Documentation (Updated 07/25/2017)

1. 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 or lease to provide Rule 132 services, it must be certified and the services must be billed as on-site.
2. 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.
3. Regarding on-site and off-site services. We have a PSR in one location and a group home in a separate location. If PSR staff travel to the group home to teach skills (let''s say laundry skills), is this PSR or CSG?
   Answer: PSR staff could travel to another site and provide services. Community support services provided in a supervised residential are billed as CS-R, but other 132 services, e.g., therapy/counseling, case management, may also be provided in a supervised setting and would be billed as those services, not as CS-R. The key is that all PSR must be delivered on-site, so whatever site is used must be a certified site. If the group home is not a supervised residential site it would be billed as CSG.
4. What requirements would a non-profit agency have to meet to use paperless records with electronic signatures?
   Answer: For providers of Medicaid mental health services, the requirements for electronic signatures are in 59 Ill. Adm. Code 132 (132.85(f)). Since you didn't mention where you work, you should probably check with your funder(s) to verify their requirements.
5. Date and time of service is required on documentation and is audited. However, our doctor has some difficulty getting the time correct on his progress notes. Would it be OK for him to write in the number of minutes, and then have the RN fill in the appropriate time? Is that legal? Otherwise, we have to go back and correct it, and have him initial the correction.
   Answer: Anyone delivering Rule 132 services must complete all documentation themselves. No, an RN may not insert times of service into a physician's documentation of Rule 132 services.
6. 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 in the note must be the date service was provided. It's always best if the service is

documented as it is occurs or immediately after. The signature should be dated on the date it is signed.

7. We were advised at an exit conference that billing for services in a car was not acceptable or billable. 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.

8. 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 medication administration with the date, time, length of time, staff delivering the service along with signature and credentials, location of service delivery, and a description of the activity.

9. Can a provider put CM for case management mental health (or other abbreviations like this) on a MHA and/or ITP if they have a reference sheet that is available to reviewers that shows that CM=case management mental health?
   Answer: As long as the provider's reference sheet indicates the three different case managements as three different codes, e.g., CM = Case management mental health; CMCCC = Case management client centered consultation; and CMTLA = Case management transition linkage and aftercare, then ok. But if they use CM for everything, that is not acceptable. The reference sheet must be kept in each record.

10. Can there only be one signature on MHA if they are QMHP and LPHA? They just sign Jane Doe, LCSW, LPHA instead of signing twice?
    Answer: The QMHP that signs must be the staff with primary responsibility for service provision who also had the required face-to-face meeting with the client. If the LPHA also serves in this capacity, then one signature is required, but it must be clear in the record that this is the case.

11. A 16 year old client is coming in for therapy for anxiety. She drives herself here. We have created an Individualized Treatment Plan with the client, and have reviewed the plan with the parent over the phone. The client has signed the plan. The clinician has documented the phone conversation with the parent, as well as the client/clinician review of the plan. The problem is, the parent will not/ cannot come in to sign the plan for several months. In the meantime, can the agency bill for individual counseling, even though we do not have a parent signature on the Individualized Treatment Plan? What if the client is under the age of 12 and is being brought in by a grandparent or step-parent?
    Answer: Rule 132 at 132.145(a)(2) is very specific about the requirements for when and how a child/adolescent may consent to services. Outside these parameters, the parent/guardian must consent. Unless a grandparent/step-parent has guardianship rights, they may not consent. How you obtain this is up to you.

12. Is it possible to combine releases into one form? For each entity, the relevant categories would be circled. We are trying to streamline the process of keeping releases up to date and came up with this idea. I could not find any information about having multiple releases on one document. If we create the release to run for example June 1, 2010 to May 31, 2011, can the client sign it June 10th? In other words, does the release begin on June 1 or on the date signed?
    Answer: No. A release must be for a specific, time-limited reason. You may use your all inclusive form, but it may pertain to only one release at any given time. The release begins on the date signed.

