MEDICATION SERVICES (Updated 07/26/2017)

1. We have several clients on Medicaid who fail to pick up prescriptions for stimulant medications prior to the prescription expiring. This requires requesting another prescription from the doctor. To do this, it takes clinician time to obtain what is needed to request the prescription for the client. We know we are not able to bill Medicaid for this time but can we charge the client a $5.00 prescription rewrite fee?

   Answer: This might be case management mental health if one of your agency staff is assisting the client in getting the new prescription and it takes at least 7 1/2 minutes. However, you are correct, that you can't bill Medicaid for writing a prescription. If you're not providing a Medicaid billable service, yes, you may charge the client a fee. You may not choose to bill the client in lieu of claiming Medicaid for a Medicaid billable service.

2. What are your thoughts on clients who receive medication services only? Some clients do not want to go to their primary care physician and continue seeing the psychiatrist here at our center. But it is challenging in proving medical necessity for these clients on the MHA.

   Answer: Anyone receiving Rule 132 services must have a MHA and ITP as detailed by Rule 132 and the services must be medically necessary. However, if a physician is providing services and billing directly to the Dept. of Healthcare and Family Services, s/he must do so in accordance with expectations of HFS and would not bill DMH for the provision of a 132 service. When there are no 132 services being provided or claimed, Rule 132 no longer applies.

3. Services to clients by nurses are not always provided in convenient blocks of billable time. Here's a typical scenario: a) Client calls and talks to nurse re med side effects. Nurse listens, tells client she will speak to doctor and call back: Med Monitoring, 6 min, not a billable unit; b) Nurse discusses case with doctor, who changes meds: CM-CCC, 6 min, not billable unit; c) Nurse calls pharmacy, orders change in meds: CM, 5 min, not a billable unit; d) Nurse calls client, lets them know of med change, answers questions: CS, 6 min, not a billable unit. The nurse provided 23 non-contiguous minutes of direct service to the client. Medication management is one of the keys to successful recovery and we spend a lot of time engaged in the above scenario. Could we bundle this service and bill it under CS-Individual? In my humble opinion it is "related to facilitating the client's ability to manage his/her illness and promotes independence in the management of the illness." It also "supports the client's well-being."

   Answer: No, these services may not be bundled together and billed as community support. We believe that a) and d) are community support (med monitoring with the client must be done face-to-face); that b) is med monitoring; and that c) is case management - client centered consultation, but that none of them can be billed because they aren't provided for at least 7.5 minutes.

4. Under what procedure would we bill for metabolic screen? It is a service that was developed in keeping with mandates from APA, ADA and the National Association of State Mental Health Program Directors. For all patients receiving anti-psychotic medications, the screen includes reviewing current medications, monitoring blood glucose (non-fasting finger stick), weight, B/P, measurement of girth, and recommendations for further follow-up.

   Answer: Metabolic screens are not necessarily 132 billable services. Any blood testing done at the time of medication administration as required for the particular medication is billable as medication administration. Reviewing current medications may be considered mental health assessment. If a physician does the other screens, they may be billable directly to HFS as physician services.

5. 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 included in the rate for psychotropic medication services.

6. 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.

7. 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.

8. We are changing our service name Medication Management to better reflect the Rule 132 service. Since Medicare recognizes Medication Management as a service, and Rule 132 recognizes the same service as Medication Monitoring, we are considering calling the service Medication Monitoring/Management. Would that be ok?

   Answer: That's fine as long as they're not doing medication administration or medication training under this name.

9. Rule 132 calls for a statement indicating that the client has been informed of the purpose of the psychotropic medication(s) ordered and its side effects. Does having the psychiatrist document that this conversation/notification has occurred in a progress note and discontinue use of Med Consent form which indicates client signature? Basically we need to know if the doctor's note/signature on the note that this occurred satisfies this standard or if a client signature is needed to document the notification occurred.

   Answer: Rule 132 doesn't require a client signature. However, some accreditation standards do, so I would suggest you also check there.

10. Must the client be present for a 90-day medication review performed by a physician/APN on staff or contracted with a facility?

    Answer: No.

11. If there is no physician/APN on staff or contracted to work with the facility, are the 90-day medication reviews still needed?

