Billing (Updated 7/25/2017)

1. If a consumer with both Medicare and Medicaid was provided a community mental health service that could not be reported/billed to Medicare, can that service be reported, billed and reimbursed through Rule 132 if the pre-service, staff and other requirements were met? (example: Case management-mental health provided by an RSA.)

   Answer: Emphasizing that Medicaid is payer of last resort, if Medicare won't pay for the service and it qualifies under Rule 132, and was provided to a Medicaid-eligible person who has a completed MHA and ITP that include the specific service at the time it is provided then Medicaid can be billed.

2. When corresponding with a hearing impaired consumer by e-mail for status/case management or even therapy. Is this a billable service?

   Answer: No. There is no provision in Rule 132 for services to be provided via email. Services, per rule, can be provided face-to-face, by telephone or with video conferencing. Please see rule for the limitations by service.

3. A consumer account representative with a high school diploma, who is not an RSA, MHP or QMHP provides a face-to-face service such as "Fee Assessment" during the initial appointment with a consumer to determine client payor source such as gathering financial information and demographics, which takes about 15 minutes prior to seeing a clinician to start their MHA. Is this a billable service? Could this be under CM-Mental health?

   Answer: No. For any service to be claimed, it must be provided to an eligible client, it must be provided by a qualified staff, and it must be a rule 132 service. Fee assessment is not a rule 132 service.

4. Staff are not required to use the exact wording of "on-site" or "off-site" if they are saying things in the body of the note such as: spoke with client by phone; received a phone call from client; met with client at home for family session; or, met with client at school for meeting. This would suffice as location without using the exact lingo (on-site, off-site) as long as it was contained in the body of the note, and we didn't have multiple on-site locations. Is this Correct?

   Answer: This is acceptable.

5. We have several certified sites; most of them are residential group homes, however, we have one that is an office where clients receive services occasionally. Is this considered on-site or off-site since it is not the client's residential home site?

   Answer: On-site and off-site are not determined by client's traveling. It is determined by staff location. If you have an office at a site that houses staff, that site must be certified and services provided there are on-site.

6. We also have a home which is not agency controlled where we go into the clients home to provide services, is this off-site or on-site?

   Answer: If staff are not housed there, it is off-site.

7. What is the definition of 'housed"? We have CILA sites in which the agency owns and are certified which have an office, company phone line, computer, etc where we have staff come in and work daily. The home in which we provide services to the clients in their home does not have an office, company phone, however we do have staff that go there and work eight hour shifts. Is that considered staff to be housed there?

   Answer: If that is the regular workplace for those staff, and it sounds like it is, then services they provide should be billed as on-site and the site should be certified.

8. I am confused as to whether a service provided in a car is on-site or off-site. We have billed off-site regardless of destination. The Collaborative told us that services provided while traveling to

a site other than the agency are off-site and services provided while traveling to the agency are on-site. Please clarify.

Answer: Since you didn't specify what services were being provided and if there was a consumer in the car, I'd start with reminding you that all services provided by telephone, regardless of where the telephone is located, are on-site. Otherwise, the rule states that on-site is service provided in a certified provider site and in the surrounding provider owned, leased or controlled property and buildings and adjacent parking areas."

9. I need clarification on doctor service for a Medicaid consumer. A psychiatrist meets with the consumer and provides psychiatric evaluation or psychotropic medication monitoring. The consumer does not have a MHA or ITP and/or the MHA or ITP has expired. Is this a billable service by the doctor? In the Service Definition and Reimbursement Guide under Psychotropic medication monitoring, it states that it is a Pre-service requirement for the consumer to have MHA and ITP. And what about Psychiatric evaluation?

   Answer: A physician may always bill directly to HFS for physician services to a Medicaid eligible recipient according to HFS requirements. However, in order to bill for a 132 service, there must be a current MHA and ITP that contain the service.

10. Is there any clarification about using the 10 and 13 codes for crisis billing? Is one code for assessment and one for intervention? Both are listed on the Service Delivery and Reimbursement Guide, with no delineation.

    Answer: Activity code 10 is for community-based crisis; activity code 13 is for state operated facility pre-screening and referral.

11. What is the time frame for submitting billing?

    Answer: Bills should be submitted as frequently as possible to ensure timely processing, and no later than 180 days after the date of service.

