General Issues (pdf)

1. We hold staffings two times per month for two hours. We usually have anywhere from 25-30 or more files at each staffing. We staff the files in 8-minute increments. Is it ok to use time frames or after business hours to cover so many files? We usually need approximately 4 hours in time frames to staff so many files. For example, yesterday we staffed from 2-4 pm, however, by 4:00, we still had almost 20 files left. We actually went back and used 12-2 PM because none of my staff had clients at that time due to meetings, etc. We're actually open until 6 pm. Feedback please!

   Answer: You have not stated what Rule 132 service you would be claiming for this. All staffings are not claimable just as a staffing. You must be providing a documented Rule 132 service. Restricting any service to just 8 minutes, regardless of the amount of time it takes to deliver, is not appropriate. This sounds like a billing maximization effort, not quality service provision. You cannot claim a service for a time period different than the one in which it was provided. You cannot provide the service at 4:30 pm and claim it was provided at 1:30 pm. DHS doesn't set your work hours and the provision of Rule 132 services is not limited to only certain hours.

2. Once we have researched and received a RIN number, what are the specific requirements for ongoing verification of Medicaid/Medicare eligibility?

   Answer: Although there is no specific requirement in Rule 132 for ongoing verification, Medicaid is a one month eligibility. Therefore, it would be wise to check it monthly at a minimum.

3. How do we code services provided to a client who is not present: 1) Going to a pharmacy to pick up medication for delivery to the client; 2) Going to a shelter to arrange for the shelter to be payee; 3) Assistance in getting lab samples to the lab for testing.

   Answers: 1. is not billable; 2. might be billable as case management if the staff is actually working with the shelter on behalf of the client to get them to be the payee, but if someone is just going to the shelter to get a signature on a form, it's not billable;
   3. is not billable.

4. When a SASS/ICG provider subcontracts, can the subcontractor bill for the services rendered or does the provider bill and reimburse the subcontractor?

   Answer: All certified providers must bill for and document, per Rule 132 requirements, only services that they, themselves provide. Additionally, any provider that provides Rule 132 services must be certified to do so.

5. Can you offer any MRO rule 132 services in your car, such as counseling, community support individual, medication monitoring?

   Answer: While services may be provided in a car, the documentation must fully substantiate that a service was provided and that it wasn't just transportation.

6. Can peer specialists bill for participating in advisory councils?

   Answer: No. There must be a billable service provided by a paid staff person to an individual with a need for that service as reflected by the ITP.

7. DCFS and BALC certificates list the Mental Health services that can be provided at the certified site location, but not the age group they can provide services to. Can a C&A provider be penalized for providing services to an adult during the period of transition from child to adult, which may be up to six months of services provided to a maturing client?

   Answer: Rule 132 services are for children and adults. There is no distinction in certification between the two groups. All providers, regardless of the age group, must comply with Rule 132 requirements.

8. Are there any diagnoses on the Target Population and Eligible Population lists that would disallow the provision of specific Rule 132 services? The example is if a consumer with only a diagnosis of

schizophrenia can be provided therapy/counseling. I think Medicare disallows therapy if it is provided by a non-physician.

Answer: There is nothing in rule 132 that prohibits any specific service to any specific diagnosis. Rule 132 services must be provided, at a minimum, the level of staff specified in the rule.

9. Can two Rule 132 services be provided on the same day? For example individual therapy/counseling and then group therapy/counseling? If a service is provided late in a day and not documented by the RSA, MHP or QMHP until the next day, should the staff signature be dated for the day of the service or the day the note is written?

   Answer: Yes, two services may be provided in the same day. The services provided must be on the treatment plan and provided at different and not overlapping times. Each service provided must be documented according to Rule 132 requirements. The date on the note must be the date service was provided. It's always best if the service is documented as it is occurring or immediately after.

10. We report service hours to DMH and bill Medicaid directly for psychiatric services that do not fall under Rule 132. Our consultant said that under the grants, psychiatric services do not fall under Rule 132. Therefore, we are not required to write Rule 132 treatment plans and mental health assessments as long as other Rule 132 services (like case management or counseling) are not provided. Is it correct that these psychiatric services do not fall under Rule 132 and therefore do not need treatment plans or assessments?

    Answer: Medical/psychiatric services are not Rule 132 services. However, it would be wise to check with the Dept. of Healthcare and Family Services about any requirements they might have for documentation of the services for which they provide funding.

11. Where can I find an updated list of Diagnosis Axis codes?

    Answer: The diagnosis codes are located at http://www.dhs.state.il.us/page.aspx?item=32632.