    Answer: No. It would be the assumption that clients are receiving therapy services at the Center, and an outside physician is prescribing psychotropic medications. No medications are being prescribed in house. If there is no physician on staff prescribing medications, there would be no mandate to provide monitoring of medications not prescribed in house.

12. If the 90-day reviews are required, and a doctor needs to sign off on a list of staff qualified to do these reviews, what staff would qualify, and would it matter what physician signed off on the list? Would a physician also have to sign off on the 90-day review?

    Answer: If a physician/APN is employed by or on contract with the certified provider, one of them must do the 90-day review. There is no provision for delegating this to anyone else.

13. Can the content of the notes for 90-day reviews be a form that lists the client's current medications, review of medications, and continue medications as prescribed, with the Dr. signature and date of signature?

    Answer: Yes.

14. The physician needs to sign the form to "designate medication responsibility" to the med passer in our program. The nurse has a place to sign but there is nowhere for the physician to sign. It is also not clear to me what it means to have the physician sign. The available materials for IL M/A Certification I have do not appear to clearly delineate "the Illinois expectations of the physician." Can you refer me to any resources on this?

    Answer: The physician requirements are covered by Rule 132. Please note that an advanced practice nurse, equivalent to this designation in Illinois, may also serve in this role.

15. I have a question about medications in the residential setting. Currently we provide the residents with their personal medication planners at times during the day when prescribed medications are to be given. The planners are locked up in the staff office until time for residents to take them. Protocol calls for the resident to request their medications and their planners are handed to them by the staff in the plastic containers. The staff are to never physically touch the meds, only to hand the planners to the residents. It is our prior understanding that this does not meet the definition of medication administration but we certainly need someone to help us make sure we are in compliance with state regulations or at least best practices.

    Answer: It should be clear that the clients have the ability to self-administer their medications. If that is clear, staff handing their meds to them in the way you describe is not medication administration.

16. Can medication monitoring be provided over the phone?

    Answer: Medication monitoring must be done face-to-face or via video conferencing. The only allowable exception is when a client is experiencing adverse symptoms from psychotropic medication and phone consultation with another professional is necessary.

17. Rule 132 says that notations shall be made in the client's clinical record regarding.... assessment of the client's ability to self-administer medications. Can you clarify the meaning of "self-administer medications?" We interpret this to mean the client can safely have custody of his medications. We are assuming that indicating a client can self-administer medications does not preclude the client needing Medication Training. Can the client be assessed as "able to self-administer medications" even if they require (or could benefit from) Medication Training?

    Answer: Yes, medication training can be provided to someone capable of self-administration of medication. As with any service, the mental health assessment must show a need for the service and it must be included on the ITP.

18. Rule 132 says, "There must be a note, describing the review of the psychotropic meds.... every 90 days. The client need not be present." In the cases where clients fail appointments for various reasons, and therefore are not present for a doctor's appointment in 90 days, we're unclear about what the doctor would write when "reviewing" the medications. If the client has failed doctor's appointments, then they would be out of medications. If they are not present, then there is no way to assess symptoms and response to previously prescribed medications. What is the intention behind "reviewing" medications if the client is not present?

    Answer: The intention is to keep the physician aware of the medications being taken and having them state that they should continue.

19. We're unclear about what the doctor would write on a note reviewing medications of a client who does not have medications and is not present.

    Answer: If no medications are being taken, then no review of medications can occur.

20. The Rule indicates that medication services are provided face to face. Does that mean that a doctor or APN cannot provide a consultation to the nurse about a medication adjustment without seeing the client? Must the doctor or APN see the client face to face in order to adjust medication? Can the doctor make adjustments in medications based on client report or staff report?

    Answer: Adjustments to medications may be made in compliance with the Medical Practice Act or Nursing and Advanced Practice Nursing Act. However, in order to be billable, psychotropic medication services must be done according to rule requirements. Both medication monitoring and medication training may be done face-to-face or via video conference. Medication administration must be done face-to-face.

21. In our residential setting, staff not yet approved by the doctor assist the client with getting their medication box out of the locked cabinet, ensure they are taking it correctly and interact with them. Is this billable as CS-Individual? The service Medication Monitoring requires approval by a physician, and I am not asking about medication administration, but about a service that assists the client in taking their own medication properly and ensuring that there are no problems with that.

    Answer: This is not billable. It does not meet the rule requirements for a billable service, i.e., staff do not have physician authorization. Just because staff haven't been authorized, doesn't then allow you to bill this as another service.