12. If MEDICARE is primary and MEDICAID is secondary in a case, 1) Can an agency bill State/Medicaid after they get paid by MEDICARE for the portion not covered by MEDICARE?

    Answer: Yes, they would bill Medicare first and then bill Medicaid for the difference. This is a third party liability claim so the agency would have to indicate the amount paid by Medicare on the claim. They may not bill Medicare and then bill Medicaid for the full Medicaid rate on top of what Medicare paid. (2/22/11)

13. If we offer a free WRAP orientation and consumers from several providers attend, can each provider bill for the session?

    Answer: When a free WRAP orientation is held for the community, there is no specific Rule 132 service provided to any specific consumer. Therefore, this is not a billable service. (6/1/12)

14. Do we need to be certified to bill 0 - 3 mental health services under Rule 132? And, is there a different list of acceptable diagnoses for these services?

    Answer: All providers that bill for Rule 132 services must be certified to do so. DMH has only one all inclusive diagnosis list. (6/1/12)

15. We are currently providing telepsychiatry. When Rule 132 allows service to be provided via video conferencing, how do we bill for the staff person in the room with the client while the person on the other end is providing the service?

    Answer: All Rule 132 requirements apply to services regardless of the method of delivery. If done via video conferencing or telemedicine site, there must still be the provision of a 132 service by a staff person of the certified provider and all documentation requirements must be followed. (9/1/12)

16. If we provide family therapy/counseling in a group situation to clients who are all members of the same family, can we bill family therapy/counseling individual for each of the clients for the full time of the session?

    Answer: No. You may not bill for more time in an individual session than was actually delivered. This may be billed as family therapy/counseling group for each of the three clients. (9/1/12)

17. Can we contract with another organization that is not rule 132 certified to provide mental health services in local schools and bill for these services under our certification.

    Answer: No, you may not. All providers that provide Rule 132 services must be certified. (12/1/12)

18. It has been a common practice to "bundle" case management services, i.e., 5 minutes on 3 occasions during the same day billed as one 15 minute period of service provision?

    Answer: As you have described it, this is not allowable. Individual units of a service may be "rolled up" into one claim as long as the services have the: Same procedure code, Same date of service, Same level of care modifier, Same license level modifier, Same place of service, and Same staff level of qualification in the claim note field. If any of these requirements are not met, a separate unique claim must be submitted. (12/1/12)

19. What is the difference between "rolled up" and "bundled"?

    Answer: Rolled up is allowed to facilitate billing for numerous incidents of the same service provision during a day. Bundled, which is not allowed, is gathering shorter than 1/2 units into a billable unit. (12/1/12)

20. Are the start and stop time and signatures for each brief service required in each note where services are rolled up?

    Answer: Yes. Notes must be maintained for the provision of each incident of a service even if the separate units are rolled up for billing. (12/1/12)

21. Are there any billing issues related to providing community support-group, group therapy/counseling and individual therapy/counseling on the same day to the same client?
    Answer: There are no problems with billing multiple services for the same client on the same day as long as the time periods do not overlap, and, of course, as long as the service is medically necessary and according to the client's assessed needs as detailed in the treatment plan. (6/1/13)

22. For billing of services provided in 1/4 hour increments, may service time be rounded up?
    Answer: A unit of service may be rounded up only after the provision of at least 7.5 minutes over the previous 15 minute increment of service. (6/1/13)

23. If individual therapy/counseling is provided to a client and then family begins to participate, how is this billed? Must it be billed as individual and also, separately, as family therapy/counseling?
    Answer: Bill the service as the service it primarily is. (12.1.13)

24. Is it allowable to subcontract Medicaid services to a non-certified provider organization as long as we are certified?
    Answer: Please see 132.27(b) on this topic. All certified providers must bill themselves for the services they provide. (6/1/14)

25. One of our clients has moved into a nursing home. We do not believe this client will return to the community. May we continue to bill Rule 132 services?
    Answer: Nursing facilities are responsible for the delivery of needed services to their residents. If the client reaches a level that indicates that she/he will be able to transition back to the community, the community mental health provider can again begin working with the client on skills necessary to live in the community. If the nursing facility wants to contract for and pay the community mental health provider for certain activities, there is no prohibition of that. (3/1/15)

