

## CASE MANAGEMENT

1. May multiple community mental health providers simultaneously provide Rule 132 services to the same client? For example, a child transitioning from a residential care placement to a foster care placement may be receiving services from a residential care provider and may need Rule 132 services upon placement in foster care. If so, under what circumstances may they simultaneously provide services to the same client and what services may each actually provide? For example, may one provider bill mental health assessment and ITP development to a child transitioning from residential care, while at the same time the residential care provider bills, e.g., Case Management-TLA, CM-CCC, etc? Rule 132 does not seem to provide guidance on this situation.

Answer: We were unclear about how you were using the term "simultaneous," so we've given two scenarios. 1) Two providers may serve any one client during the same extended period of time, e.g., over several months or years. 2) Multiple staff of the same provider or multiple providers may not provide different or same services to an individual client during a specific unit of time, e.g., between 10 and 10:15 am on Tuesday, May 3.

2. We believe that the process for completing and submitting the request for authorization of additional hours of service is no different than when completing an entitlement application or assisting a consumer in receiving (or continuing to receive) necessary services which are activities that are billable as Case Management Mental Health. Is the time spent by a clinician completing and submitting a request for the authorization of additional hours/units of service (for those services which require this) billable as Case Management Mental Health?

Answer: Your interpretation is correct.

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

Answer: The limitation relates to the individual, that transition linkage and aftercare is limited to 40 hours per year so it is across all providers.

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

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

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

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

6. Does the client need to be present when a LOCUS is completed?

Answer: No.

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

Answer: This note does not describe a billable service.

8. Can completion of reports required by external agencies without client present be billed as Case Management-MH? Please clarify what general paperwork is, and whether or not the client must be present while the service is delivered.

Answer: Billing for case management services must be linked with client diagnosis, goals & objectives related to issues described in the MHA and indicated on the ITP. Case management can be performed without the client present, however, it is expected that the activity is directed to the specific needs of the client & that the client participates to the extent possible. Completing applications or forms in order that the client may receive entitlements is billable as case management if the client is unable to do so. Refer to the Service Definition and Reimbursement Guide for examples of case management activities. Some examples of non-billable general paperwork are: scoring tests; rescheduling appointments; reading e-mails; listening to voice mail; writing checks; making copies; report writing; completing treatment summaries; writing and/or reviewing client information; transporting and waiting for clients. An administrative component is included in each defined service rate.

9. Can we bill Case Management Mental Health after the Mental Health Assessment is completed and before the Treatment Plan is completed or is it only billed 30 days prior to completion of the MHA?

Answer: You may bill for case management - mental health after the completion of the MHA and before the treatment plan is completed, with the caveat that CM is an assessed need that appears in the MHA report and the service appears on the treatment plan when it is completed. The provision allowing CM 30 days prior to the completion of the MHA allows for emergency/immediate case management when needed.

10. Are the following activities considered billable under Case Management - Transition Linkage and Aftercare? 1) Time spent in a unit staffing dedicated to multiple patients, including one or more to whom the worker is providing linkage services. Case Managers sometime sit for a long time before their patient(s) are discussed. 2) Conducting a post-discharge visit and the consumer is not at home. Unsuccessful visit attempts represent a significant amount of time. 3) Time spent faxing discharge documents and securing appointments. 4) Time spent in-route accompanying the consumer to an appointment.

Answer: 1) Time spent in a staffing dedicated to multiple patients is not billable. 2) Time used conducting post-discharge home visits when the consumer is not at home are not billable. 3) Time spent faxing documents is not billable. Securing an appointment(s) on behalf of the consumer because the consumer is unable to do this for her/himself may be billable as case management. 4) Time spent accompanying a consumer to an appointment is not billable. If there is a direct intervention with the client, some of the time may be billable. In summary, the rule is that interventions provided directly by staff to a consumer are billable. When a staff person is not providing a direct intervention, that staff person may not bill.

11. If a client transfers from adult outpatient to case management due to decompensation, is the documentation of the precipitating need on the transfer summary sufficient to show medical necessity, and then at the next treatment plan review an update to the Mental Health Assessment i.e., clinical impressions and treatment recommendations. Or should the MHA be updated to reflect the client's decompensation prior to the transfer to a more intensive (in this example) program?

Answer: The transfer summary provides documentation of the client's needs. If this is a significant change, an ITP modification should also be completed.

12. How should we report and bill a meeting with a DCFS caseworker and the client to discuss client progress and recommendations?

