relations Representative.

CALL ME MAYBE: Compliance Hotlines



In 2000, the Compliance Department established a compliance hotline to allow confidential reporting of fraud, waste, and abuse. The hotline hours of operation are Monday through Friday from 9:00 AM - 11:00AM and 2:00 PM - 4:00PM, with the capability to leave a voice message at any time. The hotline is staffed by employees of the CBH Compliance Department who are trained in confidentiality and hotline operating procedures.

What should be reported to the hotline? Any suspicion of fraud, waste or abuse should be reported. In the Code of Federal Regulations, these terms are defined as:

- **Fraud:** An intentional deception or misrepresentation that is made by an individual who knows it to be false and who receives an unauthorized benefit from the action.
- **Waste:** the careless or needless expenditure of funds, or consumption of property and/or resources as a result of deficient controls and/or judgments.
- **Abuse:** Payment for those items or services, where no legal entitlement exists and for which the health care provider has not knowingly or intentionally misrepresented the facts to receive payment.

Fraud, waste, or abuse can be committed by a CBH member, by a CBH employee, or by a staff member at a provider agency. Likewise, any CBH employee, employee of a CBH provider agency, or CBH member is able to make a report. All CBH employees are trained in the purpose and proper use of the compliance hotline upon hire and annually. We expect that the staff at all provider agencies is also trained accordingly.

The Compliance Department at CBH has instated a new electronic mechanism for fraud, waste, and abuse reporting. Confidential reports can now be sent to CBH.ComplianceHotline@phila.gov. To make a report via the telephone hotline or the email, individuals may choose to provide information such as dates of service involved; nature of the allegation; name of facility; name of staff involved; or type of service involved.

All providers are required to display the CBH Compliance Hotline poster in their agencies, visible to both staff and individuals receiving services. Additional important hotlines to note include:

- DHS' Fraud and Abuse Hotline (PA):
 - 1-866-DHS-TIPS
 - Report electronically:
<http://www.dhs.state.pa.us/wheredotaxdollarsgo/welfarefraudtipline/index.htm>
- OIG's Hotline (Federal):
 - 1-800-409-9926
 - Report electronically:
http://www.oig.state.pa.us/portal/server.pt/community/report_fraud/3775

If you are in need of additional resources, copies of the required Hotline posting, or have questions, please feel free to contact Lauren Green, Special Investigations Unit Team Leader, at lauren.green@phila.gov.

CONFIDENTIALLY REPORT FRAUD, WASTE, and ABUSE.
1-800-229-3050 or
CBH.ComplianceHotline@phila.gov

#SELFIES2015

An integral part of a successful compliance plan for healthcare providers is the ability and willingness to conduct self-audits. The Centers for Medicare and Medicaid Services defines a self-audit as, “[an] audit, examination, review, or other inspection performed both by and within a given physician’s or other health care professional’s practice or business” (CMS Self-Audit Toolkit).

Self-audits can take on many different forms in a healthcare setting. These may include audits to determine:

- Compliance with internal policies and procedures
- If human resource files are complete and current
- If productivity goals are being met
- If there is a potential problem with billing
- The scope and impact of a previously identified billing problem

Organizations should conduct regular self-audits to determine compliance with policies, procedures, and billing regulations. The process by which these are done should be included in a provider’s compliance plan and other applicable agency policies.

Once a potential issue has been recognized, self-audits should be conducted to determine the scope and impact of the identified problem. Problems may include, but are not limited to:

- Billing for services not provided
- Payments made to staff who are on an exclusion list
- “Upcoding”
- Billing for incorrect time/units

The need for a self-audit may come from internal sources (staff concerns, routine self-audits, etc) or from an external source (e.g. following a routine CBH Compliance Audit). Planning and conducting a self-audit can be a daunting task. Luckily, both the Commonwealth of Pennsylvania and the Federal government (CMS) have provided some guidance for providers completing self-audits. Links to relevant guides for both are listed here. Please note, if a self-audit is conducted that could result in repayment to CBH or other Pennsylvania Medicaid source, the Pennsylvania self-audit protocol must be followed. If the provider chooses to self-audit utilizing a



sample, the plan must be submitted for approval by the payment source. For State fee-for-service claims, this would be as directed on the self-audit protocol, to the Bureau of Program Integrity. For CBH paid claims, the work plan should be submitted in advance and approved by CBH Compliance.