12. A goal regarding maintaining a clean living environment is included on a member's care plan-learning and then demonstrating skills to keep apartment clean and sanitary. Member requires ongoing staff assistance in keeping apartment sanitary. Member decompensated and was subsequently hospitalized. Staff then needed to go into apartment and "clean it up" to an acceptable level. She also needed clothes taken to her at the hospital. We are also taking care of her cat while she is at the hospital. Is the time staff spent getting apartment to sanitary conditions while member is in the hospital and obtaining clothes for her while in hospital (not the time spent transporting them to her) chalked up to good service but not Medicaid billable or are any parts of it Medicaid billable?

    Answer: Only interventions provided to the consumer are billable. You may bill for taking clothes to the client, but not for cleaning her apartment or caring for her pet. While your assistance may be important to the client's ability to maintain her residence, they are not billable activities under Rule 132.

13. We have a DHS CILA audit being conducted right now and they are looking for a SLOF on each client. It was my understanding that the State had agreed that we could use another functional assessment tool other than the SLOF. Our Center, like several other Centers have been using the DLA which assists in defining clearly and across time how a client is doing in 20 differing functional areas to determine both functional improvement across time as well as indicate the level of functioning to determine level of care needs. We do the DLA at initial evaluation and minimally every 6 months (it is one of the elements of the tx planning process). Can you confirm that this tool can be used for CILA?

    Answer: Yes, the DLA and LOCUS have been authorized by DMH to be used in place of the SLOF.

14. Can an agency bill CM-MH to set up transportation with a van driver when the van driver is a part time staff of the PSR program/agency?

Answer: No. Scheduling staff is not a billable activity.

15. In consideration of recent DMH budgetary constraints, we are contemplating the idea of sharing resources with another agency. We are in collaboration with another MI provider and have discussed sharing occupancy and staff to deliver services to consumers now attending each program. Example: Agency A has 3 consumers and Agency B has 4 consumers that share the same treatment needs. Right now agency A has one staff member accompanying 3 consumers and agency B has a staff member accompanying 4 consumers. If all 7 consumers were enrolled both A and B, then one staff member can be utilized, a savings to both programs. Can one individual be registered to receive services from two agencies?

    Answer: Yes, two providers may provide services to the same person. Both must have a mental health assessment and treatment plan on file with all the required reviews done. Then, the provider for which the staff person actually providing the services works, is the only provider that may submit a claim for the service provided. If they're going to share space, both must have the site(s) used listed on their certificate as a certified site.

16. As part of a Wraparound Plan for youth, we have occasion to bill only Case Management/Community Support services, i.e., another provider is delivering individual therapy/counseling or medication management or the client is only needing Case Management/Community Support services (medically necessary as evidenced by a MHA and ITP, but low intensity). In prior BALC audits, we have been told we cannot bill only those services. Is that true and/or would the options identified here be billable under Rule 132?

    Answer: Rule 132 states: "A provider shall, at a minimum, directly provide mental health assessment, ITP development, review and modification and at least one additional Part 132 mental health service." Therefore, if you're doing MHA, ITP, case management and community support, you'd be fine. By the way, case management and community support are two different Rule 132 services. There is no such service as case management/community support. You may not provide only MHA, ITP and case management - client centered consultation. CCC must be provided in conjunction with at least one other 132 service, not including MHA and ITP.

17. Can we bill for socialization with a client if they have a marked and documented deficit in that area? I have been in meetings where this becomes a topic of debate and still am unsure of the final decision by the state.

    Answer: Depends on what you mean. Rule 132 allows for billing of direct interventions by staff for a client based on that client's specific mental health needs. Staff supervision of a social gathering without a specific intervention taking place is not billable. Taking clients to a baseball game, for instance, is not billable.

18. Simply taking a client to a baseball game is not billable. However, if a client has a tendency to isolate and would like to work on this deficit, we could bill for conversation with that client at the game pertaining to how he is feeling in the situation, etc, and we could have a goal on his plan to increase socialization (again, if it has been determined and documented that this is a deficit for the client)?

    Answer: Yes, you could. However, you can't bill for the entire game, just the episodes of time during which an actual intervention is provided.

19. We are working on creating new curriculum for our program. Our interest is in implementing a series of groups in which the consumer learns and practices on-site work readiness skills. These would include, for example, an in-class review and learning on restaurant sanitation/cleaning and then the following hour or session is dedicated to prompting the consumer to clean and receive feedback on use of learned skills in a kitchen in the building. Curriculum could also be created for other work skills like operating a cash register, typing, or taking inventory. The consumer would not be "working" or getting payment but we would like to allow them the opportunity to get feedback and have ample time to rehearse the skill prior to obtaining employment in their chosen field. Our question is whether a group like this, in which learning and rehearsal of work readiness skills is used, would fall under a community support or a psychosocial rehabilitation?