13. I am reviewing the billing claims that were cited during our Collaborative visit. One issue that came up several times is that the service billed is not what is documented. The problem is this: We often have 2 staff in the same group. An MHP will facilitate the group and an RSA will be writing the notes. Unfortunately, our current notes do not differentiate on who is facilitating, so that the only name and credential that is written out is the RSA. Both staff numbers are listed on the note, but reviewers do not know our ID's and our credentials. We had been given guidance some time ago that we bill according to who facilitates the group, not who writes the note. Is this still true? I will be working on a new note format that lists the facilitator and credentials.
    Answer: The staff person that delivers the service must sign and date the note. If an RSA signs and dates a note of the service delivered, that is documentation of service delivered by that level of staff. If the RSA is assigned to write the note for the MHP or QMHP, who then reviews, signs and dates it, the note would document service delivered by the M or Q. You may not claim for a service required to be delivered by an M or Q or at an M or Q rate level when the note documenting the service is signed and dated by an R.

14. Can we do a release for more than a year? For example, for the sake of efficiency, we are trying to get all of our releases on the same schedule. So if we do a release now and have it end May 31, 2011, that would be more than one year. Is that acceptable?
    Answer: Releases may never be for more than one year.

15. We currently require staff to have their progress notes completed within 1 working day of service provision. What is the State's expectation or requirement for how soon, following the provision of a Rule 132 service, must the service documentation be completed and in the clinical record, i.e., must progress notes be completed in 24, 48, or 72 hours?
    Answer: Rule 132 doesn't have any specific time frames for this. However, your current policy and practice are very acceptable.

16. We have converted to electronic medical records (EMR). I have a question about documentation for psychotropic medication administration. In EMR, the nurses have to document an injection on a hospital-wide electronic form. It is titled "Medication Administration Record" or MAR. They document the dose and site of the injection, and the amount of time involved (usually about 10 minutes). Is this acceptable for Rule 132? The MAR doesn't indicate where the service was provided (it's only provided onsite), and is not titled Psychotropic med administration. But we are trying to keep the nurses from having to document the service twice on two different notes. What do you think?
    Answer: All Rule 132 services must be documented according to the requirements of 59 IAC 132.100 (i)(1) - (6). There are no exceptions to this requirement.

17. For each progress note/service documentation the "response" section is how the client responded to the intervention that was provided during the service delivery and the "progress" section is how the client is doing working toward the goal that was addressed from the treatment plan, correct?
    Answer: You are correct.

18. In order to stay in compliance, does the LPHA have to sign the MHA the same day as the QMHP? Even if the staff member completing the MHA could technically be considered an LPHA herself? Basically, I'm an LCSW and so is one of my staff members & the other one is an LCPC. They are completing MHAs on days that I am not in the office, so I wanted to see if I could wait to sign the LPHA line on the day I get back or designate one of them to be the LPHA on days that I'm not in to sign off. I already do that for treatment plans to stay in compliance with that, wasn't sure if that's the case with MHA's as well.
    Answer: 59 IAC 132.148(a)(9) says that the mental health assessment report shall be reviewed and approved by the LPHA as documented by the LPHA's dated signature on the mental health assessment. 59 IAC 132.148(c)(4), in regard to the treatment plan, says that an LPHA shall provide the clinical direction of mental health services identified in the ITP as documented by his/her dated signature on the ITP. In the definition section of Rule 132 under the definition of medical necessity or medically necessary - the following is stated: An LPHA has determined through assessment that a client has a diagnosis of mental illness or serious emotional disorder

that has resulted in a significant impairment in the client's level of functioning and the client needs one or more mental health services to reduce the physical or mental disability of an individual and to restore an individual to the maximum possible functioning level. With that, it is obviously the intent of the rule that the LPHA be a single individual for any given client. The LPHA is the prescriber of services. While there may be other people on staff with L credentials, there can be only one who is the responsible person for determining medical necessity and prescribing 132 services. It is not just a matter of someone with the right credentials signing the MHA report and ITP, it is the responsible person. Therefore, having an available QMHP who also has L credentials sign documents because the actual L is not available is not acceptable. There is nothing in rule that requires that the Q and L must sign on the same date. The date of the L signature is the date used by reviewers to determine the timeliness of all requirements.

19. The rule states that documentation of services must include a note that includes the goal, the intervention, the client's response to the intervention and the progress made. Is there any service documentation that is exempt from this, for example, mental health assessment or treatment plan development and review? I am assuming not since the rule does not say.
    Answer: Documentation must be done in accordance with 132.100(i).

20. Do we have to keep documentation of monthly clinical supervision in each personnel file? Can we keep a central file? Can it be kept electronically?
    Answer: The rule requires that the supervision is documented in a written record. It can be in personnel files, a central location or any other location that is accessible for review which includes an electronic file.

