GENERAL / OVERALL REQUIREMENTS - RULE 132:

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General/Overall Requirements - Rule 132

Certification & Post-Payment Review

1. **Question:** Utilization Review 59 IAC 132.95 c) reads: "...The written UR plan shall address: Procedures describing the method for selecting cases for quarterly case review and the procedures for reviewing 10 percent of the clients served under this Part annually;" How is the "10% of the clients served under this "Part" defined - as 10% of the Medicaid clients served, 10% of all DHS clients served or 10% of some other client population?

   **Answer:** "Part" refers to Rule 132. Client, per 59 IAC 132.25 is defined as "An individual who is Medicaid-eligible and is receiving Medicaid community mental health services." Please also refer to Rule 132 Training July/Aug 2004, Q&A #9 under this topic.

2. **Question:** Would we be audited on new rehab/CMS regulations that are not in the state plan yet?

   **Answer:** BALC surveys only against adopted Rule 132 standards.

3. **Question:** The Illinois Division of Mental Health Child & Adolescent Service System put out a Request for Service Plan titled "Mental Health and School Collaborations". Our staff will have offices, but all services will be provided to schools in the schools. Work with community agencies is required so there might be
an occasional meeting with other community agencies' staff in the office. The office we want to designate for this RSP (chosen based on relationships with schools) is not a certified site. On page 5 of the RSP under RSP Requirements, is: "Applicant agencies for the School Based Mental Health Grant must: #2: Be Medicaid certified by the Office of Accreditation and Licensure as a provider in good standing with Medicaid for Community Mental Health Services Program - Part 132." Does this mean that the site which staff would work out of in order to provide off-site school-based services must be certified?

**Answer:** When you provide services in the employee's usual place of employment (their office or a room in the same building), that service must be billed as on-site. When something is billed as on-site, it must be billed from a certified site. Also, you cannot bill a service provided at one site as though it was provided at another (certified) site. It would be best to have the office location certified.

4. **Question:** We do not provide ACT or CST services, but we do expect a BALC audit sometime Apr/May/June, so that means we will also have a Collaborative audit. If the Collaborative needs to coordinate with BALC and our agency for the four report requests, does that mean we will have an announced BALC audit as opposed to an unannounced BALC audit?

**Answer:** No. All BALC schedules remain unannounced.

5. **Question:** We would like to hire a full-time staff to work as CST staff 90% of the time and as a crisis/intake worker 10% of the time; is this acceptable under Rule 132?

**Answer:** Yes, except for the team leader, who must be dedicated full-time to the team.

6. **Question:** If we provide any MH Medicaid billable services at our new activity center, how would we bill them? The site is not Medicaid certified, which means we couldn't bill "on-site", but we are unclear as to whether the current description of "off-site" services would allow us to bill it that way. There might be times we would provide group services to our residential and/or PSR clients (CSI or CSG services) at this site which is what has raised the question.

**Answer:** If you use a site that you own, lease or control to provide Rule 132 services, it must be certified.

7. **Question:** Our agency has a number of supported residential apartment sites where intermittent supervision is provided. There is an office at these sites and Residential Assistants work out of them. When these staff provide services at the apartment complex they bill as onsite. We also have community based case management staff who have offices at another clinic location. They travel to the supported apartment sites and generally provide services within the consumer's apartment/home. When they bill they identify the location as the consumer's home/offsite. I know there was a lot of discussion about this and my understanding was that staff working out of the office at the apartment site provide services considered onsite and staff who have to travel to the site would bill as offsite even though the site is certified. Am I correct?

**Answer:** Your understanding is correct, with a clarification. Services provided in a supported residential site may be billed as either onsite or offsite, depending on where the services are provided. Those provided in the consumer's apartment/home may be billed as offsite. Any service rendered in other certified locations at a site, such as an office, conference room or activity area, should be billed as onsite. Staff who travel from another agency office location must also bill the onsite rate for services that are provided in the office/common area.

**Documentation**
1. **Question:** What income documentation is acceptable if the client is not working and claims to have no medical benefits?

**Answer:** We recommend that you use a written document that the client signs. You may develop your own form or use the example form in the DMH Provider Manual, located at [www.dhs.state.il.us/mhdd/mh/dhs_mh_ctsc.asp](http://www.dhs.state.il.us/mhdd/mh/dhs_mh_ctsc.asp), under: VIII. Consumer Enrollment/Benefit Status, C. Required Attestation of Consumer Income (pdf).

2. **Question:** We use a template to assist in development of the treatment plan (ITP). The note therein was rejected during a DHS survey. It was suggested that the described service be billed as Mental Health Assessment (MHA). Our concern with doing so is that the template does not address the specific elements of MHA. We use a separate template to capture all Rule 132 requirements for MHA. Following is the revised version of the note. Is the content acceptable to bill as ITP development?

**Answer:** The note content does not sufficiently support the provision of any service and would not support any claim. Each note must contain the specific intervention provided to the consumer during that period of time and the consumer's response to the intervention. Any standardized format that generalizes a service to be provided is likely to end up being unacceptable unless staff are well trained to elaborate. Anything collected to assess the consumer's needs and desires for services should be billed as mental health assessment.

3. **Question:** 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:** 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 occurs or immediately after.

4. **Question:** We were advised at an exit conference that billing for services in a car was not acceptable or billable under the new Rule 132. If I am transporting a client to an appointment, am I able to bill for CSI, Counseling or any other service while that client is in the car? Many times clients share or are in need of additional support or even med training while in route to psychiatric appointments.

**Answer:** Transportation is not a billable service. The issue here is whether or not
there is actually a service delivered. The service must be on the consumer's ITP and documentation must support both service delivery and the consumer's response to it. If the documentation does not support what is billed, the billing is not allowable regardless of the service location.