Answer: The services described are not Medicaid claimable because they pertain to specific work skills.

20. Many of our clients have been identified with co-morbidity issues (like obesity) and are working on exercising regularly. We are thinking of holding a group that would combine a 20-minute walk (outside in good weather) with a discussion afterward about the benefits of regular exercise, its impact on health, possible ties with nutrition, etc. Our difficulty is this...since no community integration is taking place, I don't see it as a Community Support Group. However, we are hoping to take advantage of good weather when possible and take the walk outside. If the group were to tie the benefits of exercise on mental health, the question is do you have to separate on-site & off-site if you are combining the two to provide a service?

    Answer: As you describe the service, there is no mental health treatment going on. Therefore, it is not a Rule 132 billable service. You cannot provide any one period of service both off-site and on-site. They must be billed separately. If the service was provided to address a mental health issue, then it could be billed. Be careful though that you don't just try to write the notes up correctly to describe something that didn't really happen.

21. How do we bill for a psychologist's time when a client is referred from another agency?

    Answer: The provider agency for which the psychologist works must be certified to provide the service and must bill for it. Referral for a psychological evaluation is addressed in the mental health assessment and ultimately in the individual treatment plan. Since it is the client's treatment plan - not the agency's - the psychologist can provide the services using the mental health assessment and ITP of the other agency. He/she must keep a copy of the mental health assessment and ITP in the client's file.

22. I wanted a little more information about the Community-based services that can be used in the "Community Mental Health Services" section of Notice of DHS Community-Based Services form 2653 (spenddown worksheet). In the example given in the MH Medicaid manual, Joe uses Case Management, Client-Centered Consultation, Med monitoring, and med training. Does this mean that any service in Rule 132 is allowable? If not, what services cannot be used?

    Answer: Form 2653 is used as documentation that a client incurs specific expenses that are "predictable and steady over time so that it is reasonable to anticipate that the individual will receive the same amount of services reliably for an indefinite period." Any services provided in a residential setting, including CILA, or any Rule 132 ACT services, or Case Management services, which the provider determines to meet the aforesaid criteria, may be documented on form 2653, and submitted to the DHS-Family Community Resource Center (FCRC). These expenses are then used by the caseworker to meet the client's spenddown for up to 12 consecutive months. During that period, the provider must advise the FCRC of any change to the information originally reported by submitting another form 2653. No other community mental health services may be documented in this manner, for this purpose. If clients do not incur "predictable and steady" expenses, other Rule 132 services for "necessary medical or remedial services, funded by DHS from sources other than federal funds; medical services or items recognized under state law provided or ordered by a person or institution licensed or registered with the State of Illinois to provide them; and certain other allowable medical expenses such as transportation to and from a provider, may be used to meet spenddown on a month-to-month basis". See: http://www.ilga.gov/commission/jcar/admincode/089/089001200C00600R.html, and http://www.dhs.state.il.us/page.aspx?item=16555. These month-to-month expenses may be submitted by the client to the FCRC in the form of a receipt, or as an itemized statement from the provider. An itemized statement must include: 1. date of service, 2. total charge for the service, 3. type of service, 4. name & address of the provider, 5. name of the person for whom the service was provided, and 6. if subject to third-party liability, the bill must be adjudicated or include an estimate of expected reimbursement, from the provider. When the total amount of month-to-month expenses submitted equals or exceeds the spenddown obligation, the client will be Medicaid eligible.

23. What is the distinction between capacity grant funding and fee for service in residential settings?

Answer: Direct interventions by the staff with a consumer are usually billable services (fee for service). Capacity grants cover activities that may be important to the delivery of a service but are not billable.

24. If the consumer's goal is unrealistic, e.g., the goal of "psychiatrist" for someone with an IQ of 70. Do you enter that on the treatment plan?

    Answer: The consumer's goal is a reflection of their preferences and desires and is therefore vital to be reflected. It is the role of the professional to help the consumer translate that goal into immediate, day to day steps and interventions.

25. Some consumers resent quarterly home visits. Does individual choice in treatment mean that we can discontinue this if the consumer so chooses?

    Answer: Home visits should be based on consumer need, not arbitrary time frames. None of the Rule 132 services mandate visits in a consumer's home (though this may be most appropriate), but rather require or encourage services to be delivered in the consumer's 'natural environment' which may include home, school, work, church, neighborhood, community center, etc.

26. We serve a large number of clients with dual diagnosis of MH/MR, but for whom the MH diagnosis is clearly primary. Within this context, many of them are unable to gain independence in their community (within the recovery model) due to limitations more closely related to MR, as opposed to a symptom of MH which could be put into the medical model. We are therefore limited in the provision of services, being unable to develop an objective meeting the medical model definition. This limits the funding we may obtain & need. Do you foresee any focus on this service gap as there was with MH/SA issues?