21. I would like some clarification on the monthly supervisory note. In addition to the content of the note which would detail what occurred during supervision, is it adequate to indicate that at least one hour of supervision occurred during any given month? Or, do the specific days and times need to be outlined?
    Answer: The monthly clinical supervision note needs to indicate the date, time and duration of the clinical supervision. All of those components are necessary in order to verify the minimum requirement.

22. Must the QMHP face-to-face meeting during MH assessment be a "billable event", or is a shorter period of time and sign-off adequate? For example, the Q may spend only 5 minutes meeting with the client and MHP, then sign-off. Will auditors look for separate billing or does the Q's signature suffice for the required contact?
    Answer: The requirement for documentation of face-to-face has not changed. You are not required to bill for the activity if it does not meet the billing standard, i.e. the service must last at least 1/2 of the billing unit.

23. An agency sent me a copy of a progress note. At the top of the progress note page, the clinician gives the date, time of meeting with the client, and objective. In the body of the note, the same information is repeated. Must this information be stated twice?
    Answer: The information does not need to be stated twice. However, we don't typically advise on how a provider does documentation, unless it is non-compliant.

24. When is an LPHA required to co-sign the progress notes of other staff?
    Answer: An LPHA is not required to co-sign the progress notes of other staff.

25. I like strength-based approach and working with people on their preferences, but how does this work with medical necessity? Am I expected to provide recovery & preference based treatment and not get paid because I cannot justify medical necessity? It seems to be putting providers in the difficult position of asking consumers what they want, then having to say, "that sounds nice, but we can't help you."
    Answer: Medical necessity does not preclude incorporating the client's preferences. Client preferences reflect what they would like the outcome of treatment to be. They do not eliminate the need for those services to be medically necessary.

26. In the view of an LPHA, how is the issue of medical necessity handled when it conflicts with client preference? Is there a protocol for handling this issue?
    Answer: The consumer's goal is a reflection of their preferences and desires and is therefore important. It is the role of the professional to help the consumer translate that goal into immediate, day to day steps and interventions.

27. Some children have a need for services to reduce certain behaviors which do not meet the severity for target/eligible diagnoses. Is this "medical necessity"?
    Answer: A service is defined as medically necessary if an LPHA has reviewed an assessment and diagnosis and recommended the service as appropriate to meet the client's needs.

28. Please comment on the application of medical necessity standards to ITP goals/objectives in relation to educational/vocational plans/aspirations, and physical health care issues such as preventative care, chronic conditions, health management, etc.
    Answer: Medical necessity is a requirement for Medicaid services. Services provided that are not medically necessary may not be billed to Medicaid.

29. Please define documentation requirements for PSR & CS. Is a monthly progress note acceptable or are we going back to per event documentation?
    Answer: Monthly progress notes are not allowed for PSR or CS.

30. How long do we need to keep group attendance records?
    Answer: 59 Ill. Adm. Code 132 requires records to be maintained for six years. However, if your own policies require longer, those should be followed.

31. If a physician orders monthly monitoring of a client's blood pressure, heart rate & weight, due to possible abnormalities related to ordered psychotropic medications, can this be documented as a med monitoring service on progress note?
    Answer: Yes, if the service is on the individual's treatment plan and related to psychotropic medications.

32. Are we required to keep group rosters showing client to staff ratio?
    Answer: For any group that has a required staff to client ratio, documentation must be maintained for that group indicating who (clients and staff) participated in the group.

33. Does medical necessity include all five axes of the diagnosis?
    Answer: Medical necessity requires a diagnosis of mental illness. Part 132 requires that if the DSM-IV is used, all five axes must be completed.

34. Medical Necessity (deficit centered), Consumer Choice and Recovery (client centered), and LAN (provider collaboration) etc., while not mutually exclusive, emphasize different approaches to treatment. How would you like providers to reconcile these three approaches as we work through this next year?
    Answer: Medical necessity does not preclude incorporating the client's preferences. Client preferences reflect what they would like the outcome of treatment to be. They do not eliminate the need for those services to be medically necessary. They must be considered together.