5. **Question:** Our agency documents in a progress note the identified need/objective (as it relates to the ITP), a topic sentence and the interaction that occurred, and the consumer's response and plan. When we document med adm, do we need to include the consumer's need/objective (as it relates to the ITP) and plan? Med adm is an event-based billing and I wasn't sure if there was a need to document that information.

**Answer:** You should document it including the consumer's need/objective as it relates to the ITP. Whether a service is event-based billing or not makes no difference in the documentation.

**STAFFING - CREDENTIALS - SUPERVISION**

1. **Question:** We request that BALC and/or DMH review the resume and transcript of an applicant for employment to ascertain whether s/he would meet the Rule 132 definition of a QMHP.

**Answer:** We no longer do this. Please refer to the definition in Rule 132 for QMHP. If your agency determines that the applicant is a QMHP, your records should contain documentation of how the determination was made.

2. **Question:** We recently hired a Certified Medical Assistant as a housing technician. Her training included blood pressure monitoring, blood draws, and medication training. My questions are regarding her ability to practice those services on our clients and the billing. Is she considered an MHP? She has not worked a year; however, LPNs are considered MHPs. Can she assist in medication administration? If a client spills their medication box, can she assist in refilling it? We would love to utilize her in our nursing services if this is allowable.

**Answer:** Per Rule 132, an MHP is: "An individual who provides services under the supervision of a qualified mental health professional and who possesses: a bachelor's degree; a practical nurse license under the Nursing and Advanced Practice Nursing Act [225 ILCS 65]; a certificate of psychiatric rehabilitation from a DHS-approved program plus a high school diploma plus 2 years experience in providing mental health services; an occupational therapy assistant licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of experience in a mental health setting; or a minimum of 5 years supervised experience in mental health or human services." If she meets any of those requirements, she's an MHP. She is not qualified to do medication administration, but she may be designated to provide medication monitoring or training. The minimum staff requirement for medication monitoring and medication training are, per Rule 132: Staff designated in writing by a physician or advanced practice nurse per a collaborative agreement.

3. **Question:** 1) Can agencies bill for psychological testing done by practicum students, interns or postdoctoral candidates under the supervision of a licensed clinical psychologist? According to the Medicaid rule "...a master's level professional may assist." 2) Can an intern without a master's degree be deemed a master's level professional?

**Answer:** No. Master's level means possessing a master's degree. Billing for Psychological evaluation services must be consistent with the Service Delivery and Reimbursement Guide (page A-3) and the Clinical Psychologist Licensing Act (225 ILCS 15). The practice of clinical psychology is regulated, and includes the use of psychological testing and assessment. A person represents him/herself to be a
“clinical psychologist” when s/he renders clinical psychological services for remuneration. No one, without a valid license as a clinical psychologist, shall in any manner render or offer to render clinical psychological services. Providers may employ practicum students, interns or postdoctoral candidates to assist in the rendering of services, provided that such employees function under the direct supervision, order, control and full professional responsibility of a licensed clinical psychologist. 59 IAC 132.148b(1), 225 ILCS 15, 68 IAC 1400.30(a) and (d).

4. **Question**: As a LCSW, could I independently bill Medicaid for outpatient therapy/counseling? How can I check to see if I am already enrolled as an independent provider?

   **Answer**: You must work with the Department of Healthcare and Family Services to learn how to become enrolled, or to verify your enrollment, to provide Medicaid services. As an individual, you would not be providing Rule 132 services funded by DHS/DMH. You may learn about HFS requirements via their website at [http://www.hfs.illinois.gov/medical/](http://www.hfs.illinois.gov/medical/)

**GROUP A SERVICES - RULE 132.148: MENTAL HEALTH ASSESSMENT**

1. **Question**: The revised rule states that the mental health assessment must be completed in 30 days after the first face to face contact. There are times that we conduct more in depth assessments beyond the mental health assessment, such as sex offender specific assessments, which are quite lengthy. Can we submit bills for assessment beyond the mental health assessment as long as we have that assessment complete within the 30 days?

   **Answer**: Mental health assessment is not a one-time thing. Whenever you're doing an assessment related to the consumer's mental illness and the services being or to be provided, you may bill MHA.

2. **Question**: When a consumer's diagnosis changes during the course of treatment the ITP has to reflect the changed diagnosis. The goals, objectives, specific services and frequency of services may not need to change if so determined by the QMHP and LPHA. Would another mental health assessment be required in addition to other clinical documentation explaining the diagnosis change?

   **Answer**: An addendum to the MHA would be acceptable. The provider's clinical professionals should determine what portions of the assessment need to be updated, evaluate the consumer's changing needs and then reflect changes in the ITP.

3. **Question**: We have a case that has been open for more than 3 months, as such a MHA and treatment plan has been completed, but upon further review the provider now believes a psychiatric evaluation would be beneficial, but this was not indicated in the recommendations in the MHA. If it is before the annual review of the MHA, can you prescribe a service that was not indicated on the MHA by simply completing a treatment plan review and adding a goal/objective that reflects this service in a new treatment plan? Or does a MHA addendum also need to be completed to reflect an additional treatment recommendation?

   **Answer**: Psychiatric evaluation, if done as a physician service and billed directly to HFS, does not need to be on the MHA or ITP. If considered as part of the ongoing MHA, it does not need to be on the ITP. (R-08/26/10)

4. **Question**: An auditor said that when a treatment plan is due the MHA is also due. As of July 1, 2008 the MHA is current for one year. If a treatment plan is due or expired and the MHA is still current, is there a need to do another MHA?
**Answer:** Mental health assessments are not required to be updated until July 1, 2008. If an MHA is updated to reflect needs and preferences significantly different than the current ITP, the ITP should be amended. However, the two of them are not specifically tied together.