    Answer: Rule 132 services are not billed or designed under a medical model. They are primarily billed under a Rehabilitation Option (case management is billed under Targeted Case Management). Under the Rehabilitation Option, all interventions must be related to functioning lost or impaired directly related to a Mental Illness, and progress is expected.

27. Who determines medical necessity, how important is it, and how must it be documented?

    Answer: Medical necessity is determined by the provider LPHA and is critical to the provision of Medicaid services.

28. How does an agency in a large rural area fiscally reconcile the cost per unit of service and travel i.e., one hour travel + one hour of service = 2 hours of cost, for one hour of service?

    Answer: DMH recognizes the increased costs of community based services. To this end, off site rates for the same service are nearly 17% higher.

29. Are there any time frames on the qualifications for eligibility, e.g., hospitalizations within the last year or last 6 months?

    Answer: No. Qualification for Rule 132 services is based on medical necessity.

30. Must an interpreter be "certified", or, can an agency use someone from the community who attended the Jacksonville school for the deaf and hard of hearing?

    Answer: An interpreter for individuals who are deaf or hard of hearing must be certified.

31. How often is a psychiatric evaluation required?

    Answer: This is part of clinical judgment and medication management. It is not defined in Rule 132.

32. Traveling with client, can we bill for that time?

    Answer: Only when you have direct intervention with the client, not just providing transportation.

33. An MHP writes a service note, the QMHP co-signs it and the service is billed at the QMHP rate. Is that correct?

Answer: No. The service should be billed based on the level of staff who provided the service.

34. At the present time I am beginning talks with several hospitals, medical clinics and an FQHC regarding mental health screening for adolescents and possibly adults. I anticipate hiring one staff, possibly two that would rotate from hospital to hospital conducting assessments and providing other mental health services if they qualify. The therapists most likely will be in the hospitals one to two days per week. My question is; do we need a license to operate in the hospitals?

    Answer: If staff make the rounds of the hospitals, clinics, etc. to provide Rule 132 services, but do not have offices at those sites, then the services are billed as off-site. However, whenever a site becomes a staff person's usual work location, the site must be certified even when a provider does not own or lease it and the services will then be billed as on-site.

35. We are a children's provider. If we want to see a parent in a family session (for example) can we submit a bill for this adult? Also, what about someone that is 18? Can we submit a Medicaid bill for them?

    Answer: Certification is by service, not by age group. If a provider is certified to provide therapy/counseling, for example, that can be provided to kids or adults. Who is the focus of the treatment in the question above? If the parent is the focus of the treatment, you will need to ensure that the parent is eligible and perform an assessment, etc. If the child is the focus of the treatment, it needs to be clearly documented that there is a need for the parent to work on issues to help the child in her/his treatment.

36. We take a large group of consumers to the local YMCA. Can a large group (say sixteen people) be split into eight and eight, take two vans with two staff, and go at the same time to a community location?

    Answer: The agency would only bill for direct services provided to consumers during the time at the YMCA if the focus is skills training, is identified as an assessed need and is on the treatment plan. A trip to the YMCA in general is not billable without specific direct staff intervention.

37. Our agency is seeing a DD consumer with an MI diagnosis at its office about 1 - 2 times per month. Our agency psychiatrist is prescribing medications and we are treating the consumer for depression with psychotic features. We are claiming medication training, client centered consultation and case management. Do you see an issue with this?

    Answer: The requirement is that there must be an MHA and ITP for treatment of the MI diagnosis that includes the services being provided. Whenever treatment is provided it must be demonstrated and documented that it is for the treatment of the MI diagnosis and that the services are medically necessary. Having not seen the MHA or ITP, we cannot comment on the appropriateness of the services listed above. (5/31/11)

38. Our agency recently had a consumer pass away. Staff spent many hours dealing with the coroner and the individual's family. Is that time claimable?

    Answer: No, there must be a living consumer receiving services in order to claim. (5/31/11)

39. Regarding subcontracting - When one of our agency's consumers could benefit from a type of therapy that our agency doesn't provide, can we subcontract with a therapist or another agency to provide the specialized therapy? Can our agency submit claims for the service provided by the other agency?

    Answer: Contracting with a therapist not normally on your staff is ok. You would treat everything done by that staff person as though they were staff. Additionally, they would be required to meet all the requirements that staff must. Having another provider provide the service cannot be claimed by your agency. The other agency must be 132 certified and they must submit the claim(s) for providing the service themselves. They must also maintain all the required documentation. (5/31/11)

40. On a few occasions our psychiatrists or clinicians have been subpoenaed to testify in court abut a client's mental health status and progress in treatment. These were not forensic cases but appearances in child welfare, probate or criminal court in which testimony is required to help the court make a decision impacting the client. Is this a service that can be billed to Medicaid or DHS?

