Questions and Answers Rule 132 August - December 2007

TOPICS

GENERAL / OVERALL REQUIREMENTS - RULE 132:

DOCUMENTATION
STAFFING-CREDENTIALS-SUPERVISION

GROUP A - RULE 132.148 SERVICES:

MENTAL HEALTH ASSESSMENT
INDIVIDUAL TREATMENT PLAN (ITP)

GROUP B - RULE 132.150, AND 132.165

ASSERTIVE COMMUNITY TREATMENT (ACT)
CASE MANAGEMENT
COMMUNITY SUPPORT (CS)
COMPREHENSIVE/SHORT-TERM DIAGNOSTIC SERVICES
CRISIS
PSYCHOSOCIAL REHABILITATION (PSR)
PSYCHOTROPIC MEDICATION SERVICES
THERAPY / COUNSELING

GROUP C - NON-MEDICAID SERVICES (NMRO):

ORAL INTERPRETATION & SIGN LANGUAGE
VOCATIONAL / EVIDENCE-BASED SUPPORTED EMPLOYMENT (EBSE) SERVICES:
OUTREACH & ENGAGEMENT (O&E)
STAKEHOLDER EDUCATION

OTHER:

GENERAL ISSUES
BILLING-CODING-PAYMENT

GENERAL / OVERALL REQUIREMENTS of RULE 132:		
DOCUMENTATION		
1	Q	Where can I get a copy of sample documentation for FY '08 Community Support or Psychosocial Rehabilitation?
	A	You may get a copy from your regional DMH office.
2	Q	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?
	A	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 ½ of the billing unit.
3	Q	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?
	A	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.

4	Q	When is an LPHA required to co-sign the progress notes of other staff?
	A	An LPHA is not required to co-sign the progress notes of other staff.
STAFFING - CREDENTIALS - SUPERVISION		
1	Q	Would a person qualify as a QMHP with a Master's Administration of Justice, domestic violence specialty? The resume says s/he was a Q for another agency.
	A	It is up to the provider to determine and document the qualifications necessary to be considered a QMHP. Rule 132 definition of QMHP includes "an individual possessing at least a master's degree in counseling and guidance, rehabilitation counseling, social work, vocational counseling, psychology, pastoral counseling, or family therapy or related field, who has successfully completed a practicum or internship that included a minimum of 1,000 hours of supervised direct service, or who has one year of clinical experience under the supervision of a QMHP."
2	Q	I am writing for further clarification of the supervision requirement. We are planning on reconfiguring some of our lines of authority in relation to supervision. My understanding is that this needs to be in place before the end of the transition period. Others have stated that the clinical supervision requirement was effective July 1st. Is my assumption correct?
	A	The requirement for 1 hour of clinical supervision started on July 1, 2007. Keep in mind that it has nothing specifically to do with the organizational structure of a provider. When we look for documentation, we'll need to see what was done for one hour per month by whom and with whom. We will not look at an organizational chart or lines of authority.
3	Q	Are Osteopaths (D.O.s) approved for 132 services when a physician is required?
	A	Yes. A D.O. is licensed under the Medical Practice Act and meets the definition of a physician.
4	Q	We have 2 new MHPs, both with master's degrees and 600 hours practicum. Must we wait a full year before moving them to QMHP, or can we allow their practicum hours and status them as QMHP after they complete an additional 400 hours here?
	A	If the master's degree is relevant, an additional 400 hours would fulfill the 1,000-hour requirements.
5	Q	Can agencies bill for services provided by volunteers who are professionally qualified per Rule 132?
	A	Agencies cannot bill for services provided by volunteers.

6	Q	a) How does a licensed psychologist (Psy D) who supervises doctoral students bill psychological testing done by BA/BS students doing their externships? Students administer tests but we supervise the work and write-up. Is it 01 or 07? Students receive one hr/wk individual supervision. b) If the students conduct psychotherapy and we provide weekly supervision of their caseload, do we bill the psychotherapy under a Q or MHP level as counseling? They have co-therapy numbers for the agency. Is Q-level billing for individual or individual counseling under MHP noted as 2A? c) If they do psychological evaluations/assessment but no testing, is it billed as OQ under a licensed psychologist or as OM as an MHP?
	A	**a)** The assistance by the students is not billable. The rule states in 132.148 b) 1) that "a master's level professional may assist", and these students do not meet the criteria. **b)** The service must be billed based on the qualifications of the person who is providing the service, not their supervisor. Based on your description, the student meets the definition of an MHP. **c)** Again, billing is based on the person who is providing the service, not their supervisor.
7	Q	Is it correct that the 1hr/mo of clinical supervision for non-licensed staff can be completed by either a QMHP (not necessarily licensed) or an LPHA?
	A	The answer to this question, found in 59 ILAC 132.70 d), requires that supervision of non-licensed staff be provided by a QMHP or LPHA.
8	Q	If someone has a masters from an institution of higher learning, like DePaul University, in a program that deals with adults and identifying effectiveness in both their personal and professional life, (basically how adults learn and deal with major change in their lives). Additionally, that person has 1,000 hours post-master's experience in intensive case management and MISA recovery. Would that person qualify to be a QMHP?
	A	Please see Rule 132 at 132.25 for the definition of QMHP. It is your agency's responsibility to evaluate the person's credential and document that they meet this definition. At this time, DHS does not credential Qs.
GROUP A SERVICES - RULE 132.148:		
MENTAL HEALTH ASSESSMENT		
1	Q	Does the mental health assessment annual update have to be done based on an interview session where the client is present? If client has to be present while MHA is conducted, does the same requirement for a QMHP contact apply? If it can be done based on review of the previous assessment and knowledge of the client (client not present) is this a billable service?
	A	The same principles apply to the mental health assessment and the annual update. Some of the update is completed based on personal knowledge of and contacts with the client. Other pieces of the update can be done by reviewing the client's record, related documents or collateral contacts. The time spent completing the update can be billed; the client's presence is not required for billing. This is true for the initial mental health assessment as well. Just remember that time spent writing the report, without the client present, is not billable. Activities related to paperwork are part of the administrative component of the rate.