5. **Question:** An MHP meets with a client to complete an assessment. The assessment takes two sessions. The MHP bills assessment for both sessions. However, the QMHP does not see the client until the end of the second session. Is it correct to bill assessment for both services? Can an MHP bill assessment for meeting a client the first time, gathering background info, and determining services needs? What if a Q does not see this client?

**Answer:** See 132.148a). A mental health assessment is seldom something that happens in one sitting. The Q must have at least one face-to-face with the client before signing off on the mental health assessment report.

6. **Question:** If we discover that an MHA is not current but the treatment plan is current, can we still bill? We are thinking we cannot because the LPHA signature on the updated MHA determines medical necessity for the treatment plan. Can you clarify?

**Answer:** Services must be based on the consumer's assessed needs. If there is no current mental health assessment, the treatment plan is not reflective of those needs and services are not billable.

7. **Question:** When comprehensive testing is done by a licensed clinical psychologist, some of the tests are done by the client who is alone with paper and pen. Is that reportable and billable time? (The psychologist would be in the building but not face to face with the client.) Is the review and write-up by the psychologist reportable and billable?

**Answer:** Only interventions provided directly by staff to a consumer are billable. When a staff person is not providing a direct intervention, that staff person may not bill. In this case, the psychologist may not bill for something the consumer is doing. Additionally, the completion of paperwork is not billable.

8. **Question:** If a consumer was first seen in 1990, and the assessment done then did not have all the elements of the mental health assessment now required, does a full assessment need to be done by June 30, 2008 or may it be limited to the requirements of the annual update as listed in Section 132.148?

**Answer:** The new assessment must include all of the currently required elements.

9. **Question:** It is my understanding that Rule 132 requires a person to have a face to face contact with a QMHP prior to the billing for a completed Mental Health Assessment or Mental Health Assessment Update. Is my interpretation of the rule correct? If it is correct, would I be correct in assuming that in the process of completing and billing for the Mental Health Assessment Update by a case manager who is an MHP (with review and sign-off by an LPHA) that a recent (within the last couple of months) meeting with the agency psychiatrist (QMHP/LPHA) would be able to "count" as the face to face meeting with a QMHP prior to the completion of the Assessment Update?

**Answer:** Yes, if the psychiatrist functions as the QMHP, then the face-to-face by the psychiatrist is acceptable. (R-08/26/10)

10. **Question:** If a Mental Health Assessment/Treatment Plan is completed by a licensed clinician, can that clinician sign off as the LPHA or does the designated agency LPHA have to sign off on the documents?

**Answer:** An LPHA is required to review and approve the treatment plan so the signature of any LPHA meets the "letter of the law". However, it is better clinical practice to have the review and signature of the LPHA who is responsible for the implementation of the services.
11. **Question**: How do we bill for the newly required quarterly OHIO Scales?
   **Answer**: The OHIO Scales is a functional assessment instrument used in the web-based outcomes system for C&A, and should be billed as mental health assessment. (R-08/26/10)

12. **Question**: The Revised Rule requires annual mental health assessment updates. While we have made a good-faith effort to get them completed, some clients have been less than eager to participate in the process in a timely manner. As we approach June 30, 2008 is it possible to get a short extension for updates of a month or two for this transition year? Extending the deadline even a month or two would allow us to complete the process without interrupting service or billing.
   **Answer**: There is no grace period or extension for the annual assessment update.

13. **Question**: If a Mental Health Assessment is started and it is determined that mental health services are inappropriate for the client who is then referred out, does an LPHA still have to sign and does a Q still have to have a face-to-face?
   **Answer**: If the only service is mental health assessment and the client is subsequently determined as inappropriate for mental health services, the assessment report does not need to be completed, i.e., LPHA signature or face to face with the QMHP. Document the client status/disposition in the record and you may bill for mental health assessment.

14. **Question**: If the treatment plan expires and the client and I do the annual Mental Health Assessment in the appointment following the expiration of the plan, it would seem that would be okay because a treatment plan is not required prior to a mental health assessment. Right? Wrong?
   **Answer**: Mental health assessment updates are not necessarily tied directly to ITP updates. However, it makes good clinical sense that when assessments are updated and new needs are identified, that the ITP gets updated as well. You are correct that there is no need to have an ITP to do a mental health assessment or update.

15. **Question**: Is the requirement for an annual update of the Mental Health Assessment a licensing (rule) violation or a payback issue?
   **Answer**: Failure to meet the requirement for an annual update of the Mental Health Assessment is considered a Rule violation and a post-payment issue. (R-08/26/10)

**INDIVIDUAL TREATMENT PLAN (ITP)**

1. **Question**: Rule 132 requires that a mental health assessment be completed and that an ITP follow within 45 days of the LPHA signature. The Rule also requires an annual update of the Mental Health Assessment; does an ITP review have to follow within 45 days?
   **Answer**: The initial ITP must be completed within 45 days of completion of the mental health assessment. Subsequent ITP reviews must be completed within six months of the date that the LPHA signed the previous ITP; the time-frame is not defined by completion of the assessment update.

2. **Question**: A treatment plan was completed in March 2007. The 6-month review was due in September 2007, but was done in July 2007. The next treatment plan is due in January 2008, not March 2008, because it is 6 months after the last (July 2007) review. Is this correct?
   **Answer**: You are correct.

3. **Question**: When clients are too sick to sign treatment plans, can we note "not clinically indicated?" For instance, a client is paranoid and does not want to sign a treatment plan.
   **Answer**: Stating "not clinically indicated" without further explanation is not
sufficient. It is important to document how the client is going to participate in services when they're at this level of illness and what you've done to explain to them what is going on and what the purpose of the treatment plan is. It would also be helpful for us to be able to see what you've done to obtain their involvement in the planning process to reduce their paranoia.