26. Examples of what is billable in the ITP and MHA development and review processes would be very helpful.
    Answer: Just reading notes, assessment materials, or clinical records is not billable. The billable review of documents in preparation for a treatment plan update includes looking at the individual's clinical record to ascertain progress or lack of progress on goals, as well as to get an understanding of which services are contributing to the progress or lack of progress. From this review, the clinician develops recommendations for changes in the treatment plan which are then reviewed with others. Therefore, the document review that is part of treatment plan or mental health assessment review is not limited to a review of assessment materials, but rather the records that document the treatment services provided since the treatment plan or mental health assessment was developed. (3/1/15)

27. What billing code should be used for the provision of Cognitive-Behavioral Intervention? Can it be provided by a MHP?
    Answer: The Rule 132 code used for billing will depend on which service is provided. Since there is no Rule 132 service called Cognitive-Behavioral Intervention, the provider should review Rule 132 to determine where the interventions provider under this would best fit. The service to be used must be on the ITP as recommended by the MHA. Additionally, the service delivered must be documented according to Rule requirements. Because CBI is not a Rule service, it would not be what is included in the ITP, nor would documentation saying "delivered CBI" be sufficient. (3/1/15)

28. Can we bill for Rule 132 services of Medication Monitoring and Medication Training provided by agency staff on the same day that the client is seen by the psychiatrist?

    Answer: Yes. Rule 132 services may be provided and billed on the same day that the client sees the psychiatrist, but not during the same time period. (12/1/15)

29. Is the following billable as Case Management Mental Health? "Assisted client in continuing to access appropriate mental health services by attempting to contact client by phone following two recent missed appointments with her therapist and psychiatrist. Client could not be reached and there was no voice mail service to leave message. Writer contacted client's emergency contact by phone, who reported that client was out of town and would return on 10/26. Informed client's emergency contact of the nature of the call and requested that client call writer when she returns in order to re-connect client with mental health services. Letter was also sent to client this date with same information.

    Answer: Contact with client to reschedule missed appointments is not billable as case management or as any other Rule 132 service. (12/1/15)

30. According to the Centers for Medicare and Medicaid Services, billing for the time spent on test administration, interpretation, and report preparation, as well as integration of previously interpreted test results into a comprehensive report is allowable for billing. For Medicaid Part 132, is the time spent interpreting and preparing the psychological evaluation report billable in addition to the time spent administering the nationally standardized psychological tests?

    Answer: The time spent in clinical review of previous results, administering and interpreting the nationally standardized psychological test(s) would be considered billable service under Rule 132. The completion of case notes/clinical documentation is not billable. (2/23/16)

31. If a client who has been a mental health Medicaid client with a completed MH assessment and treatment plan goes into crisis and becomes a SASS client do we need an active treatment plan in order to bill for those SASS services (other than crisis)? For example if a client goes into the 90 day SASS period and the MH treatment plan time frame expires during that 90 days can the SASS services still be billed for the remainder of the 90 day period without an active MH treatment plan?

    Answer: SASS is a funding stream for Rule 132 services. As such, all Rule 132 requirements apply. So, if a service requires that a MHA and ITP be completed, then they must be active at the time the service is provided. (3/8/16)

32. If a Rule 132 service in provided in a HUD tenant's/ client's apartment can this service be billed off site? The HUD facility is a Medicaid site (receives 830 funding) because of there being staff offices in the building. I understand that if client services are provided in a staff's office or common's area we would bill as on-site. However, if services are provided in the client's apartment, can we bill off-site due to this being in the client's natural environment?

    Answer: Services provided from a certified site must be billed as on-site. The definition of a natural environment is independent of the definitions of on and off-site. As such, it is possible to provide a service both on-site and in a natural environment simultaneously. (3/15/16)

33. Can we provide and bill services for the transitioning clients as off-site services through our existing BH certified site until we obtain the revised BALC certificate?

    Answer: Any site that is required to be certified per Rule 132 must be certified prior to the claiming for services provided from it. Since you are in the process of certifying the site you describe, this not a site from which you may claim off-site services. You may provide and claim off-site services to the individuals to ensure continuity of care during this transitional phase, but those services must indeed be provided off-site (i.e. in the community/natural setting). (5/6/16)

34. Are nursing homes allowed to outsource clinical care (e.g., therapy, counseling) to Community Mental Health Centers when they do not have the personnel to meet such demand? If so, are there any limitations to which Rule 132 services the Community Mental Health Center is allowed to bill for in such situation? Last, by chance, does the State of Illinois have a database which lists the nursing homes that do not offer clinical care?