2	Q	We have staff in the classroom completing a questionnaire while observing a student during class. It relates to the student being either on or off the presented task and is used to help determine a diagnosis of ADHD. They are not technically providing a face-to-face service - no interaction with the client occurs. What would be an acceptable DHS activity code for a service such as this when not in the assessment period, i.e., the assessment has already been completed, CS-Individual or CM-Mental Health? The service assists the client. If we use a non face-to-face code, we have always indicated to staff that the location of the service is office; this observation is not in the office but the school.
	A	Assessments may be ongoing, not just prior to completion of a mental health assessment. The activity that you describe seems to be mental health assessment.
3	Q	I have two clients who need to see our PSR Coordinator for assessments (MHA & CASIG). She has never met one of these individuals and only had one meeting with the other, so is not familiar with either of them. One individual has a significant speech impediment. Some direct care staff have worked with him for a number of years and understand him quite well. The other individual is deaf, and though he reads lips well with people he knows, this is not the case with someone he has just met. He signs, but will not employ sign language. In addition, his conversations and responses are skewed by auditory and visual hallucinations. He sees auras, which speak, and to which he responds, therefore, you must separate responses to you from responses to the aura. That is a skill gained through experience with him. To ensure these appointments are effectual, I am having one of my MHPs sit in with these individuals to provide assistance with communication and help them answer questions, etc. Naturally, the PSR Coordinator will bill for the MHA and CASIG, but in such a situation, is it appropriate for both staff to bill different services for the same block of time or do you have an alternate suggestion?
	A	Only one staff can bill for a direct intervention with a client at the same service event. The only exception is when the client is hearing impaired or English is not their primary language, and oral interpretation/sign language services are necessary for the provision of mental health services. The MHP's time with the deaf client may be covered if the MHP is versed in sign language or oral interpreter services, and the service meets the criteria for Oral Interpretation and Sign Language in the Service Definition and Reimbursement Guide (page C-2).
4	Q	When a QMHP meets face to face with a client to gather info regarding application for service and to discuss their fee, is this considered part of the assessment?
	A	This does not appear to relate to the mental health needs of the individual and as such would not be considered part of a mental health assessment.
5	Q	For the new standard of conducting client assessment updates within 12 months of the original assessment, if client misses appointments and there is evidence of trying to re-engage the client, and the client is seen after the 12 months, assessment update done at the first appointment the client keeps, are we in compliance?
	A	No. If the client drops out of service and then returns, another assessment must be done in compliance with time frames established in Rule 132. If the client continues in services, the assessment update must be done within 12 months, every 12 months. There is no grace period.

6	Q	What service do you bill for when completing the annual re-assessment of services?
	A	Billing is always for the intervention provided. In this case, it seems most likely that it would be mental health assessment.
7	Q	Does there need to be a note for the Q's face-to-face for the MHA and MHA Update or does their dated signature verify that they had a face-to-face with the client?
	A	Often on MHA reports there is a statement or box to be checked indicating that a face-to-face has been done. This, along with the Q's dated signature is sufficient evidence of the face-to-face. However, if the agency intends to bill for the time (at least 7 ½ minutes) spent by the Q in the face-to-face, there must be a signed, dated note describing the intervention provided and the client's response to it.
8	Q	When doing an annual mental health assessment (MHA) update, does there have to be a face-to-face contact with the QMHP like an initial MHA? It doesn't really specify in the Rule in regards to annual updates.
	A	The current rule does not require face-to-face contact with the QMHP during the annual MHA update, however, the upcoming rule revision will require it.
9	Q	How often and in what programs is a provider of MH services required to administer the Multnomah?
	A	None. The Multnomah is optional, not required.
INDIVIDUAL TREATMENT PLAN (ITP)		
1	Q	Does Rule 132 require that a list of current psychotropic medication be listed on the ITP?
	A	Rule 132 does not require a list of psychotropic medication on the treatment plan. It is part of the mental health assessment and the list of psychotropic medications must be in the clinical record.
2	Q	Today we shared examples of different agency ITPs. All were different, often dramatically. Could we revisit statewide forms or formats to simplify the documentation?
	A	We are willing to revisit the issue especially when the Administrative Services Organization is operational.
3	Q	Can you have multiple interventions for a single objective on a treatment plan?
	A	Yes.