4. **Question**: I'm looking for clarification on a standard in Rule 132 which states: "If services are provided prior to completion of the ITP, and the client terminates services before the ITP is completed and signed, the provider must complete the ITP and document that the client terminated services and was unavailable to sign." 59 IAC 132.148C 11) B) Is a completed ITP required for preliminary services authorized by an LPHA if the client drops out before development of a formal ITP?

**Answer**: There must be an ITP in place that meets all requirements for an ITP as stated in Rule 132 for services to be billed. An ITP that is not signed by the client is sufficient if it includes everything required in the Rule for a treatment plan and has an explanation of why there is no consumer signature. Only MHA; ITP Development, Review and Modification; Case Management; and Crisis may be provided without an ITP. (R-09/14/10)

5. **Question**: I am requesting some clarification on the signing of the ITP. How would you handle the situation where the plan may be outdated as of April 2, 2008 and the client is scheduled for an appointment on April 20, 2008? Would you develop a plan without client input and have the LPHA sign? Can we wait and develop the plan when the client is present on the 20th? I know we are not to bill for any services without a plan in place and authorized, so we can assume this client will not have any service provision between the 2nd and the 20th.

**Answer**: It is important to plan ahead and be soliciting client input all along and incorporate it in a timely manner so that there is not an outdated ITP.

6. **Question**: I have a treatment plan completed on January 1 but not reviewed until June 30. What happens to billing? Does it affect billing as of June 1 or January 1? I did a treatment plan on March 5, 2007 and reviewed it on September 5, 2007 but was not able to do another treatment plan until March 30, 2008 - does this affect billing? If so, how much billing does it affect? How far does it go back?

**Answer**: A treatment plan is effective for six months from the LPHA's dated signature. If not reviewed and signed by the LPHA at the end of the six month period, it is no longer current. Services provided without a current treatment plan are not billable.

7. **Question**: Will we be cited in an audit if a client's diagnosis does not match between the Doctor's notes and the tx plan? When we do self audits, we always look for this. Many times our Doctors will change or add a dx, but not communicate this to the clinician. Whose signature trumps whose? Is the LPHA signature on the current tx plan what sticks in terms of the dx? Or is it a Doctor's signature on a note that was written when a current tx plan is still valid?

**Answer**: The treatment plan must reflect the current diagnosis. If there is a note in the record from the qualified professional that has done the most recent assessment to determine a diagnosis, the treatment plan must reflect that diagnosis.

8. **Question**: The rule regarding ITP states that "the results of crisis assessments, reassessments or additional evaluations after the client's ITP is completed shall be incorporated into a modified ITP, if appropriate, within 30 days." However, the service definition and reimbursement guide states that crisis intervention services are not required on the ITP. Must crisis services be added to the ITP in order to bill for crisis intervention?

**Answer**: Crisis services are not required to be in any ITP. The standard means that, if service needs change based upon a crisis, those changed needs should be reflected in the ITP.
9. **Question**: We interpret the continuity of care goal to relate to one of the following: discharge from services, transfer to a new service or discontinuation of a service, short-term goal related to recovery, or frequency of a service provided. Does the continuity of care goal have to relate to discharge from services and is the estimated transition or discharge date the estimated date that the client is discharged from MH services? Must a discharge date be included in the ITP?

**Answer**: The rule does not require a discharge date be included in the ITP. Based on the philosophy of recovery, the intent of the rule is that there be a date in the ITP for estimated transition or discharge. On that date further discussion should take place about the estimated transition or discharge and what may have changed that impacts a transition taking place.

10. **Question**: Does the 5 Axis Diagnosis need to be on the Individual Treatment Plan Review? Rule 132 does not say it does, but in the past we received a compliance citation for not having the diagnosis on the review form. I am creating a new electronic form and would like to have only the required elements to avoid confusion.

**Answer**: Yes, the full diagnosis must be on the ITP update.

11. **Question**: Can you start billing for Treatment Plan Development before the Mental Health Assessment is signed by the LPHA?

**Answer**: No. Per Rule 132, the only services that may be provided prior to completion of the mental health assessment are case management and crisis services.

12. **Question**: Does the ITP need to be completed within 45 days of completing the mental health assessment even if the client is not seen again?

**Answer**: If no services have been initiated as a result of completing the mental health assessment report (MHA), then no treatment plan (ITP) needs to be developed. If mental health services have been initiated after completion of the MHA but before development of the ITP, and billing is done, then an ITP must be developed even if the client never comes back to the provider for services. The provider must document why the client did not participate in the treatment planning process. (R-09/14/10)

13. **Question**: When the Mental Health Assessment is complete but the Individual Treatment Plan is not developed and is not signed off on, do we need to have a stated goal for the services provided? Do we bill for these services as ITP development or some other service?

**Answer**: Mental health services may be provided upon the completion of the mental health assessment and prior to the completion of the treatment plan, with the expectation that the services provided will be on the treatment plan. Services should be provided based on the client's assessed needs and correspond to goals on the treatment plan.

14. **Question**: Does counseling and therapy have to be stated under each goal? For example, a client's mother dies; the clinician provided therapy for the overall mental health goal/well-being of the client, and to stabilize. Does the counseling have to be listed under each goal of the ITP?

**Answer**: We find it difficult to visualize that there is no goal on the individual's treatment plan that does not tie to stabilizing a client after the death of a parent. Life has both planned and unplanned events but goals such as "learning how to cope with stressors and appropriate responses" can be generalized to a variety of activities. If there is no treatment goal that can be tied to the activity, a treatment plan modification should be completed.