35. Will monthly summaries be eliminated with the required note for each session?
    Answer: Yes.

36. Per IAC 132.100(a), the clinical record must contain the RIN. Must we also use the RIN as the client ID in the client record and on documentation like the MHA/ITP/Reviews/Psych Notes, etc?
    Answer: No. The Rule does not require that the RIN be used as the agency client ID.

37. Our question pertains to IAC 132.100(i)(5). How should we document on-site and off-site? Are we required to identify an on-site location as the specific program, the cafeteria, school, on grounds, etc., and off-site as a specific address?
    Answer: For documentation of a specific on-site location, reference the site as per your certificate. For off-site, you may provide the name of the location, for example, "Burger King" or "Lincoln Park."

38. Is it acceptable for consumers in community support or group counseling to use their copy of the ITP and write down which objective they worked on, their response and plan in the official progress note that becomes part of their record? Staff would still write the interaction section; add/clarify the response and plan section as needed; make sure that the consumer records an appropriate objective; sign and date the document.
    Answer: Provider staff are responsible for the necessary and complete documentation of services per 132 requirements. Involving the consumers in this is not prohibited, but should not take the place of staff documentation.

39. We are moving to electronic health records (EHR) and electronic signature solutions. It is relatively simple to capture a staff signature electronically. Capturing electronic signature of a client is more complex and requires an investment in additional hardware. We would capture the electronic signature of staff on the Individual Treatment Plan (ITP). We would have the client sign a separate, one page attestation to the fact that they have participated in and received a copy of their ITP, then scan it into the EHR. This would be done each time the ITP is updated. Is this permissible?
    Answer: Yes, that would be fine. As long as everything is available to surveyors, this is ok.

40. Is the client's signature on a group sign in sheet required for billing for group services, such as Group Therapy, Psychosocial Rehabilitation-Group and Community Support-Group?
    Answer: An attendance sheet does not need signatures. It may be a prepared list of names checked off, names recorded by someone other than an attendee, or a sign-in sheet.

41. Regarding documentation for participation in the member advisory council, will the documentation look different?
    Answer: Consumers meeting with staff to provide input into the PSR Service may be a billable activity. However, progress notes still need to relate the individual's progress to their treatment plan. This might include goals/objectives related to self-advocacy and/or identifying their own treatment goals and if the scheduled groups adequately meet these needs. This could also include how to be more active in one's treatment, how to communicate their own goals (communication skills), staying on task, waiting your turn to speak, appropriate tone of voice instead of getting aggravated, etc. For this activity, the documentation would be by individual consumer.

42. How does community support fit into the weekly billing note? Do progress notes have to be individual?

    Answer: Community support documentation must be per event and by individual. Weekly notes are not acceptable.

43. What type of documentation is required to have CSG and CSI that is provided off-site counted as a natural setting?
    Answer: Indicate in the document where the services were provided, i.e., the individual's apartment, library, park, etc.

44. Will services be considered a natural setting if in a community kitchen? (Assumed this meant in a group home)
    Answer: Not if the "community kitchen" is in an agency certified site.

45. A professional has tendonitis and has a hard time signing documents. She has a stamp with her signature that she would like to use. The stamp would not be accessible to others. What do you think?
    Answer: In order for a signature stamp to be acceptable there must be a documented medical reason for it. Additionally, there must be written protocols for its use and safeguarding against anyone else using it.

46. I have tried to find this information, but couldn't. Does DHS/DMH have a requirement about how long we must keep a former employee's personnel files?
    Answer: Rule 132 at 132.85(b) requires records to be kept not less than 6 years.

47. Please clarify the mandate, and explain how will you monitor that the Program Assistant is in charge of: managing medical records, accounting, budgeting, reception, triaging calls and coordination of team communication? In addition, with the current move to electronic health records (EHR), how will this be monitored?
    Answer: Documentation may include a job description or other evidence of performance of these duties. Compliance may be confirmed through review of documentation and interviews.

48. What is acceptable documentation of clinical supervision of non-licensed staff?
    Answer: Signed and dated notes in the staff files. Other documentation is acceptable as long as you meet the requirements of 132.70(e).

49. How would you recommend we document the QMHP's on-site PSR time?
    Answer: There are a variety of ways, for example: a schedule of weekly activities that indicates QMHP on-site time or sign-in/sign-out sheets, etc. Surveyors will need to see some type of documentation that shows this QMHP time on-site.