22. A case manager picks up medication for a consumer and transports it to their home because they were unable to get it themselves. Is this billable as CM-Mental Health?

    Answer: Picking up medications is not a billable service.

23. We are trying to interpret the documentation requirements for 90-day medication reviews. Rule 132 indicates that "psychotropic medication is reviewed at least every 90 days by a physician or advanced practice nurse." The rule then discusses notations that should be made in the clinical record re: psychotropic medication and other types of medication, but does not state that all items on the list need to be documented every 90 days. The rule states that "services shall be provided face-to-face with one exception..." We interpret that to mean Medication Administration, Monitoring and Training all need to be provided face-to-face or, when allowed, via video conference. It does not state that the 90-day review has to be face-to-face. Who must see the patient and/or sign the documentation, and what specific information must be documented every 90 days? How should we handle it if we are making diligent efforts to see the client at least every 90 days for this review, but the patient does not appear or cancels the appointment?

    Answer: The two sections of the rule are not related. One states that a 90-day review must be done and we would expect to see a note signed and dated by the physician or APN that it was done. The other identifies the information that must be kept in the file on medications. That should be updated as medications change. The consumer does not need to participate in the 90 day reviews.

24. (a) If a consumer/client is first seen and prescribed 30 days worth of medication but is not seen again for 100 days, must the medication review occur 90 days after the first appointment? (b) If a client was advised to taper off a prescribed medication over 30 days, would the physician have to review the medication 90 days from when the client was last seen? (c) If a client saw a psychiatrist, was prescribed medication and scheduled to be seen again in 80 days, but was hospitalized at the 80th day under the care of another doctor, would the psychiatrist need to review the medication h/she prescribed by the 90th day? (d) When a client is prescribed a 60-day supply of medication and is scheduled to be seen in 60 days, but fails the appointment, does the doctor need to review medication at the 90 day interval?

    Answer: The rule requirement is for a review of all psychotropic medications at least every 90 days. This does not preclude any physician from wanting to review any specific medication separately during each 90 day period.

25. Does a psychiatrist have to be "in the building" when the APN is seeing clients?

    Answer: The collaborative agreement defines the services that an APN can provide and under what conditions. DHS will audit the provision of service and presence of the psychiatrist based on the collaborative agreement. If the collaborative agreement states that the psychiatrist must be on site when the APN provides services, we will look for evidence that the psychiatrist was on site. Otherwise, it is not a DHS or HFS requirement.

26. Can an Advanced Practice Nurse who works under the supervision of a Psychiatrist do the 90 day medication review?

    Answer: The rule states that a physician or advanced practice nurse may do the 90 medication review.

27. Per Rule 132, medication monitoring can only be done with the client present. It seems a little odd that one cannot do medication monitoring when speaking with the guardian who (especially in the case of younger children) is the one responsible for ensuring that the client takes their medications and monitors for side effects. Would this be billable as Community Support?

    Answer: For Medication Monitoring, the client must be present and medication monitoring cannot be billed as another service.

28. Can an agency RN bill one unit of medication training for filling a medication box for a consumer that is unable to do so and is not present?

    Answer: Filling meds without the client present and participating is not billable. It is not billable as case management, psychotropic medication management or any other service. It is paid for as part of the indirect costs that are used in calculating the rates.

29. A citation from Rule 132 in a BALC memo to Provider Agencies Dated October 1, 2007, speaks of doctors reviewing patient medications every three months. In our May 2007 Medicaid Certification survey, doctors were told to review records of patients prescribed psychotropic medications every 3 months, even if the patient has not been seen in that time period. Our general practice is to see patients on psychotropic medications monthly. Some stable patients are scheduled every 2-3 months. Occasionally, a few do not keep their appointments and become inactive due to incarceration, relocation, hospitalization, etc., and return after 4-5 months to see the doctor again. The inactive cases are kept open for at least 6 months after the last appointment to avoid frequent closing/re-opening. Does Rule 132 require non-CILA outpatient clients who have been prescribed psychotropic meds, be reviewed every 3 mos., regardless if patient is currently inactive, if the case is still open with DMH?