15. **Question**: Can we bill for Treatment Plan Development, Review, and Modification if the client is not present?

**Answer**: No, the Rule does not require face-to-face contact however,
client/parent/guardian (as applicable) participation is required each time
development, review and/or modification of the ITP occurs. (R-09/14/10)

GROUP B SERVICES - RULE 132.150 & 132.165:

ASSERTIVE COMMUNITY TREATMENT (ACT)

1. **Question**: Our agency has an ACT program and we want to make sure we are billing correctly in the situations when we have an ACT client in transition or in crisis. If an ACT client is coming out of an inpatient treatment and needs transition to an independent living arrangement, we can put them into our supervised residential program. There they will receive services from non-ACT staff. Same in the situation that we are attempting to prevent hospitalization, or are dealing with another type of crisis. We assumed this was ok given the Rule 132 June/July 2007 Q&A #11 from your website. Also we checked with Network staff who said it was ok. Please confirm this. Then confirm that we need to bill for codes other than ACT as stated in this Q&A. Somewhere along the way we were given the impression that we could keep an ACT client in supervised residential for up to 30 days. Is there a time limit on these transitional services?

**Answer**: A client who is receiving ACT services should receive all of their services from the ACT team. If the individual has a psychiatric crisis and crisis residential services are likely to avert a psychiatric hospitalization, the individual can receive both ACT services and services from the staff at the crisis residential setting for a maximum of 30 days. The crisis must be related to a psychiatric crisis. During the period that the individual is in the residential setting, the ACT team may continue to bill for ACT services and the residential staff may bill for their services - Community Support Residential and therapy for example. The billing rule that only one staff can bill for face-to-face contact with the client at the same time remains in effect.

2. **Question**: 1) How do we bill for a client whose status with ACT is pending? Does the ACT staff bill the case management codes to do the assessment and ITP and then convert to ACT codes after acceptance? 2) We have some clients who are pre-approved for ACT but do not yet have an assessment completed by ACT staff or an ITP with ACT services; how do we code them during the interim?

**Answer**: Until a new consumer is in ACT, you should bill for the service provided. In this case it appears that those would to be mental health assessment, case management and treatment plan development, review and modification. If the consumer already has an ITP and has been receiving other services from your agency, those other services may continue for 30 days as the consumer transitions to ACT.

3. **Question**: In the Service Definition guide under the Notes section of page B-20 (ACT-Transition), it states, "This service is not billable for dates of service on or after October 1, 2007" 1) Does this mean we cannot use this code at all for clients transitioning in/out of ACT? 2) Do we just use the ACT code if a client is transitioning to another program? 3) Do we need to ensure that the Transition is formally tracked in order to avoid a compliance problem?

**Answer**: 1) This code was not for the consumer transition, but for the transition from the old ACT to the new ACT. As of October 1, 2007 all ACT services were to be coded with the new code. 2) Yes, or the other service code if that is what is provided during the allowed 30 day transition. 3) Yes.

4. **Question**: Is transportation built into the ACT rate? We have an ACT client that has no way to get back to us in Rockford (he is in Aurora) and the only option we
have is to go get him.

**Answer:** It is interesting that you would transport someone from Aurora to Rockford for ACT. ACT is primarily a community service provided to a consumer in his own community. Yes, transportation is built into all rates. Transportation as a unique service is not billable.

5. **Question:** If a few ACT staff are all absent/sick at the same time and we use non-ACT staff to fill in for the day, how do we bill? Should we use the ACT code or other coding?

**Answer:** You may bill for ACT. This should be done only as necessary to cover periodic staff absences.

**CASE MANAGEMENT**

1. **Question:** Does the Case Management Transition, Linkage and Aftercare limit of 40 hours per calendar year per client apply to each provider organization or across all providers offering services to the client?

**Answer:** The limitation relates to the individual, that transition linkage and aftercare is limited to 40 hours per year so it is across all providers. Obviously that is difficult to know but it is also difficult to monitor.

2. **Question:** Could you please advise us on whether the following would be billable as case management? Objective: "Sue" will use skills and strategies to make and follow a budget that meets personal needs. Staff Intervention: After assisting member with creating a budget to address financial needs and obligations, staff made a deposit/withdrawal on member's behalf. Member Progress: Member continues to have difficulty with managing finances independently. Staff will continue to monitor and support member with budgeting skills in order to become more self sufficient. We understand that subsequent notes would want to move to CSI and the member being coached on doing the money transactions for herself. The agency is representative payee for the member.

**Answer:** Financial transactions made by staff on behalf of a consumer is not billable. If the consumer goes with staff to the bank and watches how to do the transaction(s), it would be case management. If staff accompany the consumer to the bank and support them while consumer does the financial transaction(s), it would be CSI. What is described, however, is neither and is not billable.

3. **Question:** For Case Management-Transition linkage and aftercare, the service definition guide discusses inpatient psychiatric facilities or IMD's. It does not discuss nursing homes. If we have a client in a nursing home due to post op, can we use this code to bill for transition in and out of the nursing home? And also what if the client is in an ICFMI?

**Answer:** Transition linkage and aftercare is an acceptable service to be provided to a consumer leaving a nursing home and re-entering mental health services in the community. However, the move to the nursing home from the hospital is a medical service due to post operative needs and not due to mental health needs and cannot be billed as a mental health service.

4. **Question:** Does the client need to be present when a LOCUS is completed?

**Answer:** No.

5. **Question:** Would the following note be considered Case Management or CS-Individual? "Worker met with mother and engaged in conversation with mother regarding member's rent. Mother stated that Louis' rent was due and he needed assistance in paying rent. Worker assisted and spoke to mother and gave the mother the rent check. Mother provided a receipt upon receiving rent check."