Answer: This may be CM-CCC, as long as no direct mental health service is being provided to the client. If the client is receiving services, then it would be billed as that service.

13. I am wondering about the use of case management and the restriction to 40 hours per client of case management services. Is that per year or per client for the time they are with an agency?

Answer: This is 40 hours per year per client.

14. One of the populations that the Bridge Program targets is persons in a nursing home. There are many activities that a care manager does with the consumer as part of making application for the Bridge Program, finding an apartment, completing documents, purchasing items for move in, etc. Does anyone see a problem with a community mental health agency billing Medicaid for a person that is currently in a long term care facility/nursing home/ICF if the case is also open to the agency?

Answer: Rule 132 allows this to be billed and we believe it would best be billed as CM Transition linkage and aftercare.

15. Can an MHP who assists a client in obtaining entitlements (e.g., completing an SSI or Medicaid application) bill Case Management-Mental Health if they provided the service prior to it being added to the treatment plan? We occasionally have clients who need this assistance but do not yet have that specific objective on their treatment plan even though they may have the Case Management Mental Health intervention on the plan for another objective. It's a timing issue, as the staff assisting the client needs to get the applications in ASAP prior to being able to amend the treatment plan.

Answer: When there is an ITP in place and there is no goal/objective related to this need, then case management may not be billed for it. The ITP needs to be amended and the assessed need change documented. Remember, the ITP is a living, breathing document that should be changed to reflect changes in need.

16. A clinician becomes involved in a DCFS investigation with their client because either Staff called to make a mandated report and are contacted by DCFS during the investigation, or, the client was involved with DCFS before beginning treatment, and DCFS staff call for information on status or treatment. May clinicians bill any of the following? a) Case Management-Mental Health, if the client has become distressed by the investigation and asks the clinician to call the investigator on their behalf to determine if there are legal issues or other treatment needs. b) Treatment Plan review, if the clinician is talking about what type of treatment needs are identified as part of the investigation and are then implemented into the treatment plan. c) Case Management-Client Centered Consultation, if you are contacting the courts/teachers after providing services to determine if they are seeing changes within the client and to see how the client's case is proceeding.

Answer: These services are allowable assuming the ITP supports them. Work with DCFS would be no different than work on behalf of the consumer with any other agency.

17. It is clear that using a USARF/Hospital Discharge Plan to authorize CM-Transition and Aftercare is allowable. Can Community Support also be indicated as needed on the hospital assessment/discharge/treatment plan and subsequently provided by a community linkage team using this assessment and not a full MHA that is completed by the community agency? Could you please define the services that are allowable under CM TLA--Specifically what services in addition to residential linkage are allowable. Is linkage and follow up that client is linked and seeing psychiatrist and linkage and follow up with benefits allowable as CM TLA?

Answer: CM-TLA is defined by rule as "Planning with staff of a client's current or receiving living arrangements (including foster or legal parents as necessary); Locating placement resources; Arranging/conducting pre- or post-placement visits; Developing an aftercare services plan; or Planning a client's discharge and linkage from an inpatient psychiatric facility, including an IMD or nursing facility, for continuing mental health services and community/family support." The Service Definition and Reimbursement Guide gives the following examples of CM-TLA: Services provided to clients identified for transition from a nursing facility to the community; Time spent planning with staff of the nursing facility or the receiving living arrangement and community service providers; Assisting client in completing paperwork for community resources; Arranging or conducting pre- or post-payment visits; Time spent developing an aftercare service plan; Time spent planning a client's discharge and linkage from a nursing facility for continuing mental health services and community/facility support; Assisting the client or the client's family or caregiver with the transition; Post placement assessment of community stability. Community Support may be provided after the community provider has completed the mental health assessment report that indicates the need for CS and while the treatment plan is being developed as long as it then becomes a recommended service on the ITP. It may not be authorized by the hospital treatment plan.

18. What service description code should be used for a 24-hour post discharge linkage appointment? Is it transition linkage and aftercare or case management? It is my understanding that except for mandated follow-up, all transition linkage and aftercare should be billed while client is inpatient.

Answer: Transition linkage and aftercare is provided to assist in an effective transition in living arrangements. It is not limited to services while the client is in a facility.

19. In the past, when a case manager accompanied a client to a doctor appointment and assisted the client during the appointment, it was legitimate to bill for case management, even if it was simultaneous with the doctor's billing for the appointment. Can we do the same with CS-Individual?