4	Q	I have a question about the Delay of Services form that we use. I wonder if you could tell me if it is sufficient to hold up under MRO guidelines. If not, could you let me know what we need to do to change it?
	A	While a form may document various reasons for delay in treatment plan development, it does not meet Rule 132 expectations. The ITP must be completed within 45 days following completion of the Mental Health Assessment and every six months after its completion.
5	Q	When an MHP meets with a client for treatment planning development, review, modification, does the Q or L have to meet with the client face to face?
	A	The rule does not require the QMHP or the LPHA to meet face to face with the client for treatment plan development, review or modification. We also want to caution you on best practice versus minimum requirements in the rule. The QMHP is designated as the responsible staff for the delivery of the services and the LPHA recommends medical necessity. It seems that it would be advantageous for the LPHA and QMHP to be familiar with the client and his/her needs, which may include a face-to-face meeting with the client.
6	Q	Rule 132 has a section on what is needed in an individual treatment plan. However the regional training has been promoting the use of recovery language. Can an ITP be called an Individual Recovery Plan? This has been a staff and consumer question.
	A	There is nothing in rule that limits your ability to re-name an ITP. Regardless of the name, it must contain all required elements and staff must know what to produce when reviewers request to see an ITP.
7	Q	For a current active treatment plan where no interventions, goals and treatment codes have changed, is it required to redo a treatment plan before 09/30/07?
	A	No, but make sure that frequency is included in the plan.
8	Q	I have heard different interpretations from Medicaid staff as to how to list the number of times a service is recommended on a treatment plan. Is minimum, range or maximum expected?
	A	Use your best estimate; all of these options are acceptable at this time.
9	Q	Some of our treatment teams are large and may involve 6 or 7 providers. One provider may be the Q and another an LPHA. The way we read the rule is that as long as the QMHP, the LPHA and the client sign the ITP we can just list the other providers and their involvement per objective/task. Is this correct?
	A	Yes, the Q, L and client must sign the ITP. Others listed on the ITP must only be the staff person who is responsible for implementation of each objective.

10	Q	I am working with EPS hospitals in developing a procedure that will allow the clinics to receive a copy of the ITP for billing transition and aftercare service. The hospital would include an intervention on the ITP and the clinic would request a copy of it. Must the hospital send to the clinic only the page with the problem, goal, and aftercare intervention, or the entire ITP?
	A	It is important to give the clinic a copy of the objective(s) reflecting the need for transition and aftercare services, and the signature and date page.
11	Q	We use the service description from the Service Definition & Reimbursement Guide to indicate an authorized service on the ITP. For example, we write Case Management-Mental Health, or Case Mgmt-Mental Health. Clinicians may also put our agency service activity codes next to the description for reference. We do not put DHS or HCPCS codes/modifiers in the ITP because the service description clearly indicates what the authorized service is. Listing multiple codes/modifiers takes a lot of space and time. To allow practitioners flexibility, and substantially reduce documentation time, our system translates agency codes to the appropriate codes/modifiers based on staff credentials, locations, and who we are billing, i.e. DHS, SASS/HFS, commercial insurance and/or Medicare. Recently, a surveyed agency was asked to write the DHS 2-digit codes on an ITP. Is this is a new requirement from your office?
	A	There is no need to write DMH code numbers on the ITP as long as you have included the service as you described.
12	Q	Can we prescribe both S2-CS-Group-MHP & S3-CS-Group-QMHP to meet one objective in a treatment plan? A consumer may receive services from both. The Q may run the group on Monday; the MHP may run it on Wednesday. Can the ITP look like this - Goal: To achieve mental health stability & reduce unnecessary hospitalization; Service: S2, S3; Frequency: 2 times weekly; Objective: Consumer will identify 2 community resources for stress management.
	A	The ITP need only reflect CS-Group. You do not need to specify level of staff prescribed. You must, of course, bill for the actual level of staff providing the service. Additionally, there may be more than one service prescribed for any one objective.
13	Q	When does the ITP become active, when developed and signed by the QMHP, when the client signs, or when it is signed by the LPHA?
	A	The official active date of the ITP is the LPHA signature date.
14	Q	Does the 6-month ITP review follow the date the LPHA signed, or the date it was developed by the QMHP?
	A	The LPHA signature date.
15	Q	Does the LPHA need to sign prior to any services on the ITP being provided?
	A	Services included on the ITP may be provided following completion of the MH assessment as long as the ITP includes the service and is completed within the required time period.

16	Q	I would like to describe our treatment team staff meeting for clarification about how this is billed. The plan is not developed in this meeting and the client is not there. It is discussed after the development and the Q is present in this meeting. If it is the ITP, this is discussed. If it is the MTP, then any changes made are discussed. This could be any change in the entire plan.
	A	We don't know what an MTP is. The rule does not specify that the client must be present when the ITP is developed, reviewed or modified. The part of ITP change that is not billable is the time during which the actual paperwork is done to make the changes.
17	Q	Please clarify what is expected for treatment plan reviews. Is it ok to make a statement that the treatment plan was reviewed and all elements are to be continued, or must we specifically address each goal, objective, service, frequency, and staff? Must the 5-axis diagnosis be on the reviews as well as on the treatment plans?
	A	Details for completing and reviewing the ITP are outlined in 59 ILAC 132.148 c), while certain documentation requirements are discussed in 59 ILAC 132.100. A thorough review of the ITP must include documentation of the client's response in relation to the goals in the ITP and an indication of how each criterion will be addressed in the forthcoming 6 months. If modifications will be made or not made, that should be documented as well.
18	Q	Do we have to identify a specific staff member for Community Support Activities in the Treatment Plan? During Day 1 of the the workshop - Rehabilitative Interventions, Fall of 2007 - under the Section listed CMH Proposed Rules for Rehabilitative Plan and under bullet 11 - it was stated that "Anticipated Providers be listed on the plan." On Day 2 of the Training it was listed that "under a Primary Community Support Model each consumer should have an identified primary community support staff member who serves as a point person for coordination and communication among staff." In an agency without a Primary Community Support model and where PSR and Community Support Services are offered by a small team of three, is the specific name of an staff member required when listing anticipated Community Support Services or can the treatment plan be more general? As a further complication, our agency has a Supported Residential Program and its clients are often in PSR services. Because of this, Community Support Activities are often provided by both PSR and SRL staff in a cooperative manner. Therefore, in the treatment plan can we specify, for example - PSR or SRL staff will assist John to ...?
	A	If a consumer is receiving community support services per the ITP, a responsible staff person must be designated for each objective, either by name or by title if there is only one person in that title.