**Answer:** This note does not describe a billable service.
6. **Question**: In relation to the May 2007 Rule 132 Q&A, Case Management #13: Can completion of reports required by external agencies without client present be billed as Case Management-MH?  
**Answer**: Yes, as long as this is not general paperwork and (there is) documentation of (the) service delivered. Please clarify what "general paperwork" is, and whether or not the client must be present while the service is delivered.

Billing for case management services must be linked in some way with the client's diagnosis, goals and objectives that are related to issues described in the mental health assessment and indicated on the individual treatment plan. Case management can be performed without the client present, however, it is expected that the activity is directed to the specific needs of the client and that the client participates to the extent that is possible. Completing applications or forms in order that the client may receive entitlements is billable as case management if the client is unable to do so. Please refer to the Service Delivery and Reimbursement Guide for examples of case management activities. Some examples of non-billable general paperwork are: scoring tests; rescheduling appointments; reading e-mails; listening to voice mail; writing checks; making copies; report writing; completing treatment summaries; writing and/or reviewing client information, assessment, treatment plan development, review or modification; transporting and waiting for clients. An administrative component is included in each defined service rate, and capacity grants cover activities that may be important to the delivery of a service but are not billable.

7. **Question**: Can we bill Case Management Mental Health after the Mental Health Assessment is completed and before the Treatment Plan is completed or is it only billed 30 days prior to completion of the MHA?  
**Answer**: You may bill for case management - mental health after the completion of the MHA and before the treatment plan is completed, with the caveat that CM is an assessed need and the service appears on the treatment plan when it is completed. The provision allowing CM 30 days prior to the completion of the MHA allows for emergency/immediate case management when needed.

8. **Question**: Are the following activities will be considered billable under Transition, Linkage and Aftercare? 1) Time spent in a unit staffing dedicated to multiple patients, including one or more to whom the worker is providing linkage services. Case Managers sometime sit for a long time before their patient(s) are discussed. 2) Conducting a post-discharge visit and the consumer is not at home. Unsuccessful visit attempts represent a significant amount of time. 3) Time spent faxing discharge documents and securing appointments. 4) Time spent in-route accompanying the consumer to an appointment.  
**Answer**: 1) Time spent in a staffing dedicated to multiple patients is not billable. 2) Time used conducting post-discharge home visits when the consumer is not at home are not billable. 3) Time spent faxing documents is not billable. Securing an appointment(s) on behalf of the consumer because the consumer is unable to do this for her/himself may be billable as case management. 4) Time spent accompanying a consumer to an appointment is not billable. If there is a direct intervention with the client, some of the time may be billable. In summary, the rule is that interventions provided directly by staff to a consumer are billable. When a staff person is not providing a direct intervention, that staff person may not bill.

9. **Question**: If a client transfers from adult outpatient to case management due to decompensation, is the documentation of the precipitating need on the transfer summary sufficient to show medical necessity, and then at the next treatment plan review an update to the Mental Health Assessment i.e., clinical impressions and treatment recommendations. Or should the MHA be updated to reflect the client's decompensation prior to the transfer to a more intensive (in this example) program?
**Answer:** The transfer summary provides documentation of the client’s needs. If this is a significant change, an ITP modification should also be completed.

**COMMUNITY SUPPORT (CS)**

1. **Question:** Following are examples of notes I received from a case manager. The second is a revision that occurred when I said that I did not see a service defined in the note. Only the body of the notes are included. They were billed as .5 hr of case management and read: "To see that client has his medications for one week, I took client to pharmacy to get his medications. Client did not speak much as usual. He claims to be taking his medications on a daily basis with his mother’s prompting." The revision read: "Client is in need of support to pharmacy to receive his medications to ensure compliance and to ensure medication refills as he would not do so independently. Client has a history of noncompliance with getting medications." Is there a billable service provided when a client who, without a ride, would not get his meds, go to the MD, get labs etc, and the ITP addresses this need with a statement such as "Problem: client states trouble getting medications."

**Answer:** You’re on the right track in asking what service was delivered. Transportation is not a billable service. If a service was delivered while driving, and is described in the note, it would be billable. There is no service in either of the notes submitted. An example of providing community support individual might be: "With client on the way to getting meds, reviewed with him how to order meds himself, showed him the location where he could pick up public transportation, discussed with him how he would be sure to be able to pay for the bus, and asked him to repeat the information back to me ."

2. **Question:** We recently had a CST client admitted to a nursing home. It is an IMD. How long can we provide client centered consultation and case management-transition, linkage and aftercare? Is there a cut off time or is this up to our agency? If the nursing home has determined that the client will be out in 4-6 weeks, and it is determined that the client will continue regular CST services after discharge, is that ok? Or, what if the time is longer for the stay at the nursing home, like 3 months? Should we close the client to our services and re-open when released from the nursing home, or can we continue client centered consultation as needed/appropriate? If we can bill for these services, we continue to use our CST code but document in the note the above services...correct?

**Answer:** There are a number of issues and questions imbedded in your correspondence. First, if a client is a nursing home, Community Support Team (CST) is not an appropriate service for the community mental health agency to provide or to bill unless it is authorized by the Collaborative. CST is an intensive team service that the client needs in order to remain in the community. The only service that may be appropriate while the client is in the nursing home is case management - transition, linkage and aftercare. Keep in mind that the Illinois state plan limits transition linkage and discharge services to 40 hours per year. In addition, the federal CMS regulations on Medicaid case management only allow for transition linkage during the last 14 days prior to discharge, effective March 3, 2008.

3. **Question:** If a Community Support-Team client is in an SOF/IMD and is provided Case Management-Transition, Linkage & Aftercare, should they be using the CST or the Case Management billing code? If the service is provided by phone (on-site) instead of at the SOF (off-site), will it look like double-billing, or should we use an off-site code?