In instances when a self-audit reveals improper payments made by CBH, the reports must be shared with CBH Compliance. Providers are encouraged to include the following when submitting self-audit reports to CBH:

- The method by which the issues were discovered. (Was this the result of a routine internal audit, or was there something that aroused agency suspicion?)
- The time period reviewed, including start and end dates.
- The steps taken to conduct the investigation (review of records; interviewing clients, involved individuals and other staff; etc.). It may be helpful to present this information in a timeline by listing the dates of each activity performed throughout the investigation, including the name and title of the individual performing each activity.
- The findings of the investigation, in summary form.
- If relevant, a list of the clients and dates of service with improper billing. Data should include: Client’s name, CIS Number, Date of Service, Type of Service, Number of Units billed, and Amount Paid.
- Any changes made to internal policies, procedures, staffing, and/or Compliance Plan as a result of this matter.
- Include the total of all monies to be repaid to CBH as a result of this investigation.

Many providers find an Excel spreadsheet to be the easiest way to present this information. In addition to the below listed resources, please feel free to request a spreadsheet template from CBH Compliance that outlines the information to be provided.

Pennsylvania Self-Audit Protocol:

<http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/medicalassistanceprovidersselfauditprotocol>

CMS Self-Audit Toolkit:

[https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/audit-selfaudit-booklet\[April-2015\].pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/audit-selfaudit-booklet[April-2015].pdf)

Compliance Dirty Words

Healthcare compliance seems to have a language unto itself. Terms like variance, non-variance, error rate, claim lines, BPI, OIG, and MFCU can all confound a person with minimal experience in dealing with compliance. In addition to the words we become all too familiar with, compliance analysts know there is a grouping of compliance “dirty words.” It seems that, as was the case with the father in *A Christmas Story*, some people can weave a tapestry of compliance dirty words during visits. To be fair, some of the compliance four letter words have benign, even positive connotations. A brief primer on the queen mothers of the compliance bad words:

FIX – Compliance Analysts and provider compliance staff are working to “fix” documentation issues moving forward. When “fix” is used in the past tense, though, compliance analysts tend to sit a little more upright. A medical chart, whether electronic or paper, cannot be retroactively “fixed.” When, for example, a CBH Compliance Analyst notes that a treatment plan is missing a required signature, the provider may NOT return to the treatment plan weeks, months, or years later to sign it in order to “fix” the problem. CBH expects that chart documentation for a billed service is complete and at the time the claim is presented for payment to CBH, or within seven days of the date of service, whichever occurs first. If a provider feels that something must be added to the record, addendums should be completed, leaving the original chart documentation intact. If the author needs to amend an error in a paper chart, he or she can do so

within aforementioned deadlines. The ONLY acceptable correction is a notation of error that is initiated by the staff person. White-out, correction tape, scribbling through an entry, etc. are all unacceptable and may cause the documentation to be included in the variance of the audit.

CHECK-BOX – CBH Compliance Analysts are reviewing chart documentation to ensure that the behavioral health service that was paid for was delivered to our member. It is crucial that the documentation provided clearly exhibits that a behavioral health service was delivered to the unique individual for whom the claim was submitted. When documentation relies solely on check-boxes, it proves challenging to demonstrate that an individualized service was provided to the member. Undoubtedly, check-boxes serve as an important component of many ‘forms’ in order to streamline documentation. Using check boxes to designate the service provided, for example, can save time and provide valuable information to the provider. However, check-boxes should never be used to replace a narrative comment written by the competent and trained staff person who provided the service.

ROUNDING – In the movie *Rounders*, John Malkovich sent shivers down viewers’ spines as a creepy Russian mobster involved in illicit activities. While this reference may be a bit of an exaggeration, when Compliance Analysts hear the term “rounding” used, it has the same effect as a creepy John Malkovich character. In compliance terms, rounding refers to the practice of rounding up (typically) to the next nearest full unit. For example, if medication management visits are paid as 15 minute units, and the session lasts 20 minutes, a provider who rounds up would bill for 2 units. To be clear, in nearly all levels of care this practice is not permitted. Keep in mind that CBH Claims Management allows for the billing of partial units, so in the above scenario the provider may bill for up to 1.25 units. The claim should accurately reflect the service provided, both in terms of service and duration.

In the next Issue:

- eHealth
- A Tough Call: Whistleblower Protections
- Extracurriculars: Non-billable Activities



Suggestions for future Compliance Matters features?

Contact Kate Fox at Kathleen.Fox@phila.gov