Answer: The act of accompanying a client anyplace is not a billable service. Only the time that is spent intervening for or with the client is billable time. If staff advocates on behalf of the client during a doctor appointment while in the room with the client and doctor, it is billable as CM-Mental Health. If staff is in the room with the doctor and client, and prompts the client to speak up for her/himself as part of applying skills learned in a natural setting, it is billable as CS-Individual.

20. If we complete a summary of treatment in lieu of court testimony or as requested by DCFS on a quarterly basis, is this activity billable as CM-Mental Health?

Answer: No, paperwork is not a billable activity.

21. We receive huge requests for records for our clients as part of their attempts to receive benefits. Can time spent by the case manager collecting and disseminating records to SSA, DHS, etc., on a client's behalf, be billed as case management?

Answer: No, not if the activity is strictly clerical in nature. However, assisting the client to meet the requirements necessary to receive entitlements may be case management activities even in the client's absence. It is expected that the activity is directed to the specific needs of the client and that the client participates to the extent that is possible.

22. A recently posted Q&A on the DHS web site classifies writing up court reports as "paperwork", excluding it from case management. Such advocacy on behalf of the client seems to fall within the definition of case management. Likewise, filling out forms for entitlements such as Social Security, even without the consumer present, seems to be a case management function consistent with the Rule, which includes "coordination and advocacy" as part of case management. Please clarify your position.

Answer: Report writing is not billable, including reports to the court. The rates for all services include an administrative component that includes report writing. However, assisting the client to

meet the requirements necessary to receive entitlements may be case management activities even in the client's absence. It is expected that the activity is directed to the specific needs of the client and that the client participates to the extent that is possible.

23. Does the concept of case management being provided prior to completion of the assessment mean I can provide case management services prior to assessment or in the 30-day window from first face to face contact?

Answer: Case management can be provided up to 30 days prior to the completion of a mental health assessment.

24. If case management was provided and the client disappeared prior to the assessment being completed, should the assessment and/or a treatment plan still be completed? If so, should the treatment plan include case management?

Answer: If the service is provided and the client disengages prior to completing the mental health assessment or treatment plan, document the client's status in the record and you may bill for the services.

25. Is client centered consultation part of the 240 hrs/yr of Case Management, or its own separate 240 hours? Will it be tracked and disallowed in an audit?

Answer: The 240 hours includes case management and client centered consultation. It has not been tracked or disallowed at this point.

26. Is the limit on CM -Transition Linkage and Aftercare 40 hrs/yr?

Answer: Yes.

27. Can Case Management-Transition Linkage and Aftercare services be used only while a person is in the hospital, or just immediately after?

Answer: CM-TLA is transition from one living arrangement to another. This includes to and from the hospital.

28. A child requested that her caseworker be present during her psychiatric evaluation. She felt it was important because her mother, with whom she has a conflicted relationship, would be present and she becomes a bad reporter when under stress. Can the caseworker bill MRO case management for the same time period that the psychiatrist bills for the psychiatric evaluation?

Answer: Time spent in the room with both the psychiatrist and client during a psychiatric evaluation, advocating on behalf of a client, may be billable as case management-mental health. Time spent prompting the client to speak up for herself, to apply skills learned while in a natural setting, may be billable as community support-individual.

29. If specific clients are discussed in supervision, can the time spent discussing the clients be billed as CM-client centered consultation?

Answer: Discussion during supervision is not billable.

30. Is Case management-LOCUS a separate service for which an agency must have certification?

Answer: Separate certification is not required for CM-LOCUS. If the provider is certified for CM-MH, that is sufficient.

31. Can an RN call medications in to the pharmacy for a consumer, and bill it as CM? The consumer picks up the medications at the pharmacy.

Answer: This is acceptable, though we encourage the agency to work with the consumer in Community Support-Individual, enabling him/her to become more independent.

32. Can an agency go to the pharmacy, pick up medications for several consumers and bring them back to the agency to fill medication boxes then bill it as case management under one consumer?

Answer: This is not billable as performed.

33. Can we provide CM-MH and one other service such as medication monitoring and training, or are we required to provide CM-MH and Community Support with another service?

Answer: Rule 132 requires that "A provider shall, at a minimum, directly provide mental health assessment, ITP development, review, modification and at least one additional Part 132 mental health service."

34. Can a consumer receive only psychiatric services, e.g., see the doctor for psychotropic medications, and not receive any other mental health services?

Answer: Yes. We would expect the services to be billed directly to HFS for physician services.

35. If staff provides CM-TLA at a community hospital psychiatric unit for several patients, or sees several community support consumers who live in an apartment building not owned, managed or leased by the agency-would all of the individual services be coded as off-site?