    Answer: Because this is not a direct Rule 132 service to the consumer, it is not billable. (9/1/11)

41. Do you know how long we are required to keep our Utilization Review documents?

    Answer: The only reference in the Rule to record retention says that required records shall be retained for a period of not less than 6 calendar years. (9/1/11)

42. The definition in Rule 132 of medical necessity says that for clients under age 21 "the client has more than one documented criteria of a mental illness or serious emotional disorder as listed in the DSM-IV…". Could you clarify what is meant by "more than one documented criteria"? Does this mean that the client does not need to meet all the criteria for a MH diagnosis? If this is the case, what ICD-9 code will HFS accept when submitting services for children under this Part?

    Answer: This applies to clients under age 21 who are referred to services by a physician following a Healthy Kids mental health screen that recommends mental health services. The documentation required to begin services while completing the MHA and ITP is the Healthy Kids mental health screen in the file. (9/1/11)

43. Rule 132 requires that the LPHA sign the MHA and ITP in order to document clinical direction and recommendation of medically necessary services. It further states that the LPHA shall consider and document her/his consideration of several factors which might impact medical necessity. This seems to suggest additional documentation beyond the LPHA's signature is needed. If so, what documentation in addition to the signature of the LPHA is acceptable to meet this standard?

    Answer: This could be something as simple as a statement above the signature line that states that the L has considered these elements. It could also be something already in the record that is referenced. The included elements are typical of what an L would consider when recommending a service as medically necessary. The rule is just asking the L to actually state that she/he has considered important factors instead of just singing a plan placed in from of her/him. (9/1/11)

44. We have a psychiatrist that would like to use a nurse practitioner to review and prescribe medication under the physician's direction. Is this allowable?

    Answer: Medical services provided by a physician or a NP with a collaborative agreement with a physician to Medicaid eligible consumers are billed directly to HFS. If the NP is functioning as the LPHA for your agency, all rule 132 requirements must be met. We suggest that you verify with HFS the requirements for claiming for medical services provided by an NP. (9/1/11)

45. If the psychiatrist and client agree to a "medication holiday" but the client has requested that they continue to be seen by the psychiatrist on a regular basis to assess any significant changes without the meds, what billable service is this?

    Answer: This should be billed directly to HFS as a medical service. It is not a Rule 132 service. (9/1/11)

46. If a consumer has a diagnosis of TBI and becomes depressed or at some time in their adult life is diagnosed with an eligible rule 132 mental health diagnosis may he/she receive Rule 132 services, or is the TBI considered primary and rules out the rule 132 service provision?

    Answer: Rule 132 services may be provided to consumers with dual diagnoses. The key is that the 132 service must be provided for the purpose of addressing the mental health issues. When providing a rule 132 service, all requirements of rule 132 must be met including having a current mental health assessment and treatment plan. Of course, the consumer receiving the service(s) must be Medicaid eligible and all third party payment must be used prior to billing Medicaid. (9/1/11)

47. Our agency is currently working on integrating healthcare into our services with our clients to come in line with the direction that the federal government is heading. Through our experience we know that many times our clients' physical illnesses impede their mental health recovery and, likewise, their mental illness can impede their physical illnesses from recovering. How do we document helping clients with their physical illnesses to benefit their mental health recovery via Rule 132 services such as community support, case management, or therapy?

    Answer: Rule 132 services may only be provided to treat a mental illness. Examples - when treating someone with depression and working with them to find ways to reduce the depression, you may discuss with them that getting some exercise may help. However, although their lack of exercise may be increasing their depression, you may not use 132 services to work with them on an exercise program. Physical illness is treated using other Medicaid State Plan services as provided by a physician, etc. and billed to HFS for payment. (9/1/11)

48. We are using telepsychiatry to make psychiatric services available to our consumers. Often a staff person sits in on the appointment with the consumer. How do we bill that as a rule 132 service?

    Answer: We have discussed this with HFS. The telepsychiatry appointment is considered the same as an actual office visit. If a staff person accompanies a consumer into the examining room to provide a medically necessary 132 service per the ITP, then it may be billed. Typically, the service is either community support or case management. However, there is one exception. If the mental health provider operates the originating site, the staff person required and paid for by HFS to be at the originating site may not be the same staff person providing and billing for a 132 service. (9/1/11)

49. Is there a State law that requires if you are running a group with Medicaid and non-Medicaid clients, that you must be billing all participants for the group service? For example, if there are 5 clients in a group with Medicaid and 5 clients who are uninsured, must you be charging the 5 uninsured clients for the service if you are going to charge Medicaid for those clients covered by MRO? Also, to clarify, we believe there is a difference between "charging a fee" and "collecting a fee".