50. What credentialing or documentation is required to be a co-occurring specialist?
    Answer: Documentation in personnel record that staff have received training on or have experience in co-occurring disorders.

51. We are in the process of implementing a new EMR. The new system has the option of using electronic signature pads which could allow for clients to electronically sign treatment plans, releases, financial assessments, etc. I am wondering if the state has any rules against using electronic signatures from clients.
    Answer: There is nothing in rule that prohibits electronic signatures for clients. They must comply with the rules for electronic signatures in Rule 132. They key component is that there is an assurance that no one else can make that signature on behalf of the client. (6/1/12)

52. I have a question regarding 132.100(i)(1) where it states, "….including whether the service was rendered in a group, individual or family setting…". There are several interventions/services/activities where this piece does to seem to fit. They are: Case Management-Mental Health, Case Management-Client Centered Consultation, Community Support Individual, Mental Health Assessment, Treatment Plan Development, Review and Modification, Crisis Intervention, and Crisis Intervention - Pre Hospitalization Screening. These services are always provided to the client even when family members are present. Staff often get confused on what to check (individual or family) for these when others are present during service provision. Can you clarify what you mean by setting?
    Answer: Setting is used here to indicate mode of service delivery. The services that require that a mode of delivery (individual, group, family)be included are: ACT, Community Support, Community Support Residential, Mental Health Intensive Outpatient, PSR, Psychotropic Medication Training, and Therapy/Counseling. (6/1/12)

53. Is there any signature needed when a client is discharged from an agency?
    Answer: There is no requirement in Rule 132 for signatures on a discharge document. (12/1/12)

54. We sometimes have a "gap" between service date and signature date on our electronic records. For example, crisis services are provided and staff creates the billing and documentation which is signed and date stamped for the service date. The staff has his/her supervisor review the documentation, and modifications are suggested. The staff modifies the documentation and, because it is done on a different date, the automatic date for the signature changes. Will we have a problem if the staff signature date differs from the date of billing for the service?
    Answer: The documentation of service being provided must contain the actual date of service provision. You will have to find a way to document when the service was provided within your electronic record. (12/1/12)

55. In section 132.100(i) the following was added, "shall support the amount of time claimed". How will this aspect be determined for compliance at reviews?
    Answer: The guidance given reviewers is that the note supporting the provision of service must include a narrative that shows that the indicated Part 132 service was provided for the entire

duration of time indicated on the note. When the documentation of the intervention that occurred obviously doesn't support the amount of time indicated, a citation will be made. (3/1/13)

56. The phrase "original signature" seems to have been added in many places in the December 2012 amended rule. What is meant by this?
Answer: Original signature is a signature affixed to a document that is made by the person to whom the signature belongs, either in ink or via electronic means compliant with 132.85(f). Signature stamps are not allowed without a specific medical condition with a statement to that effect in the personnel file from a physician. (3/1/13)

57. 1. 2. Section 132.100(i)(6) specifies the requirements for written documentation. However, in 132.165(a)(3) and 132.165(b)(4) there are other different requirements specified. Which do we follow?
Answer: The written documentation requirements specified under each service in 132.148, 132.150, and 132.165 are the specific service requirements. Section 132.100(i)(6) gives the general requirements, but then defers to the specifics under each service. (6/1/13)

58. In an electronic medical record, does compilation of all the mental health assessment elements in an area of the record labeled "assessment" meet the intent of the standard which requires compilation of data into a written mental health assessment report (132.148(a)(5))? Is there an expectation that a written MHA report must be able to be pulled from the EMR?
Answer: Rule 132 says that the LPHA must review and approve the mental health assessment report and that such review is noted by a dated signature. The signature, of course, in an EMR is an electonic signature, but unless there is a compilation of documents into a report, no one would be able to determine what t was the L reviewed and is signing. While it may not be necessary to provide a written MHA report, there must be an electronic one. MHA reports are also often critical to be able to be shared among providers and with government entities that determine disability. These many reasons support the need for a complied report in either an electonice or written format. So, yes, out expectation would be that there could be a report pulled from the EMR should one be needed that would have the LPHA date signature on it. (6/1/13)

59. Can credential be automatically affixed to an electronic record when the electronic signature is signed?
Answer: Only if the staff person uses only one credential at all times. For example, sometimes a staff person might need to sign as a licensed clinician, but at other times as a CRSS. Electronic records must allow the staff person to either affix a credential electronically or select from a menu of credentials. (12/1/13)