Answer: All the services would be billed as off-site as long as there is no staff office maintained in the building, or the site is not certified.

36. The Service Definition and Reimbursement Guide states "assessing the need for service, identifying and investigating available resources, explaining options to the client and assisting in the application process." Please clarify the phrase "assisting in the application process". If I spend 30 minutes copying an application and supporting documents to assist a client in applying for an ICG, public benefit, etc., is that billable as CM-MH as an "assisting" action?

Answer: No, the activity that you describe is not billable. Copying, report writing and other paperwork is factored into the rate for case management as an indirect cost, not as billable time.

37. Doing things on behalf of a consumer e.g. picking up medications, purchasing groceries, etc., is not billable. Here are two examples for which we hope that an exception can be granted: 1) a client requires outsized clothing and cannot fit into a car to go shopping. If a client is not physically able to go shopping for food/clothing with the case manager, can it be billed as CM-MH? 2) a client emits a strong, foul odor despite all efforts. Having them in a case manager's car to take them shopping is either impossible or intolerable. Can we bill CM-MH for obtaining groceries on the client's behalf? These activities take considerable time for staff who are under significant pressure to meet minimum direct service expectations.

Answer: Doing things on behalf of a consumer e.g., picking up medications, purchasing groceries, etc., is not billable. 1) Is not billable as CM-MH. Mail-order is a distinct possibility in this situation, and an even greater variety of clothing may be available through catalogs or the internet. 2) Is not billable as CM-MH. If a client has been determined to be disabled (receives SSA-disability and/or SSI benefits), other state or community agencies may be able to assist. We encourage you to be creative in meeting your clients' needs.

38. 1) The Service Definition and Reimbursement Guide states "Services to the family on behalf of the client..." Would services such as advocacy regarding rent with a landlord, coordinating a class schedule with a teacher or providing documentation to an employer as part of an application for special accommodations for the client be viewed as legitimate case management services on behalf of the client? 2) Is it okay if the client is not present? 3) Representative Payee duties are not Medicaid reimbursable. What about services closely connected such as helping the client prepare a budget with his or her Social Security benefits?

Answer: 1) Those are considered to be services to the client. 2) No. If you're assisting the client in doing something, the client needs to be there in order to be assisted. 3) Yes, assisting the client with budget preparation would be ok, again, as long as the client is there to be assisted and you're not just doing a budget and then giving it to him/her.

39. 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.

Answer: 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.

40. 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?

Answer: 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).

41. What can state hospitals do to support CBOs in billing for CM-Linkage services, i.e., linkage case managers attend staffings and/or meet individually with patient on the unit, they bill for the services. Do hospital staff need to include any documentation to support that billing?

Answer: CBOs must have an ITP with the service included to bill for service other than mental health assessment or treatment plan development. If the state hospital has an ITP that includes transition and linkage services and they make a copy of that available to the CBO, the CBO may use that for the transition period while the client is still hospitalized and prior to beginning their own mental health assessment process.

42. When two provider staff from the same agency consult regarding a client, and the consultation meets the requirement of CM-Client Centered Consultation, can the agency bill for the time of both staff?

Answer: No.

43. If we apply for entitlements for a client, and bill it as CM-MH services (it falls under the state guideline of "doing for") would it still fall under federal CM guidelines? Please clarify the federal requirements/definition of CM, i.e., wasn't there a recent federal audit which required payback for all CM services that were not linkage, assessment or referral?

Answer: There were no such findings in Illinois' recent federal CMS audit. Applying for entitlements for clients is case management - mental health.

44. Under Notes for psychotropic med monitoring in the Service Definition & Reimbursement Guide, there is a note that a "designated staff ordering medication or communication with a pharmacist is not billable as med monitoring but is billable as CM-Client Centered Consultation". CM-CCC, under example activities, "...contacts between provider staff & staff of other agencies concerning the client's status" -- does not sound like ordering meds is a CM-CCC service as much as it is CM-MH (doing for the client).

Answer: If you are consulting with the pharmacist, bill MH-Client Centered Consultation. If you are ordering medication and no consultation occurs, bill MH-Case Management.

45. Will we still be paid for CM services that we now can bill 30 days before assessment, if the CM we provide does not result in an assessment, and/or client does not engage and/or drops out after our CM services?

Answer: Yes.

46. Can you bill CM-LOCUS for an ACT client?

Answer: Yes.