19	Q	We had treatment plans that were off by the 6 month review by a few days. No services were provided/billed for. We did get cited on this despite the fact that no services were provided during this lapse. In these cases, the reason for the delay was because the client was unable to participate for whatever reason until a later date. When we asked the auditors about what was more important, having the client participate in their tx plan or being off by a few days, they explained that the LPHA needed to sign off on the tx plan regardless if the client participated or not to ensure the 6 month deadline. Is this accurate?
	A	There is no grace period for 6 month reviews. Our suggestion is to start sufficiently early engaging the client so that input is received and the 6 month deadline is still met.
GROUP B SERVICES - RULE 132.150, and 132.165:		
ASSERTIVE COMMUNITY TREATMENT (ACT)		
1	Q	In Rule 132 Q&A under ACT, there is a question that addresses the situation of the ACT nurse being out sick/vacation. The answer states that the agency must have a back up plan in place. a) Can a non-ACT agency nurse fill-in during sick leave, vacations, etc? b) Is the fill-in nurse allowed to bill under ACT when s/he is not part of the ACT team?
	A	a) Yes. b) Yes. She is considered a part of the team while filling in for the nurse position on the ACT team.
2	Q	I am an employment specialist on an ACT team. On the treatment plan where it lists services provided for Supported Employment, my name is listed in the column under Staff. Is that okay or should the case manager and other staff be listed?
	A	The same rules apply to treatment planning whether it is Medicaid or non-Medicaid. We expect to see "the responsible staff" listed by name but that does not mean that s/he is the only staff that can provide the service.
3	Q	In a discussion with our ACT supervisor, she stated that there are nine clients in the hospital. Is it correct that no billing can occur while they are in the hospital, or is the hospitalization considered "receiving residential services to stabilize a crisis?"
	A	The ACT team should focus on the client's transition to the community. Services may be provided in the hospital but they cannot duplicate services that are provided in the inpatient setting. The exception to the exclusion for ACT, "receiving residential services to stabilize a crisis", relates to crisis residential services, not hospitalization.
4	Q	An agency has ACT clients who get medication through sources such as the VA, private psychiatrist, etc. One even receives therapy from a private therapist. This is assumed to be acceptable since these are their preferences. Can you confirm that this is correct, or does it mean that ACT cannot serve them because they choose an outside therapist?
	A	The rate for ACT includes all of these services (psychiatry, therapy). You should reevaluate the need for ACT if the client is able to maintain relationships with private practitioners. CS-Team or a less intensive service may meet the needs of the client.

5	Q	Is there a time frame during which an agency should continue to try and connect with an ACT consumer before they consider discharging him/her?
	A	The source document used to develop the Rule definition defines "persistent engagement" as at least two attempts per week for three months.
6	Q	If an ACT consumer is placed in an inpatient psychiatric facility, inpatient medical hospital, or nursing home for rehabilitative services, how long does the ACT program keep them active and how long can ACT be re-authorized when a consumer may be in another setting for more than 6 months?
	A	If a consumer is going to be in an inpatient setting for 6 months, it would seem that ACT is not an appropriate service.
7	Q	An agency has a consumer who insists on seeing a psychiatrist in the community who is not the ACT psychiatrist. Can this consumer remain in ACT? The ACT psychiatrist will not be comfortable filling out a form to indicate that there is medical necessity for ACT on someone they have not seen. Can the community psychiatrist complete the pre-authorization and/or reauthorization section of the form that requires completion by ACT psychiatrist?
	A	The rate for ACT includes psychiatric services, but the psychiatrist is not the only ACT staff who recommends medical necessity. You should re-evaluate the need for ACT if the client is able to maintain relationships with private practitioners. CS-Team or a less intensive service may be more appropriate to address the client''s needs.
8	Q	We operate a Crisis Center and want to verify information provided in Rule 132 May 2007, Assertive Community Treatment Q&A #38: If a client is in crisis residential, both the services in the residential program and ACT team are reimbursable. If an ACT client was assessed to need this service in lieu of psychiatric hospitalization, would crisis center staff use billing codes specific to the service and not ACT codes?
	A	Yes, as long as there is an authorized referral to crisis residential. When general crisis services are provided to clients in ACT, the crisis services are to be provided by a member of the ACT team and billed as ACT.
9	Q	An ACT member receives Medicare. When this member sees the ACT doc, would ACT or Medicare be billed for this service?
	A	ACT is not a covered Medicare service. ACT team services and the corresponding rate include ongoing involvement of a physician. Services by the physician assigned to the ACT team to ACT members should be billed to DHS as an ACT service.
10	Q	An ACT member receives Medicaid. When this member sees the ACT doc, would ACT or Medicaid Professional be billed?
	A	The service should be billed to DHS as an ACT service. The ACT client is receiving an ACT service from one of the team (a doc).