60. Our electronic record system was hit by a virus and we lost lots of information. Can we retroactively create new records from our memory along with paper copies we still have on some people, or do we need to do all new assessments and treatment plans? How do we bill for treatment where the notes were lost?
Answer: Rule 132 requires that providers protect their records from loss. For electronic records this should include regular and dependable backup. Lost records cannot be recreated. Services provided for which there is no documentation, may not be billed. New MHAs and ITPs will need to be redone from scratch, not from memory. (12/1/13)

61. We had an employee leave the agency without completing a mental health assessment note for a client. We have the MHA and it is signed by the LPHA. The client is receiving services from another staff person. Can we submit bills for other services without that one MHA note?
Answer: As long as you have a current and valid MHA and ITP that contains the service(s) provided and have documentation in the record of the service provided, you may bill. You may not, of course, bill for that incident of mental health assessment for which there is no note. (9/1/14)

62. When providing a group service, can the intervention description in the notes be the same for each person, as long as the client response and progress toward goals is different for each

person? Additionally, can the intervention description be "met with" or does it need to be more active such as, "prompted, assisted, provided education, facilitated, redirected, encouraged", etc.?
Answer: The intervention is the description of what was done to provide the service. "Met with" doesn't describe the provision of any service. In a group, the intervention would likely be the same with different responses and progress unless, even in a group, something different was done, such as a different response from the client, a specific question or prompt given to one client. Anything that happened differently that may then have resulted in the different response and progress would be important to note. (9/1/14)

63. In our paper record, a form is used for the admission note that clearly blends the initial assessment and treatment plan into a written report. As we move to an EMR, the functionality of the admission note will require that the clinician move from a distinct assessment module/set of screens to a distinct treatment planning module/set of screens. The interaction with the consumer will not change, just the documentation flow. In the EMR process described above for the admission note, does it remain correct that both the assessment and treatment planning processes be billed as mental health assessment (MHA)? Assume that an expectation would be the capacity to produce a written report/document from the EMR that captures both initial assessment and treatment planning as the admission?

    Answer: Because the Admission Note is an abbreviated MHA and ITP, the creation of the Admission Note is billed as a mental health assessment. However, when a AN is used to begin services, both a full MHA and ITP must be completed within 30 days of the first face-to-face. When those are being completed, the MHA is billed as MHA, but the development of the full ITP is billed as ITP development, review and modification.

    You are correct that there needs to be a way to show, either electronically or on paper, an Admission Note. Remember, the AN is separate from the full MHA and ITP and must show up as separate entities. Since you're trying to go paperless, it would seem that your EMR should be able to include two separate things for you in the system without having to print out a document for a state review. (6/1/15)

64. Would a scanned copy of the original treatment plan (signed by all parties as required) in our electronic health record meet the expectation of Rule 132 for having the required treatment plan report in the client record?
    Answer: Scanned documents containing all required signatures and dates are acceptable. (9/1/15)

65. Does any software exist that can be purchased that assist clinicians in all the documentation/charting/date requirements, etc. for Rule 132? We spend a great amount of time in the documentation to follow protocol and would appreciate any references to software that would assist the clinicians.
    Answer: The State of Illinois does not endorse any specific software vendor. You are encouraged to talk to your colleagues in other agencies for referrals. (8/16/16)

66. When writing a progress note, are providers required to list the symptoms of impairment in each note, i.e., "provided case management to address symptoms of dysfunction in client's mood and anhedonia" or can providers simply identify the goal and objective in which we are treating?
    Answer: When documenting services, the clinician must clearly link each service provided back to the interventions on the treatment plan, which are connected to the assessed needs. (9/2/16)

67. Asking for clarification about documentation requirements for the different modes of therapy which might be delivered in a single therapy session. For example, a family is being met with for therapy services. In the course of a single meeting, the therapist meets with the parent and child, followed by

the child individually, the parent individually, and again meets with the parent and child. From previous post payment reviews, we were left with the impression that this would require 4 different notes to document the four different therapy meetings which occurred. Given this is really one service (therapy) but only represents different modes of the service, we were wondering if this level of documentation is required.
Answer: An Interdepartmental policy group reviewed your question and has the following response: Rule 132 requires that documentation to support services provided must specify the modality provided and the name and/or code of the services provided. As described, the intervention would be billed as Therapy/Counseling, with a modality of Family, and claimed and documented as such. (9/19/16)