    Answer: The note in the quarterly memo applies to the specific requirement in Rule 115. Rule 132 requires a 90-day review of psychotropic medications when the prescribing physician/APN is employed by or on contract with the certified provider. However, if your agency is not providing services to an individual, review of medications seems impossible. We suggest that, until you know the individual is inactive, the 90-day reviews continue. An example: if medications are reviewed on 9/1/07, the individual continues in service consistently until 10/31/07 and then seems to disappear, the 12/1/07 review should be done. If the individual does not show up and the case is deemed inactive, a note should be in the file attesting to that and the 3/1/08 review would not be done unless the individual returns to services before that date.

30. Is Medication Administration only billable if the medication is given at the time of service or can they bill for it if a prescription is given?

    Answer: Medication administration is administration of psychotropic medication, not writing of prescriptions.

31. I understand that review of lab results is now medication monitoring. Is it acceptable to bill a phone discussion of these results, and if so only with the client or with another service provider, etc?

Answer: The answer to this question is found in the Service Delivery and Reimbursement Guide, Psychotropic Medication Monitoring, Example Activities. Basic requirements are outlined in Rule 132.

32. Can an RSA bill for medication monitoring? It is not stated in the revised rule. The Service Delivery and Reimbursement Guide states the minimum staff requirement as "Staff designated in writing by a physician or advanced practice nurse..."

    Answer: As per Rule 132, there is no minimum staffing requirement for medication monitoring. Staff eligible to provide the service are those designated in writing by the physician or APN.

33. Can an RN bill for Medication Monitoring or Case Management, if she does not possess one year mental health experience or does not have a master's degree in psychiatric nursing?

    Answer: Medication monitoring can be provided by staff designated in writing by a physician or advanced practice nurse per the collaborative agreement. Case management mental health shall be provided by at least an RSA. Case management client-centered consultation shall be provided by at least an RSA. Case management transition linkage and aftercare shall be provided by at least an MHP. Any higher level staff may always provide 132 services.

34. In order to claim medication monitoring for doing a TD screen, must medication monitoring be on the ITP or can TD screening be claimed as some other service?

    Answer: For medication monitoring to be claimed, it must be on the ITP. TD screening may not be claimed as any other service. (5/31/11)

35. May a doctor run a medication group? The rule says that psychotropic medication training shall be provided by staff designated in writing by a physician or an advanced practice nurse per the collaborative agreement. The Service Definition and Reimbursement Guide includes a rate for an APN, but does not specify another credential level. Is it possible for a doctor to run a group but have it charged at a rate other than the APN rate?

    Answer: Anyone, as authorized by a physician or APN, can do psychotropic medication training in a group setting. There is no LPHA rate for this because it is very unusual for a provider to use such a high level of staff to do this. There are only two levels of staff - MHP and APN designated. (9/1/11)

36. The Service Definition and Reimbursement Guide indicates that telephone is an accepted mode of delivery for Medication Monitoring and also shows an example activity that is not limited to emergency situations. Is telephone now an acceptable mode of delivery?

    Answer: The SDRG is confusing because the boxes checked do appear to say that medication monitoring may be done by telephone. That box is checked only to allow that medication monitoring by telephone is acceptable in the one case of the emergency consultation. It may not otherwise be done by telephone. (6/1/12)

37. In the Service Definition and Reimbursement Guide (SDRG), in the minimum staff requirements for medication training, nothing is checked which suggests that any level staff can bill for this service. However, in the coding summary at the bottom of the page, the fees only start at an MHP level. I just want to verify whether or not an RSA can bill for medication training, and if so, what are the appropriate fees?

    Answer: In the SDRG under staff, "Other" is checked and below under staffing notes, it says, "Staff designated in writing by a physician or advanced practice nurse per a collaborative agreement." Therefore, you must have documentation that a physician or APN has designated the staff providing medication training as appropriate to do so. Then they may deliver the service. Unless the staff doing the training is an APN or MD, the rate indicated as MHP is billed. (9/1/12)

38. It is common for our nursing staff to administer several different psychotropic medications (two or more) at a scheduled medication time for clients in our crisis residential program. Each

medication has to be prepared for administration and then given to the client to be taken. Is this billed as a single medication administration or once for each medication given?

Answer: Because psychotropic medication administration is an event mode payment, it is not specific to the number of medications administered, but specific to the time at which it is done. Therefore, no, you may not bill a separate event for each medication. (9/1/12)

39. After a visit with the physician, the RN calls the client the next day to review the medication changes and talks about side effects, etc. This service meets the criteria for either medication training or medication monitoring. However, the rule says that neither service can be done by phone. What service would you suggest we use for billing purposes?