    Answer: Per HFS: A general principle of the Medicaid program (at both the state and federal levels), with the exception of services provided under Title V (maternal and child health) and IDEA (early intervention and special education in schools), is that if services are free to the public, they are free to Medicaid. The law in Illinois reads: 89 Ill. Adm. Code 140.6 Medical Services Not Covered The following services are not covered under the Department's (HFS) medical assistance programs: (a) Services available without charge. See also the HFS Handbook for Providers, Chapter 100 (General Policy and Procedures), Topic 104 (Services not covered). Chapter 100 applies to all enrolled providers. Regarding charges - Providers are to bill Medicaid the same ("usual and customary") charge that would be billed to other payers. They are not to bill Medicaid the "Medicaid rate" unless that is what they bill everyone. See also Chapter 100, Topic 101.1 (Participation requirements). Also, note that a general principle is that payment is the lesser of charges or the established rate (adjusted for copayments and third party payments when applicable). There is not a requirement that a provider must collect a fee or payment - only that Medicaid will not pay for services provided free of charge to others. (12/1/11)

50. I work on a CST team and we have a client who is in a nursing home now for a trial period of 30 days to see if he can regain mental stability enough to return to the community. Can we continue to bill for him while he is in the nursing home? If yes, what would we bill?

    Answer: According to Rule 132, services provided must be assessed to be medically necessary and be included on the ITP. Additionally, any client receiving CST may not also receive CSI or CSG prior to the provider completing and having approved a transitional authorization request from the Collaborative. Additionally, the service provided should not be duplicative of what the nursing facility is providing. Within those parameters, the certified provider should bill for services provided. (3/1/12)

51. Can provider staff provide services from a site that is certified and bill the services as off-site?

    Answer: Services provided at certified sites must always be billed as on-site. Sites where provider staff typically report to work must be certified regardless of ownership. (6/1/12)

52. DCFS and DMH have different diagnosis lists. Should we use the diagnosis list for the agency that is paying for the services?

    Answer: Yes. (9/1/12)

53. Are agencies mandated to use diagnosis codes and the corresponding diagnostic descriptor, or is the code alone sufficient for each applicable axis?

    Answer: Rule 132 requires that there be a full five axis diagnosis. It does not specify whether that be using codes or diagnostic descriptors or both. Therefore, in your clinical record, you may indicate the diagnosis using either. (12/1/12)

54. Currently we do not bill self-pay clients for case management services. Is this ok? Wondering since we bill for Medicaid clients for these services.

    Answer: Medicaid rules state that no only is Mediciad the payer of last resort, it also will not pay for something that is routinely given away to non-Medicaid clients. So, no, this is not ok. The solution is to give a bill to the self-pay clients. They don't have to pay, or can pay on a sliding scale, but they must be given a bill for your usual and customary charge, which must be at least the Medicaid rate. (12/1/12)

55. We are trying to decrease our no show rate and are wanting to hire a person to help engage the person and find out what barriers to treatment are keeping them from coming in. If this person bills case management prior to the assessment, and the person does to come in, I know there still has to be a treatment plan, but does it have to contain a five axis diagnosis?

    Answer: Outreach and engagement is not a billable Rule 132 service. (12/1/12)

56. Rule 132 defines off-site as "locations other than those considered on-site." It defines on-site as "location that is a certified provider site as described in Section 132.90 and the surrounding provider owned, leased or controlled property and buildings and adjacent parking areas." We have a supported residential program that is also a certified site. Is it correct that I cannot bill services provided at this site as "off-site"?

    Answer: Off-site cannot be billed from a certified site, nor can it be billed when staff routinely report to work at the site. When there is an office where staff work in a residential site and the site is certified, services provided at that site must be billed as on-site. Additionally, all provided leased or owned sites must be certified. (12/1/12)

57. Is it acceptable to use blue ink color for DMH documentation including staff signatures and any other staff documentation included in the consumer record?

    Answer: There is nothing in Rule 132, nor are we aware of anything in the DMH Attachment B or Provider Manual about ink color. Use whatever color you feel is appropriate. (3/1/13)

58. Would the provision of service during transport in a staff person's car be billable as off-site?

    Answer: If actual 132 service is provided for at least the minimum amount of time required; if the service provided is provided by the correct level of staff; if the service is documented per all Rule 132 documentation requirements; and if the car is moving toward a destination and is not parked in the parking lot of a certified site, then, yes, this would be considered off-site. (3/1/13)

59. There is a rule requirement for a provider to have an active system for determining compliance with all client record requirements. Please explain what this is.