47. The definition of case management includes "assessment". If a SASS client with no mental health assessment has a staffing at a hospital, is this billed as mental health assessment or case management?

Answer: It depends on what is being done. If it includes gathering information to complete a mental health assessment, it would be billed as that. The rule allows the provision of case management for 30 days prior to completion of the mental health assessment, so if case management services (doing for the client) are being provided, it would be billed as case management.

48. We received an opinion that representative payee activities without the client present, e.g., processing check requests, were billable as case management. Is this still true?

Answer: "Processing check requests" is not a Medicaid service. The part of rep payee that may be a Medicaid service includes activities such as: assisting the client in completing benefit applications (CM), working on budgeting skills (CS). The act of simply making out a check is not a Medicaid service. Social Security has a program that will pay for rep payee which can be accessed at: <http://www.ssa.gov/payee/>

49. Can completion of reports required by external agencies without client present be billed as Case Management-MH?

Answer: Yes, as long as this is not general paperwork and documentation of service delivered.

50. What are the caps for Case Management services, and do they include all CM services including LOCUS? What if there are multiple treatment episodes during that time?

Answer: CM-transition linkage aftercare is limited to 40 hours per year per consumer and all other case management services are limited to 240 hours per year per consumer.

51. Understanding that Case Management can be provided 30 days prior to completion of the mental health assessment, how does a provider bill Case Management before a MH diagnosis is obtained?

Answer: It is billed using a deferred diagnosis.

52. In our agency, when a client calls requesting/needing services, basic information is obtained such as service need, risk assessment, previous MH treatment, current/previous psychiatric medications, etc. From this intake screening, a mental health assessment appointment will be scheduled. As long as the client has been verbally informed of their rights, can this contact be billed as Case Management?

Answer: The activity (face-to-face or on the phone) of collecting social history information and assessment of needs is considered Mental Health Assessment.

53. What service code should a therapist bill for telephone calls from a client, between sessions, when they are not describing any SI/HI, but issues addressed during therapy sessions? Examples of things these calls may address include: needs support after a fight with family/friend/partner; having a panic attack & unable to regain control; just found out they have a terminal illness; grieving the loss of family member, friend, pet, etc.; were sexually or physically assaulted; having a severe depressive episode & difficulty coping.

Answer: This should not be billed as Case Management-Mental Health, but as Community Support-Individual or Therapy/Counseling.

54. Is a youth, recently released from detention eligible for Case Management-Transition Linkage & Aftercare?

Answer: Yes.

55. A client sees an outpatient counselor and does not fit the criteria for CS-Individual, Group, Team. When a counselor talks to the client on the telephone in order to decrease stressors, may it be



billed as Individual Therapy/Counseling on the date/time of service? If not, is it billable as Case Mgt-MH?

Answer: It is unclear why someone would not fit the criteria for Community Support-Individual. These calls should not be billed as CM-MH, but as Community Support-Individual.

56. Can a SASS agency use the hospital's mental health assessment and ITP to bill for SASS CM-transition linkage while a client is hospitalized?

Answer: Yes, as long as a copy is maintained in the SASS agency file and transition linkage and aftercare services are mentioned in the ITP. When the client is released, the agency must begin its own mental health assessment process.

57. The Service Definition & Reimbursement Guide examples list "helping the client apply for public entitlements" as CM-MH, yet training seemed to indicate it would be CS-Individual; how is the distinction made between CM-MH & CS-Individual?

Answer: CM focuses on doing things "for" a consumer (getting them their benefits, finding them housing, etc), while CS is an active intervention "with" the consumer to build their capacity and teach them how to access resources.

58. It has been a common practice to "bundle" case management services, i.e., 5 minutes on 3 occasions during the same day. Can we still do that?

Answer: Yes, that has not changed.

59. Is there a unique billing code for case management, collateral contact?

Answer: No. You may be referring to client-centered consultation which has not changed.

60. Does client-centered consultation have to be without the client? I looked at Rule 132 and saw nowhere that CCC could only be billed if the client was not present. An example is the client, our staff, client's mother, and physician meet and are discussing client's current status, issues, etc. If the physician is not billing for that time, can our staff bill client-centered consultation?

Answer: They can bill CCC if they're not also billing any other service for the same period of time. Yes, the client may be present.