CASE MANAGEMENT		
1	Q	Should our linkage case manager use Case Management-Transition, Linkage codes or a Client Centered Support code when she attends staffing and is a representative of our agency regarding discharge?
	A	This is considered as Case Management-Transition Linkage and Aftercare.
2	Q	In reading the Q&A from June 2007 thru July 2007 (under Psychotropic Medication) your answer to the question of whether or not picking up and delivering psychotropic medications on behalf of a client was billable as Case Management Mental Health was "No." In 2005, the response I got to the same question indicated that this was in fact billable as CM-Mental Health. I am concerned that I have a training and compliance issue to deal with based upon the answer I got from BALC in 2005, which contradicts what you are now saying. I am requesting that BALC hold us harmless for billing of this service as CM-Mental Health based upon the response and clarification we received in 2005. I am also requesting time to re-train staff on the correct billing for this service.
	A	When Rule 132 was revised, effective July 1, 2007, we narrowed the definition of case management. Picking up and delivering medications to a client's home is not billable as case management; you are simply transporting medications. We expect you to comply with the more focused definition of case management beginning July 1, 2007. We cannot hold your agency harmless.
3	Q	Is this a billable service as written: "Writer provided case management services to client this afternoon while in the car on the way to, from, and while at the lab and the pharmacy. Client takes Clozaril and writer wanted to make sure he gets his weekly labs done since it is a high-risk medication. Client was in a good mood today and was dressed and groomed appropriately. Client talked to writer about getting some extra money at the end of November or beginning of December so he can go on a trip. This time he isn't sure where he is going. After client's labs were completed, writer assisted him with obtaining his weekly amount of prescribed Clozaril from the pharmacy. Client voiced no complaints with mood or medication at this time.
	A	The note submitted does not specify the time and duration of the proposed service. From the note, it appears that perhaps a limited amount of the time could be billable as case management. The only intervention described is assisted client with obtaining weekly amount of Clozaril. That brief (minimum 7.5 minutes) amount of time would be billable as case management. The rest of the time is not billable per this note because no intervention is described.
4	Q	If a staff member brings a question to the supervisor/team leader outside of scheduled supervision time, such as a consult as to whether a call should be placed to DCFS, is it billable as case management MH or Client Centered Consultation?
	A	No. Regardless of the time during which said consult occurs, as described, it consists of a supervisor guiding subordinate staff on the proper direction of services. It is not assisting the client to access resources (CM-MH), or a consultation regarding the treatment plan (CM-CCC).
COMMUNITY SUPPORT (CS)		

1	Q	We have several CS-Group clients who, due to their mental illness, have no support system except our staff and very limited access to transportation. If we took them to eat and bowling, to decrease their isolation and increase peer interaction, could you give us an example of how to write the note to ensure it is a billable activity?
	A	Going bowling and to dinner may or may not be a billable activity. Things that are billable are provision of a service intervention specific to the individual's needs as specified in the treatment plan. When documenting the provision of the service, document the active intervention that took place, how it related to the ITP and the individual's response to the treatment.
2	Q	We just started a new group that meets several blocks from our clinic in a hospital computer-training lab with a bank of 10-12 computers and an overhead. The building is not a Medicaid certified site but is used for general training. It is not associated with psych activities. The group is led by a licensed occupational therapist (OT) who works with clients to help their concentration, impulse control, socialization, ability to handle frustration and interpersonal skills. Using a computer lab outside of our clinic has a normalizing benefit and puts clients in the community. Most people have had some computer training in the past and they have typically left frustrated and feeling bad about themselves. The OT is trying to change that; she is not a computer expert. Her strength is providing treatment to clients and she is using computers as another way of engagement and care. Does this qualify as off-site?
	A	The service as described is billable as CS-Group, off-site.
3	Q	One of our CS-Team consumers in need of housing was referred to an agency whose residential program is not DMH funded, but "permanent supportive housing" from HUD. The agency is also certified to provide Case Management, CS, treatment plans and assessments. Instead of an in-house doctor, they have employees there, funded by other sources. Can the consumer: **a)** Receive residential services with them? **b)** Receive other services such as CS-Individual or Case Management there? **c)** Is residential the only service the consumer can receive there?
	A	a) Yes. b) Yes. c) No.
4	Q	Are we able to bill for CS-Individual and Group, off-site, for services provided to clients in a nursing home?
	A	Yes, the services are considered to be off-site. See our previous to response to PSR question #32 in the May training Q&As located at: http://www.dhs.state.il.us/page.aspx?item=32647#a_toc9
5	Q	In regard to youth, the rule states that points will be deducted if taken out of their natural supports, such as school. If they were seen during study hall, would this be considered a deduction? Most kids have limited time they can be seen with homework, dinner, and early bedtime during the school year.