    Answer: This requires that the provider have and implement a policy for doing reviews to

determine that they are in compliance with Rule 132 requirements. This is not utilization review. (3/1/13)

60. It appears that Rule 132 doesn't allow the use of interpreters as a separately billable service. Is this correct?

    Answer: This is not a Rule 132 service. Intermittent use of interpreters may still be billed to DMH using the existing billing code. However, in regular bilingual programs where staff speak the second language, including sign language, then there shouldn't be additional billing because the rates paid for Rule 132 services include the cost of staff. (3/1/13)

61. When client record compliance audits are done by the provider, what is meant by "persons not involved in providing services to the clients whose records are reviewed"?

    Answer: Staff considered involved are the LPHA and QMHP who sign the ITP and any staff who directly provide services to the person whose record is being reviewed. (9/1/13)

62. Can we provide Rule 132 services to persons who live in IMDs?

    Answer: Please note that IMDs/nursing facilities are funded and expected to provide active treatment to all individuals served. The only time that medical necessity for community mental health services, in addition to the active treatment being provided by the IMD/nursing facility, would be met is when a person residing in an IMD/nursing facility is getting ready to transition to the community. (9/1/13)

63. Please clarify for us what sites must be certified in order for us to use them to provide Rule 132 services.

    Answer: All sites, regardless of who controls them, must be certified for the provision of Medicaid community mental health services provided under Rule 132 **WHEN** a site is the primary work location for staff regularly providing services from the site. That means that if the site is where particular staff typically report for work and have their offices, then the site must be certified. Otherwise staff would be billing services as off site when they aren't truly provided off site. Services must be billed from the location at which they are provided and not from one central location. (9/1/13)

64. When must residential sites be certified as Rule 132 sites?

    Answer: Rule 132 defines site as, "discrete locations, other than a licensed foster family home, that are owned or leased by a provider for the purpose of providing Medicaid community mental health services." If a provider leases apartments for people to live in, they are not leased for the purpose of providing 132 services and wouldn't necessarily be required to be certified. HOWEVER, if there is an office in the building to which staff routinely report for work (see #63 above), then the building must be certified. This doesn't mean that each apartment must be certified. Please note that providing services anyplace in the building will be considered on-site. If there is an office available for staff who occasionally use it while there, and no staff consider this their "home-base", then services at this uncertified site would be considered off-site. (9/1/13)

65. Services funded through the DHS Division of DD require that employees get fingerprinted as part of the background check. Does this apply to employees in DMH services, too?

    Answer: Rule 132 requires compliance with the Healthcare Worker Background Check Act. (12/1/13)

66. A client in our outpatient mental health center wanted a referral for substance abuse treatment. We referred him to our substance abuse center across the street and assured that he was enrolled for treatment. Can we bill this as case management - mental health?

Answer: The client must have a mental health assessment and treatment plan that includes the service provided and billed. The service must take at least 7.5 minutes and be documented according to Rule 132 requirements. The service must result from a mental health need. (3/1/14)

67. When a clinician signs clinical documents such as progress notes, must he/she list credentials? Our EHR automatically pulls clinician first and last names, degree, license and Medicaid credentials from the staff database and prints them on documents. We don't see anywhere in Rule 132 that credentials must be hand-written. Is it correct to say that clinicians do not need to hand-write their credentials on a document as long as they are preprinted by the EHR system?

    Answer: That's acceptable as long as your system has a protected way that the clinician then "signs" the document. Certifying State Agency reviewers would expect to see how that is protected to make sure that no one can "sign" any notes other than their own. Having just a printed name
    placed by the system is not necessarily a signature. (3/1/14)

68. One of our participants passed away recently and we are providing assistance with final arrangements. Would any of this be billable?

    Answer: Once a person dies, no services can be billed to Medicaid on her/his behalf. Since Rule 132 is a Medicaid rule, no Rule 132 services can be billed for making the arrangements. (3/1/14)

69. Is the use of Facetime, Skype, etc. allowable for the provision of Rule 132 services?

    Answer: As long as both parties have the video capabilities of Facetime, Skype, etc., then this is an acceptable form of video conferencing. (3/1/14)

70. May we, in our EHR, have a client signature on file that they use a pin number to bring up their signature, or do they have to sign each time?