**Answer:** When a consumer is in an IMD of any kind, CST may not be provided and billed unless it is authorized by the Collaborative. It cannot be assumed that the consumer will be CST upon discharge simply because s/he was CST prior to
hospitalization. When planning discharge from an IMD, the appropriate service to be provided is Case management-transition, linkage and discharge, and must appear on the consumer’s treatment plan. Service provided by phone should be billed as on-site.

4. **Question**: We would like to bring to the committee's attention that when delivering "off-site community support group" a staff member must have at least 4 consumers in the group for the provider to capture a billing amount similar to "off-site community support individual." From the perspective of providing individualized services, minimizing time spent writing billing notes, QA of billing notes, data entry of billing, and capturing billing revenue we find it is best for the consumer, the staff, and the agency to provide these services to consumers individually rather than as a group because of the current rates.

**Answer**: Services are to be provided in response to the consumer's needs and desires, not according to billing concerns of the provider.

5. **Question**: Will the application of the 60% threshold for CS services to be delivered in the community be applied to CSG and CSI in aggregate or separately? It is more difficult to provide CSG in community settings, but if taken together with CSI, the threshold is much easier to attain.

**Answer**: It will be applied separately to CSI and to CSG.

6. **Question**: The online Q&A #32 in May 2007 training under PSR indicates that an individual residing in a nursing home can receive community services. Q&A #66 Under Community Support indicates that a person residing in a 24 hour residential setting can only receive Community Support Team services for 30 days and that it needs to be billed as Community Support Residential. My questions are: 1) Does this apply to individuals living in nursing homes or IMD's? 2) Can individuals living in nursing homes or IMD's be eligible for Community Support Team services? 3) Can the Community Support Team bill for Community Support Residential services or must that be done by the residence?

**Answer**: 1) The Collaborative is responsible for authorizing CST services. Services may be authorized up to 30 days. 2) Community Support Team services are intensive services to support an individual while they are learning to live, work and participate in their community. These services are not appropriate for consumers living in nursing homes. If a consumer is transitioning from the nursing home to a community setting, transition linkage and aftercare services may be provided during a 30-day transition period if it is called for in a treatment plan. Additionally, if the individual transitioning from the nursing home has been assessed by The Collaborative and determined eligible for Community Support Team, CST may be provided for the same 30-day transition period. 3) Rule 132 does not require members of the CS team to provide only CST services. Therefore, if they provide community support services in a CILA, Supervised Residential or Crisis Residential setting, they should bill Community Support Residential.

7. **Question**: It is my understanding that if we have supported housing in a building we own and a licensed office is attached to the site, all billing whether in a client’s own apartment or not is considered on-site. If we are supposed to provide skills training in the home, but cannot bill this effectively through Community Support services, how are we supposed to provide the service? I realize that only 60% must be off-site; however a significant majority of our CS-Team clients live in supportive housing which makes it difficult to maintain 60% if their apartments are considered on-site. We want to ensure that our clients receive the services they need while still meeting guidelines. Any feedback or suggestions would be appreciated.

**Answer**: Off-site is billed only when travel is involved. During training last year, we recognized that in instances such as these, some on-site billing would be recognized as in a natural setting.
8. **Question**: Our Community Support-Team nurse reviews medications delivered by the pharmacy against the last prescription, then contacts the team to inform them of any changes and that the medications are ready for delivery. Is the time spent reviewing the medications Medicaid billable or just the contact with the other staff regarding the medication and changes?

**Answer**: Inventory and sorting of medications is not billable. The CS-T nurse discussion with other members of the team concerning any changes to the ITP resulting from medication changes is billable.

**PSYCHOSOCIAL REHABILITATION (PSR)**

1. **Question**: We would like to add a problem solving activity that focuses on planning a garden, and a money management group on the cost of planting a garden as a spring/summer activity, both of which will result in the planting, maintaining, and harvesting of a garden. Does this sound acceptable?

**Answer**: Be sure to develop groups that meet identified needs and make sure that the treatment provided relates directly to the assessed need. Look at assessed needs, then develop program goals/objectives/lessons that address those needs and make sure progress notes stay focused on the mental health treatment.

2. **Question**: Does the mental health assessment have to address a specific problem area for each group that the treatment plan includes or can it state that PSR services are needed based on client's diagnosis and need to learn daily activity skills to increase the level of independence or to gain a better understanding of the diagnosis and how it impacts independence?

**Answer**: Each group needs to be clearly linked to an assessed need; more than one group may clearly meet the assessed need. For example, if the person has difficulty managing money and shopping for weekly groceries. Goal: Achieve skills to live independently in community. Objectives: client will be able to develop a weekly budget; client will be able to develop a grocery shopping list each week; client will be able to identify at least three healthy foods to purchase each week. Groups: budgeting/money management; comparative shopping class; nutrition class. Each group clearly relates to the goal and identified assessed needs. The treatment plan could state the intervention as "PSR Services". The group descriptions & progress notes would have to clearly demonstrate that the intervention(s) addressed the needs and objectives of the treatment plan. Specific groups do not have to be listed in the treatment plan, just the billable service.

3. **Question**: Is there a daily maximum billing for PSR services; i.e. 5 hours a day?

**Answer**: No. The amount of PSR service a consumer receives is based on the consumer's assessed needs, desired services and outcomes and treatment plan.

4. **Question**: Can two different agencies provide PSR services to the same client? Our agency and another share a client and want to offer PSR services at both sites (addressing different goals and objectives for identified needs with client preference). We are working on an integrated plan to direct the services. As long as the services don't overlap in time and duration, are the services billable?