    Answer: Nursing facilities are funded and expected to provide active treatment to all individuals served. Since a facility is already being reimbursed for the individual's care while in the nursing facility, the issue of "outsourcing clinical care to a CMHS" is an issue between the facility and the CMHC. This means that a community mental health center could make a business arrangement with the facility to provide care, but it would be the responsibility of the facility to reimburse the CMHC for that care. It **cannot** be billed to the State (i.e., Medicaid) because the State has already paid the nursing facility. (9/2/16)

    A Community Mental Health Center may provide and bill for medically necessary Medicaid rehabilitation services when an individual is ready to transition to the community, specifically Case Management – Transition Linkage & Aftercare.

35. When billing a treatment plan note, we were informed that a provider can bill a treatment plan note without the client as long as the provider explains why the client is not present in session (i.e., "client has been injured and in the hospital"). The presenter clarified saying that in order to bill a treatment plan note the provider must be *consulting the treatment plan with another staff*. Is this true? If not, do providers bill a treatment plan without the client depending on the length of time required to create this treatment plan? What are the parameters?

    Answer: Please review the example activities listed in the Service Definition & Reimbursement Guide. (9/2/16)

36. We have staff that provides services to clients in the community, most often in the client's home. They will sometimes gather all the information and write the initial mental health assessment and then move into the treatment planning session. We have gathered all the information required to determine the client needs at that point but the LPHA has not signed the assessment prior to beginning the treatment

planning session since they are not there with the staff and client. Is this acceptable? Or must the assessment be signed by the LPHA prior to beginning treatment plan development?

Answer: The Rule specifically requires the completion of the mental health assessment report, which includes signature by the LPHA, before you begin to bill for individual treatment plan development. It appears feasible that there may be some discussion with the client regarding treatment recommendations that occur as a part of gathering the mental health assessment information, and such activity would be included in the time billed for mental health assessment. (10/05/16)

37. We received a federal grant for an integrated wellness clinic which has been up and running for a year now. We know many of our drugs and the illness contributes to smoking and diabetes. If we have educational classes that cover healthy living, stress reduction, nutrition counseling, illness awareness, awareness of the interaction of the comorbid issues, etc., all of which is what is covered in those health classes, can we bill for them if they are on the MHA and RP as needed for the care of the client?

    Answer: In order to bill for services in Rule 132 the individual must be eligible for such services as determined by the medical necessity documented on the Mental Health Assessment and then prescribed on the treatment plan. (11/17/16)

38. Can you tell me if we can bill Medicare for QMHP services or where I may look to find an answer to my question?

    Answer: The federal Department of Centers for Medicare and Medicaid services set forth the requirements for Medicare providers. (11/17/16)

39. Please advise the MHA requires a minimum of one face to face encounter. Can a MHA be billed for client not present where information is being collected from various sources? Also, does the same scenario apply for treatment plan?

    Answer: Yes, both services allow for billing of activities when the client is not present. However, each service has specific requirements regarding participation of the client in the process which must be met. There are numerous Q&A's on the web that may of assistance to you. (11/17/16)

40. If someone is admitted to a residential setting and an Admission Note is completed for the resident, can our staff only bill for "assessment" for those first 30 days prior to the full MHA and ITP being completed? Or, can staff bill for services such as therapy/counseling, community support, and case management based on the Admission Note?

    Answer: Yes, you may provide and bill for the full array of services recommended on the Admission Note for up to 30 days as you develop the full MHA and ITP.

41. Below is an example listed in the Reimbursement Guide under ITP development and Review. As I understand this it means that if I am the QMHP or MHP who will be developing the ITP with the client I can write a progress note and bill for the time I spend reviewing the assessment that has been completed. Does the client have to be present? Would you please provide any guidance on content of an acceptable progress note for this activity? If I record 30 minutes reviewing the assessment (no client present) is it acceptable to document "Reviewed assessment in preparation for ITP development/review" as my total note content?