68. We have a question regarding the continuity of care requirement. We are wondering if you can provide us with an example of an acceptable continuity of care goal. We are referring to the 132.148 C.6: The ITP review and how it should look. Also, I want to clarify, we do not need to include a continuity of care goal during the initial treatment plan?
Answer: 132.148 c)6) – "The ITP review shall include continuity of care planning with the client or the client's parent/guardian. The ITP review shall also include an estimated transition or discharge date and identify goals for continuing care." Continuity of care planning and goals for continuing care can be documented on the ITP Review in a number of ways – whether integrated with the ITP goals and objectives or documented in a separate section on the ITP Review document. The essential requirement is that the ITP Review includes documentation of desired plans and/or linkages for the client's care following the end of the current service period (i.e., following discharge from your program), along with the estimated transition or discharge date. We do not typically provide examples of specific language since the ITP must be individualized for each client. This item does not apply to the initial ITP, only the ITP Review(s). (10/25/16)

69. Does DHS have a list of the ICD-10 CPT codes that will be accepted under Rule 132? If so, how might I access this list? In addition, I am hoping to gain some information about the documentation requirements under Rule 132. When must documentation be submitted with a claim? Should required documentation be submitted with every claim or should documentation just be kept on record by the provider for reviews?
Answer: The DHS list of ICD-10 codes and DSM-V codes can be found at this website: http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/ProviderManual/10012016-DMH-DSM5-ICD-10-Diagnoses.pdf. No additional documentation is required to be submitted with a claim. Required documentation should be kept on record by the provider and available for any state reviews/audits. (10/25/16)

70. When staff do their documentation on services recommended on the admission note, what is the best thing to list for "goal/objective" that is worked on? Sometimes the QMHP lists the services recommended such as case management, and therapy/counseling, but there is no "formal" goal numbers (such as Goal 1, Goal 2, and so on) until the actual IEP is completed.
Answer: There is no specific requirement in Rule 132 regarding this issue. It is up to the agency to define their own policy. Your example to list the service seems reasonable. (1/10/17)

71. How detailed do progress notes have to be for assessments, given that the assessment done is extensive? Can one say (for instance) that for intervention: "intake completed"?
Answer: Stating "intake completed" would not be an acceptable progress note. Please refer to Section 132.100(i)(1-6) of the Rule for specific requirements which is copied below for your convenience:
Section 132.100 Clinical Records

i. Documentation to support services provided for which reimbursement is claimed shall be in the format specified by the Public Payer, shall be legible, shall support the amount of time claimed, and shall include, but not be limited to, the following elements:

1. The specific service, including whether the service was rendered in a group, individual or family setting and a note in the periodic report indicating the specific Part 132 mental health services billed by name or code;
2. The date the service was provided;
3. The start time and duration for each service;
4. The original signature, name and credential of the staff providing the service;
5. The site or, if off-site, the specific off-site location where services were rendered; and
6. Written documentation of each service provided as described in Section 132.148, 132.150 or 132.165; (4/11/17)

72. Our agency recently transitioned from doing our treatment plans on paper to doing them online in our CIS program. However, we are wondering if this change will give us permission to shorten our progress note for our treatment plans. Prior to this transition, our mental health assessments have been online and our progress note has been more generic like:
"Met with client per scheduled appointment, reviewed opening information, confidentiality and the exceptions to confidentiality. The client relayed they understood opening information, confidentiality, and exceptions to confidentiality. Obtained appropriate signatures from the client and the client received a copy of Client Rights."
"Obtained historical information from client of presenting issues for completion of a comprehensive assessment."

We have been told that this is acceptable because our assessment is available in our CIS program where the progress notes are located. Therefore, we want to know if we can condense the progress note for our treatment plan session as this information is now also located in CIS. Up until this point we have been inputting the information we have collected in the paper treatment plan and putting it into the treatment plan progress note. Is this necessary still? If it isn't, what kind of information needs to be included in the progress note for it to be sufficient?
Answer: This is a decision that your agency has to make. As long as the progress notes meet the requirements of Rule 132 and can be available for review to state auditors, the agency may organize medical records and processes that make sense to your particular system/situation. (7/12/17)