**Answer**: Two agencies may serve one individual. Both agencies must be fully compliant with Rule 132 by having completed assessments and ITPs. Neither may bill for the same service provided at the same time. Each may bill only for services provided by their own staff.

5. **Question**: One of our agencies wants to split their PSR program during the summer by providing the program at one building on three days and another building on the other two days. They want to do this because their Teen REACH
program will change hours of operation during the summer and they need the space in the main PSR building. Do you see any problems with this? Would this be a certification site issue?

**Answer:** The only concern we would have is consumer access. If the region is comfortable that those served will continue to have access to the services they need, then this would be acceptable. It is assumed that both sites are currently certified sites. If not, the new one will need to become certified.

6. **Question:** We have a consumer that lives in an Intermediate Care Facility (ICF) and is attends our PSR Program on site during day hours. He is not receiving PSR services in the ICF, and states that he does not get any type of group support or treatment at the ICF and does not work with a case manager there. Can we bill PSR services for this consumer?

**Answer:** If the consumer has an MI diagnosis, you may provide Rule 132 services to this person. Everything that applies to other Rule 132 services apply in this case. The consumer must have been assessed and must have an ITP that reflects the identified needs and desires of the consumer. PSR, if meeting the assessed needs, i.e., being medically necessary, must appear on the ITP. The provision of services must be documented according to Rule 132 requirements.

**PSYCHOTROPIC MEDICATION SERVICES**

1. **Question:** When an agency nurse prepares, packages & labels psychotropic & non-psychotropic medications for a client, who is not present, is it billable under Part 132 as case management, medication training or as community support individual if there is an assessed need and objective identified on the ITP?

**Answer:** Without the client present this is not a billable service. It is an administrative activity which is covered by the indirect costs for psychotropic medication services.

2. **Question:** Can we bill for the time we are transporting psychotropic and non-psych medications when there is not a client with us? The ACT staff gathers several client medications from locked storage. We deliver the meds to each client, spend time monitoring symptoms and ensure they have taken them. We might do a housekeep at that time, but it’s usually a one billing unit event centered around the medication. We then take the client’s med box back to the car and repeat the same service. After the last med delivery, staff drive back to where they lock-up all the meds. This is a critical piece of our medically necessary services. The storage and safeguarding of medications is critical to each client's recovery. Not to mention the liability we incur while in transit. We make 150 deliveries which is about 22-28 hours per week.

**Answer:** No, you may not bill for time spent transporting medications.

3. **Question:** The CST nurse reviews medications delivered by the pharmacy against the last prescription. Then s/he contacts the team to inform them of any changes and that the medications are ready for delivery. Is the time reviewing the medications Medicaid billable or just the contact with other staff regarding the medication and changes?

**Answer:** The CST nurse's discussion with other members of the team concerning any changes to the ITP resulting from medication changes is billable. Inventory and sorting of medications is not billable.

**THERAPY / COUNSELING**
1. **Question**: I was told that with some of our past audits, we were supposed to produce a group sign in sheet for our Mental Health Intensive Outpatient Services (MHIOS) program for the auditors to review. When I read the Guidelines, instructions and checklist that the auditors use, only PSR and CSG require a roster for review. Adult and adolescent MHIOS do not require this. They only require a schedule. Do we need to keep sign in sheets/rosters for MHIOS?

**Answer**: Mental health intensive outpatient services, although they can be provided in a group, do not have required group sizes or ratios. Therefore, there is no need for a group list as long as it can be verified that group services actually took place instead of individual services.

**OTHER:**

**GENERAL ISSUES**

1. **Question**: Q&A #5 in the General / Overall section of the August thru December Q&A document of states that agencies cannot bill for services provided by volunteers. Q&A #6 includes the statement "Based on your description, the student meets the definition of a MHP," suggesting that the student involved is/was billable as an MHP. Often, students (master's/doctoral level, meeting the definitions of MHP/QMHP) in mental health agencies are not paid. Does that mean they are volunteers?

**Answer**: Providers may not bill for services rendered by unpaid persons.

2. **Question**: 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.

3. **Question**: Does the federal prohibition against Medicaid paying for services during a person's residence in an IMD mean that an IMD patient cannot receive outpatient individual counseling or therapy through a clinic and have those services billed to Medicaid?

**Answer**: Yes. Medicaid will not pay for services to residents of an IMD.

4. **Question**: We report service hours to DMH and bill Medicaid directly for psychiatric services that the services 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. We report psychiatric service hours to DMH through ROCS, bill Medicaid straight to Healthcare and Family Services (HFS), and receive "psychiatric services in mental health center" grants. 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 a Rule 132 service. 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. 350 funding through DMH may require reporting which is/will be defined by DMH.
5. **Question:** 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](http://www.dhs.state.il.us/page.aspx?item=32632).

6. **Question:** A goal regarding maintaining a cleaning 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 maintaining 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.

**BILLING-CODING-PAYMENT**

1. **Question:** In the Service Definition guide under the Notes section of page B-20 (ACT-Transition), it states, "This service is not billable for dates of service on or after October 1, 2007" Does this mean we cannot use code 90 for clients transitioning in/out of ACT?
   **Answer:** Code 90 was not for consumer transition, but for transition from the old ACT to the new ACT. As of October 1, 2007 all ACT services should use the new code.

2. **Question:** What are acceptable codes for intensive outpatient services? Do we use the intensive outpatient code for everything, kind of like ACT, or should we use other codes to bill for services such as ITP and MHA?
   **Answer:** Intensive outpatient is not an all-inclusive, bundled service. You should use the intensive outpatient code to bill for that service only, and the appropriate code for any other service(s) provided.

3. **Question:** Can two Rule 132 services be provided on the same day? For example individual therapy/counseling and then group therapy/counseling?
   **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.

4. **Question:** 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.