    Answer: Medication services may not be provided via telephone. This does not qualify as any other service and is not billable. Perhaps consideration could be given to having the nurse do this while the client is in the office to meet with the physician. Then it would be face-to-face. (12/1/12)

40. I a nurse prepares the medication, offers it the client and the client refuses to take the meds, can this still be billed as a medication administration event? There has been no actual administration of medication or an opportunity to observe for possible side effects.

    Answer: This cannot be billed as Psychotropic Medication Administration. However, depending on the further interaction with the client, it might be billable as another service. (3/1/13))

41. Do we have to document that children are able to self medicate?

    Answer: You must document that you have assessed their ability to self-administer medication. (6/1/14)

42. An example under "Psychotropic Medication Administration" states, "In addition to the activities in the service definition; drawing blood per established protocol for a particular psychotropic medication" is considered this service. Does this mean that the payment for the venipuncture/blood screening is included in this payment for $10.21 per event?

    Answer: This is an all-inclusive event payment for whatever needs to be done per established protocols when a psychotropic medication is administered. (9/1/14)

43. Which activity code is used for medication distribution/administration? This is when the client meets with the RN to receive either a daily or weekly medication box fill, medications and their use are discussed. Also, what code is used for blood pressure checks for the client's scheduled visit to the doctor?

    Answer: Medication administration, as long as it appears in the treatment plan and has been identified through the mental health assessment process as medically necessary, is billable as medication administration. See the SDRG for billing codes and rates. The SDRG is available at http://www2.illinois.gov./hfs/SiteCollectionDocuments/cmhs.pdf. Blood pressure checks and medication fills are not Rule 132 billable services. Since the physician visit is billable directly to HFS, those are treated as "incident to" the physician visit however that is directly billed to HFS. (9/1/15)

44. How can we demonstrate that staff are designated in writing by a physician or advance practice nurse to provide medication training? Is there specific wording that the letter from the nurse or doctor needs to contain in order for staff to provide this service?

    Answer: There is nothing specific. Whatever written documentation given must be kept in the personnel file(s). (9/1/15)

45. 132.150.6.C states psychotropic medication training shall be provided by staff designated in writing by a physician. When training is provided to staff by the physician, can that be done via videotape or do you have any oversight on how that is done?

    Answer: There are no regulations in Rule that addresses the modality of training to be used. (12/13/16)

46. Are we able to bill Psychotropic Medication Monitoring under Rule 132 provided by a nurse on the same day a psychiatrist provides Psychotropic Medication Monitoring/Management that is billed to HFS? There are times the nurse will meet with the client and reconcile medications, as well as assess the client's side effects using the AIMS, etc. prior to the visit with the psychiatrist.

    Answer: The Division of Mental Health has been able to confirm that this would be acceptable and that the claims would pass through the system's duplication check without issue. (9/12/16)

47. Can you verify that a Licensed Practical Nurse can bill under a Medical Doctor supervision?

    Answer: Yes, an LPN may administer psychotropic medication under the supervision of a physician. (2/9/17)

48. When psychiatric nursing staff receive telephone calls or voicemail messages from clients or guardians regarding medication refills and nursing staff review the medication record and any side effects or symptoms related to the medication with the client over the telephone, what Rule 132 service activity does this apply to, considering Medication Training cannot be provided over the telephone?

    Answer: Sounds like it could be medication monitoring if it meets all of the requirements of Rule 132. Here's the link to the Service Definition & Reimbursement Guide for you to review the language regarding medication monitoring.
    https://www.illinois.gov/hfs/SiteCollectionDocuments/10.11.16%20SDRG%20Handbook%20-%209-30-16.pdf (7/12/17)

49. Per the service definition and reimbursement guide example activities for psychotropic medication administration, drawing blood per established protocol for a particular psychotropic medication is an allowable activity. The minimum staff requirement is stated as an LPN w/RN Supervision. Some Certified Medical Assistants are trained to do blood draws. May a CMA bill for drawing blood?

    Answer: No, a CMA may not bill for drawing blood. The minimum requirement in Rule 1232 is LPN with RN Supervision. (7/25/17)