Answer: The answer in the SDRG is misleading and will be clarified in future editions. The only time "reviewing the assessment materials for use in developing the ITP" would be billable is if the client or collaterals are present. (11/13/16)

42. Can an agency bill crisis intervention for a youth without the child being SASS or going through CARES? If a child is in an emotional state that we (staff/school official/ etc.) do not identify a need to call CARES (the highest threshold, e.g. suicidal, homicidal, or possibly needing hospitalization), however the child is presenting need for brief and immediate intervention to address a decrease in functioning, is it possible to use the Rule 132 crisis intervention code as we would for adults?

Answer: Yes, as long as the activity meets all of the requirements of the Rule. (1/10/17)

43. Can an unlicensed social worker be classified as a mental health practitioner? Scenario Example: Patient has dual pay source of Medicaid & Medicare. If seeing a licensed social worker the claim is submitted to Medicare for payment. However, can the patient see a non-licensed social worker and the claim be submitted directly to Medicaid for payment since Medicare will not pay?

Answer: Language from the DHS FY17 Attachment B which addresses your concern.
IV. Payment
A. Payment for Fee-for-Service

- Services paid on a fee-for-service basis are reimbursed after the services are delivered. Payments are made based on a bill or claim from the Provider containing the appropriate service documentation as directed by the Department and/or the Illinois Department of Healthcare and Family Services. **Third party payers must be billed prior** to DMH due to the fact that DMH is the payer of last resort. Payment for Non-Medicaid services will not be paid in excess of the contract amount.
- Providers are prohibited from submitting Medicaid, Non-Medicaid, and ICG claims to the Department for any services delivered to enrollees in the Integrated Care Program.

In summary the provider is expected to bill services to the third party payer and must receive the denial before submitting the claim to HFS. (3/7/17)

44. A Case Manager (MHP level) completes an initial MHA with the client as well as the Initial Treatment Plan on 12/21/16. The LPHA does not review and sign the documents until 12/28/16. If the client requires Community Support Individual and Individual Counseling in the interim (both are recommended on the MHA and placed on the Treatment Plan), are these services billable during that timeframe?

Answer: A case manager/MHP is not qualified to COMPLETE an MHA. They may work on/gather information for an MHA, but a QMHP must participate, including at least one face to face with the client before the report can be written. The report is also the responsibility of the QMHP, meaning it must have the QMHP's signature, but is still not considered COMPLETE per Rule until signed by the LPHA.

132.148.c.11 gives the conditions under which services may be provided concurrent with ITP development, but it does require a COMPLETE (i.e., QMHP contact, signature; LMHP signature) which the provider would not have in the instance described above. (1/10/17)

45. What is the average or reasonable billing time necessary for a LOCUS Assessment?

Answer: Unlike most of the Rule 132 services, LOCUS is billed as an event, and therefore there is no "billing time" reported. The provider can bill for one event of the LOCUS each time it is administered. (12/6/16)

46. Please clarify when case management services may be provided and billed. If we have provided crisis intervention and are aware of client needs may we provide and bill case management services prior to the initiation of an MHA? Or do we need to have at least initiated the MHA to be able to provide the case management services? And to confirm – initiation of the MHA then starts the 30 day clock to complete the MHA.

Answer: Please refer to Section 132.165 a)1)A), which allows for "Case management provided during the 30 days immediately preceding completion of the assessment". Number 50 of the Mental Health Assessment Q&A's states that the MHA report is to be completed within 30 days of the initial face-to-face contact. (12/6/16)

47. We have a question regarding DMH Medicaid clients and billing. We understand that claims have 180 days; however does that include appeal time. If for some reason we notice a denied claim has been denied incorrectly and we wish to appeal, what is the time frame?

Answer: Questions regarding the appeal of denied claims should be directed to the HFS billing specialists at 877-782-5565 (ask for Community MHC billing consultant). (4/11/17)

48. We are going to begin billing DMH Medicaid for foster care clients whom are enrolled in our counseling program. Because these clients are counseling clients, they have MHAs and ITPs. However we were not billing DMH Medicaid for them before but we going to. Do these clients, require new MHA's and ITPs?

Answer: Please consult with Bari Rothbaum of IPI/DCFS. (4/11/17)

49. Can staff bill for time spent doing research on interventions and/or activities for community support groups. What activity code should be used to bill for these types of services?

Answer: No, staff may not bill for time spent doing research. (7/25/17)