	A	The corresponding Rule language states: “CSI services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings, and at hours that do not interfere with the client's work, educational and other community activities.”[132.150 e)3)C)] The focus is the client and his/her needs.
6	Q	Client lives in a group home at Agency A. Agency A provides CS-Residential, Individual, Group. Client attends Agency B for PSR services. Skills learned at PSR are practiced and implemented via CS-Group, Individual services provided by Agency B as they take clients into the community. During the transport home they also discuss ways to practice and implement skills learned at PSR etc. The services provided by Agency B do not include case management nor do they duplicate services provided at Agency A. Can two agencies work with a member and both provide CS services?
	A	Two agencies may serve one individual. Both agencies must be fully compliant with Rule 132 by having completed assessments and ITPs. Neither may bill for the same service provided at the same time. Each may bill only for services provided by their own staff.
7	Q	During the two-day Community Support Services training at Chicago's Thompson Center in October 2007, we were informed that a video tape of the training would be made available. Is it available yet, and if not, when will it be?
	A	We apologize for the delay in releasing the tapes. DHS is in the process of editing the sessions that were taped. We also have to transcribe the voice for individuals with hearing impairments. It will probably be several months before the tapes are available for distribution.
8	Q	We have an out of home placement program with foster parents. They are considered contract employees. When staff are discussing the kids in placement with the foster parents how should we consider the foster parents? Are they "other professionals" and so these conversations would be Case Management-Client Centered Consultation? Or are they "family" and so these conversations would be considered Community Support-Individual?
	A	Foster parents are considered to be family. Support and consultation to the client's support system, directed primarily to the well-being and benefit of the client is Community Support-Individual.
9	Q	Where may I access the PowerPoint presentation from October 2007 Community Support Services Training?
	A	The link to the slides is located on the Parker-Dennison website at http://www.parkerdennison.com/IllinoisServicesWorkGroup.html
COMPREHENSIVE / SHORT-TERM DIAGNOSTIC SERVICES		

1	Q	After reading the definition in the Service Definition and Reimbursement Guide, it sounds like short-term diagnostic and mental health services are for crisis residential services. The unit is per diem and the rate is provider specific. Also, the service will only be available until the end of the fiscal year. Am I correct?
	A	This service is purchased only by the Department of Corrections for their delinquent youth assessment process. It does not relate to crisis residential services.
CRISIS		
1	Q	We are trying to figure out what to bill for SASS staffings done prior to the mental health assessment. Our Rule 132 guru has said that only case management-mental health, crisis intervention, and pre-hospitalization screenings can be billed prior to mental health assessments. However, there was some thinking that other services may be billable prior to the MHA for SASS clients.
	A	Only the services you list are billable prior to completion of the mental health assessment.
PSYCHOSOCIAL REHABILITATION (PSR)		
1	Q	Should all PSR clients receive CS-Group or CS-Individual? What about individuals that reside in long-term care facilities?
	A	Community Support is important as clients practice the skills that are learned in PSR. The extent of Community Support depends on the client's goals and objectives.
2	Q	If individuals reside in long-term care facilities, have no potential for independent living due to health, age, severity of mental illness, etc., should they be enrolled in PSR?
	A	We hesitate to give a definitive answer for all circumstances. The determination should be based on good clinical judgment and the goals and objectives of the client.
3	Q	When providing CS-Group, only time providing direct staff intervention interaction is billable. Is that requirement the same for PSR Group?
	A	Yes.
4	Q	The PSR service program director must be a QMHP, on-site 50% of the time. Must it be the same Q every day? If the program director cannot be at the site and another Q is available, would that cover the terms of the Rule?
	A	It must be the same Q each day unless the program director is on vacation or sick. Then per 59 IAC 132.150 j) 4) A), C), D), another Q must be designated as the fill-in.
PSYCHOTROPIC MEDICATION SERVICES		

1	Q	A citation from Section 115.240 e) 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 records 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?
	A	The note in the quarterly memo applies to the specific requirement in Rule 115. Rule 132 requires a 90-day review of psychotropic medications. 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.
2	Q	Under section 132.150 d) 1) B) it states that psychotropic meds have to be reviewed every 90 days by a physician or advanced practice nurse. The Guidelines, Instructions and Checklist indicates that the client need not be present. A few sentences later in section 132.150 d) 1) C) 3) the rule states that services shall be provided face to face. What is this referring to? Does this mean that the 90-day review of psychotropic medications has to be a face-to-face with the doctor? If so, then this conflicts with the statement in the Guidelines, Instructions and Checklist. Can you clarify what section 132.150 d) 1) C) 3) face-to-face is referring to?
	A	This 90-day review of medications is not necessarily done with the client. It is not medication administration, medication monitoring, or medication training. Most typically providers bill mental health assessment for 90-day medication reviews. MHA is not one of the three medication services that are required to be done face-to-face. It is a mental health assessment function to determine if the client's needs continue to be met.
3	Q	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?
	A	Medication administration is administration of psychotropic medication, not writing of prescriptions.
4	Q	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?
	A	The answer to this question is found in the Service Delivery and Reimbursement Guide, Psychotropic Medication Monitoring, Example Activities, page B-16. Basic requirements are outlined in 59 ILAC 132.150 D) 3), and 5) A).