61. The SDRG leads me to believe our agency has been too conservative in prior interpretations of the scope of CM-Client Centered Consultation. It states "Only in the instance of Case management - Client centered consultation is it allowable for a provider to bill the time of more than one staff person serving the client." Does this mean that if we have two staff with a scheduled 15-min meeting or telephone discussion regarding one client's status, both can report/bill CM-CCC (15 min for staff A & 15 min for staff B)-assuming both document the session? If so, is there a limit to the number of staff who can report participating in this type of consult? If 4 staff schedule a 15 min meeting to discuss one client's status e.g., Case Manager; Supportive Employment Specialist; Peer Mentor & a receiving Case Manager, when client is transferred from outpatient to CST, can all four staff report/bill the service (a total of 1hr)? What does "Administrative case review (ACR)," as listed in the CM-CCC Example Activities section, include/not include?

Answer: If two staff are meeting together doing Client Centered Consultation, only one can bill. The piece in the guide refers to an instance where one staff is doing CCC at the same time that another staff is actually working with the client providing a direct service. Both may bill in that instance. ACR is an activity provided by DCFS providers for DCFS wards and is paid for by DCFS.

62. In regard to staff who have done a SASS Screen and the child that was screened has been deflected from inpatient care: Can the services provided to a child who has been deflected from inpatient care as a result of a SASS Screening (in the Emergency Department) include Case Management - Transition Linkage and Aftercare? There is a lot of linkage and aftercare that needs to occur following a deflection and our staff want to make sure they use the appropriate

intervention/billing code. Of course, this is assuming that Case Management - Transition Linkage and Aftercare is an assessed need and that the intervention is on the client's treatment plan.

Answer: CM-TLA is only for transition linkage when a client is transitioning from one living arrangement to another. The services described might be case management mental health services.

63. For a consumer who was moved out of a nursing home into a CST program, how long can the Case Management Transition Linkage and Aftercare (Nursing Facility) code be used? There are post placement visits, assessments etc that are required quarterly.

Answer: TLA can be provided only until the new placement is secure. It cannot go on for quarter after quarter. Once the client is placed in the community, the community provider has 30 days to complete a MHA.

64. What do you mean when you state that we cannot directly provide services under case management?

Answer: This point was intended to highlight the difference between CS and CM. CM focuses on doing things 'for' a consumer (getting them their benefits, finding them housing, etc), while CS is an active intervention 'with' the consumer to build their capacity and teach them how to access resources.

65. Will Case Management continue to include support services provided to help clients maintain access to services? For example: Peer conflict support to a client refusing PSR treatment or a doctor appointment due to an anger issue.

Answer: Case Management will continue to include facilitating consumer access to services. However, direct interventions that include conflict management, anger management and other skills/supports should be billed as the appropriate Rule 132 service (e.g. CS or Therapy/counseling).

66. Can two staff bill Crisis Intervention at the same time, for the same client? For example, one staff person provides brief crisis counseling while a second staff member links with the police department.

Answer: No. The first staff person can bill for Crisis Intervention Services and the second staff can bill for Case Management Services.

67. 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.

68. I understand from reviewing previous Q & As that the client doesn't have to be present to bill for the LOCUS. However, the Service Definition and Reimbursement Guide says the service must be done face-to-face. I need clarification.

Answer: Agencies bill for the administration of the LOCUS as an "event", meaning that it is a set rate regardless of the amount of time spent completing the scoring of the tool. All parts of the scoring must be based on information obtained through face to face contact with the client for whom the tool is being scored, but the client need not be present at the time the tool is scored in order to bill for the event of completing the LOCUS. There must be a separate LOCUS tool completed for each time an event of LOCUS is billed. (9/1/11)

69. I need guidance on what we bill while someone is in a SOH and while they transition out.

Answer: When a client is in a SOH, the community provider should be involved related to return and transition to the community. The delivery of all other services during that period of time is

the responsibility of the SOH. Mandated follow-up is the same service as the 132 service Case Management- Transition Linkage and Aftercare. It should not be provided to a client the entire time they're in a SOH, but when discharge is nearing and transition is needed. A community placement includes discharge to the client's home. (9/1/11)

70. Our nurses spend a lot of time completing patient assistance forms for medications from the pharmaceutical companies. At one time we were told that was considered a case management activity and we could bill for it even if the client wasn't present when staff were completing the forms. It is our current understanding that this is considered paperwork and without the client present, is not a billable activity. Is this correct?

Answer: Because this is assisting the client in accessing a benefit that will assist in his/her recovery and not just paperwork, it MAY be billable as Case Management – Mental Health. It is important that the service be identifiable to one client and be for at least one billable unit of time. Staff may not spend 15 minutes, for example, completing forms to obtain this benefit for four clients and bill for each of them. (9/1/11)