    Answer: The process you use for all electronic signatures must comply with the security measures specified in Rule 132. (3/1/14)

71. One of our clients recently had a stroke and no has a very limited ability to communicate. Staff are helping her with coping skills and advocating for her needs with her nursing home and her family. At this time, she can still participate in treatment planning and service provision, but we are not sure how her condition will progress. It is possible that she could have another stroke, in which case her communication skills may be lost entirely. Her medical staff have advised us that her skills seem to be improving, so she may regain verbal skills. If she cannot communicate for a period of time, can she still receive 132 services if staff are reasonably sure that her receptive skills are intact?

    Answer: Please remember that Rule 132 services must be medically necessary for the treatment of mental illness and must be rehabilitative in nature. As such, the individual being treated must be able to participate in and respond to treatment. Additionally, however small it might be, progress toward mental health recovery must be able to be demonstrated. When someone reaches a point where they can no longer respond to and participate in treatment, the requirement of Rule 132 would not be met and services could not be billed. (3/1/14)

72. We are in the process of incorporating some additional elements into our electronic health record, inching closer to making it an all-encompassing record. In the winter, we started with digital signatures for progress notes and MHAs, which has been going well; our next step is capturing signatures of clients/families in the system. We plan to introduce signature capture pads, which would allow clinicians to capture the signature of a client or foster parent out in the field-and have it uploaded directly into the Avatar system (thus, eliminating the paper copies/files). I have briefly reviewed Rule on this subject, and didn't seem to find anything that would prohibit us moving in this direction, but wanted to verify with you that this would be okay. This technology would be used specifically for our Intake documentation (Consents, Rights,

Releases of Information, etc). and ITPs. Clients/foster parents would review the document and then sign acknowledgement of review/approval of the items; we are working out plans for then getting this to DCFS for signatures. Staff signatures would be affixed digitally to these items, as they are now (not actual signature; just an indication of who signed/approved and when). Rule references electronic signatures for users, but not necessarily clients; captured signatures would appear in the system with each corresponding document. Do you foresee any issues with this? Are there additional policies that need established for this process? Second, specific to Intake documents-would you be okay if this was an acknowledgement of receipt and understanding? Families would be provided a hardcopy of Consent, Rights, etc.; after review, they look at the screen, select Yes or No and then sign in Avatar space that they have received/understand/consent (similar to below screenshot). Is this acceptable? Signatures would then be captured, similar to a credit card machine in a store.

Answer: In principle, we see no problems with your proposal. We caution that you must be sure that your system is in compliance with 132.85. It is also important that your policies and procedures assure that the captured signature is used only once and only on the document to which it was originally affixed. (6/1/14)

73. 132.148 appears to allow for a video conference contact to be counted as the minimum of "one face-to-face or video conference contact" for completion of a mental health assessment. However, in the Rule 132 non-deemed status checklist, the contact only references a "face-to-face meeting". Is a video conference considered a face to face meeting for this purpose?

    Answer: The rule always takes precedence. A video conference is considered face to face. (6/1/14)

74. We have a potential Medicaid client who is being served in another county. May we also provide Rule 132 services to this person? We have a Community Support Group for parents of foster children and this parent is interested in attending.

    Answer: An individual may receive mental health treatment in any location she/he chooses. Each provider must comply with Rule 132 by having a complete and current mental health assessment and treatment plan signed by their own LPHA. Each must also comply with the requirement that treatment is for the benefit of the person with the mental illness who is the identified client. The services provided must be medically necessary for that treatment. (9/1/14)

75. Please clarify the prohibition for Rule 132 providers subcontracting with other providers.

    Answer: All Rule 132 services must be billed by the certified provider that provides them. Additionally, all certified providers must maintain a current MHA and ITP. If two providers are using the same MHA and ITP, each provider will be responsible for the MHA and ITP being reviewed and current. The LPHA from each provider must also sign both the MHA and ITP. (9/1/14)

76. When was Rule 132 changed to allow for billing of services for kids 0 - 3?

    Answer: There has never been a restriction in Rule 132 for billing of services to kids of any age who have an MI diagnosis and for whom services are medically necessary, except for the specific services that are restricted to adults only. (12/1/14)

77. Can the required face-to-face meeting between the individual and the QMHP for completing the MHA be done by video conference?

    Answer: Video is considered face-to-face. (6/1/15)

78. When we are working with someone is has an intellectual/development disability and a mental illness, may we provide Rule 132 services to her/him?

Answer: For an individual to receive Rule 132 services, that personmust be Medicaid enrolled, have a mental illness diagnosis, be assessed to need 132 services per a mental health assessment report signed by an LPHA and have an indivdiual treatment plan signed by an LPHA that prescribes 132 services to achieve identified goals/objectives related to the diagnosis of mental illness. The service provided must be for the treatment of the mental illness, must meet the definition of the service in 132 and must be documented according to rule requirements. (6/1/15)