5	Q	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……"
	A	As per 59 IAC 132.150 d) 5), 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.
6	Q	I need clarification on 90-day medication reviews. I am not referring to Medication Monitoring, but to the Medication review conducted by physicians. In the Guidelines, Instructions and Checklist, it states: If a physician is employed by or on contract with the provider, there shall be evidence that psychotropic medication is reviewed at least every 90 days by a physician or an advanced practice nurse. There must be a note, describing the review of the psychotropic meds, signed and dated by the physician or advanced practice nurse every 90 days. The client need not to be present. During our audit, the auditors confirmed that the client need not to be present. I just wanted to verify that this is true. In the rule, it does not have that exact statement, so it is confusing.
	A	It is true that the client does not need to be present. There is no specific service in 132 that covers this requirement.
THERAPY / COUNSELING		
1	Q	Can staff provide Therapy/Counseling to clients on-site at a Residential facility, or do they need to use CS-Residential no matter what type of service they are providing?
	A	Community Support services provided in supervised residential, crisis residential or CILA should be billed as CS-Residential. Any other service provided to clients in residential sites should be billed as the service provided, (Therapy/Counseling in this instance), not as Community Support.
2	Q	On Page 35 of the Guidelines, Instructions and Checklist, the last line, (G.) states that Therapy/Counseling is not a separately billable service for clients receiving CS-Team services. Is this correct? If non CS-Team staff does therapy with a client, what code should they bill to?
	A	Thank you for pointing out this error. It will be corrected. If a client receiving CS-Team receives Therapy/Counseling, Therapy/Counseling should be documented and billed.
3	Q	Under what procedure could they bill for a Multi-family group where patients do not attend? The group consists of family members only. Can client-centered-consultation be used?
	A	The interaction may be Family Therapy/Counseling if it is on the client's treatment plan, and the focus of the treatment is the client.

4	Q	Is it necessary to document the interactions among group members in a Group Therapy/Counseling note?
	A	Yes. As for all services, the note must describe the intervention provided and the client's response to it in relation to his/her goals/objectives. For confidentiality, no other client's name may be listed in the note.
GROUP C - NON-MEDICAID SERVICES (NMRO):		
ORAL INTERPRETATION & SIGN LANGUAGE		
1	Q	How do we bill oral interpretation and sign language for a 132 billable group service, utilizing one interpreter for two consumers? Do we submit individual bills for each of the two people who need an interpreter? Is a progress note or other documentation, in addition to that in the MHA, required for interpreter services?
	A	The only allowed mode of delivery for oral interpretation and sign language is "individual"; therefore, it cannot be billed as a group service, (Service Delivery and Reimbursement Guide, page C-2). Regardless of the number of persons present, the service can be paid only once for any given period of time. Submit only one billing, under one of the individuals in the group. Documentation to support services provided for which reimbursement is claimed must be in the clinical record. The client's mental health assessment must indicate a need for this service, and it must be performed in conjunction with another medically necessary billable service.
VOCATIONAL / EVIDENCE-BASED SUPPORTED EMPLOYMENT (EBSE) SERVICES		
1	Q	We have clients who are employed and request to keep seeing me just to check in and receive support. There isn't any real problem, but they like the support and encouragement. With the new codes and following the model of providing on-going support as needed, what code would you suggest we bill that under and is it all right to write a note stating that?
	A	You are correct that ongoing flexible support is part of the EBSE model. However, for any service to be billed, it must be needed. We recommend you talk further with the client to identify what their need is. In this case, it would seem that the client needs support, encouragement, reassurance, and perhaps help with managing or altering their responses to various events or challenges in the workplace. We recommend that you review the service definitions and guidelines and the SE payment grid to help define the reason for your intervention. You, as an employment specialist, can bill any service that you provide as long as you meet the requirements to do so under Rule 132. General support, encouragement, and reassurance specific to employment would likely be billed as Job Retention Supports. You might also consider helping the client identify and make use of their natural support system to manage concerns about work.
2	Q	If a person has a job but wants supported employment services, should we sign them up, and do we start with a vocational assessment or with engagement?
	A	If the person does not require vocational engagement services, then do not provide that service. Services do not have to be provided in any particular order, as long as they meet the requirements listed in the Service Definition and Reimbursement Guide. You may consider providing job retention supports.

3	Q	Will Division of Rehabilitation Services (DRS) accept a client who is currently working?
	A	Ask DRS under what circumstances someone who already has a job may be eligible for their services. You may provide and bill EBSE services for persons who are not eligible for DRS.
4	Q	Is the SE Specialist considered part of the ACT staffing pattern or are they a stand-alone?
	A	Yes, they can be considered a part of the ACT staffing pattern.
5	Q	Can other members of the ACT team provide SE services on a limited basis?
	A	According to Rule 132, the ACT team must have a person that is knowledgeable about employment. The Rule does not specify who provides what services. However, some agencies receive special funding to implement evidence-based supported employment on an ACT team, which specifies that a full time position be dedicated to providing EBSE services to persons receiving ACT, and that the employment specialist be a fully integrated member of the ACT team.
OUTREACH & ENGAGEMENT (O&E)		
1	Q	While I understand that you wouldn't use the outreach and engagement service code for a consumer known to the local agency, what if the consumer being engaged has a RIN from previous involvement with an agency outside of the geographic area? They go ahead and do what needs to be done to engage the person but down the road find out that s/he had previous service and a RIN. Would that create a payback situation from BALC?
	A	When the provider becomes aware that a person has a RIN, they need to discontinue outreach and bill for other services if appropriate. BALC is not reviewing these services; there is no plan for payback. DMH will credit up to 1% of their Medicaid and non-Medicaid contract amount for services reported as outreach and engagement.
2	Q	Is outreach to a no-show referral from a State Operated Facility allowable as O&E? Is it allowable if the attempt is made but you are unable to locate them? Although they may have a RIN from the hospital, outreach to the client and attempting to engage them in services seems to be in the spirit of the O&E definition.
	A	The procedural aspect of the activity may fit the definition of O&E, but this client does not fit eligibility criteria for the service. The client must be unknown or someone for whom there is insufficient information available for a RIN.

3	Q	Through word of mouth, many homeless persons come to our facility; we are known as a resource. Efforts to engage with persons who are in need of services yet resistant to provide identifying information are made using on on-site resources such as food and the pool table. Active efforts to engage, assess and link are billable as "Outreach and Engagement" (up to the point that the person provides identifying information, declines services or is effectively linked)? If Outreach and Engagement is not the correct code, how should we report and bill for these services?
	A	The Q&As for stakeholder education and outreach and engagement should be posted within the next week.
STAKEHOLDER EDUCATION		
1	Q	Can Stakeholder education be billed if a provider does a formal presentation to an employer with the aim of: helping dispel myths about people with mental illness and their ability to be effective employees; strategies employers can use to reduce stigma and encourage employees to make use of needed mental health services, with the aim of improved mental health and improved attendance and performance at work; general/universal supervisory or organizational culture strategies that support good mental health within the work place, e.g., universal accommodations; a description of services available at the mental health agency including supported employment? Can stakeholder education be used to help people learn some general ways of approaching people they suspect of struggling with mental health problems/mental illness?
	A	Stakeholder Education is not meant to cover marketing activities and should be presented to more than one person. Formal presentations to several managers, administrators, supervisors, etc., at one employer site fit the intent of the service.
2	Q	Does Stakeholder Education apply to talking to a mixed group, i.e., an educational meeting at a nursing home with both staff and residents, or at a community fair with both professionals and potential consumers present, with the purpose being to explain the range of mental health services offered by our agency and clarifying appropriate referrals?
	A	Yes.
3	Q	Does Stakeholder Education apply when outsiders come to our agency for a presentation to learn about our range of mental health services offered and clarifying appropriate referrals and referral procedures?
	A	Yes.
4	Q	If Stakeholder Education is only applicable to groups, why does the Service Definition and Reimbursement Guide list "Individual" as an allowed method of service delivery?
	A	The Department will not reject Stakeholder Education to an individual. However, we encourage you to address a larger audience to maximize your time and resources.
OTHER		

GENERAL ISSUES		
1	Q	I wanted a little more information about the Community-based services that can be used in the "Community Mental Health Services" section of Notice of DHS Community-Based Services form 2653 (spenddown worksheet). In the example given in the MH Medicaid manual, Joe uses Case Management, Client-Centered Consultation, Med monitoring, and med training. Does this mean that any service in Rule 132 is allowable? If not, what services cannot be used?
	A	Form 2653 is used as documentation that a client incurs specific expenses that are "predictable and steady over time so that it is reasonable to anticipate that the individual will receive the same amount of services reliably for an indefinite period." Any services provided in a residential setting, including CILA, or any Rule 132 ACT services, or Case Management services, which the provider determines to meet the aforesaid criteria, may be documented on form 2653, and submitted to the DHS-Family Community Resource Center (FCRC). These expenses are then used by the caseworker to meet the client's spenddown for up to 12 consecutive months. During that period, the provider must advise the FCRC of any change to the information originally reported by submitting another form 2653. No other community mental health services may be documented in this manner, for this purpose. If clients do not incur "predictable and steady" expenses, other Rule 132 services for "necessary medical or remedial services, funded by DHS from sources other than federal funds; medical services or items recognized under state law provided or ordered by a person or institution licensed or registered with the State of Illinois to provide them; and certain other allowable medical expenses such as transportation to and from a provider, may be used to meet spenddown on a month-to-month basis". See: http://www.ilga.gov/commission/jcar/admincode/089/089001200C00600R.html, and http://www.dhs.state.il.us/page.aspx?item=16555. These month-to-month expenses may be submitted by the client to the FCRC in the form of a receipt, or as an itemized statement from the provider. An itemized statement must include: a) date of service, b) total charge for the service, c) type of service, d) name & address of the provider, e) name of the person for whom the service was provided, and f) if subject to third-party liability, the bill must be adjudicated or include an estimate of expected reimbursement, from the provider. When the total amount of month-to-month expenses submitted equal or exceed the spenddown obligation, the client will receive a Medi-plan card. Providers should note that expenses used to meet spenddown cannot be billed to DHS-DMH for Medicaid reimbursement.
BILLING-CODING-PAYMENT		
1	Q	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."

	A	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.
2	Q	In our supported residential program we have 19 units that we report nights of care under DHS program 820. Should all services (CS-Individual, case management, etc.) provided by case managers to the 19 clients residing in these apartments be reported under 820?
	A	Yes.
3	Q	How can we provide and bill for art therapy under Rule 132?
	A	This may be a viable service for some clients. However, as a Medicaid reimbursable service, the documentation needs to reflect that there is an assessed need; the service must be on the treatment plan and case notes should reflect therapeutic intervention, not the quality of the art work. Activities such as skill building and assisting clients in the development of interpersonal skills to live, learn and participate in their community is most compatible with the service definitions of Community Support and Psychosocial Rehabilitation.
4	Q	Can peer specialists bill for participating in advisory councils?
	A	No. There must be a billable service provided by a paid staff person to an individual with a need for that service as reflected by the ITP.
5	Q	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.
	A	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.
6	Q	How do we bill return to fitness and evaluation services for Unfit to Stand Trial (UST) consumers?
	A	Providers of fitness and evaluation services for UST consumers should speak with DMH forensic staff - Debra Ferguson or Anderson Freeman - for billing information.