DHS/DMH POST-PAYMENT REVIEW INTERPRETIVE GUIDELINES

FY12 PPR Tool Items

1. No valid note documenting the service could be located.

If there is a bill for a specific date and service there must be a progress note in the clinical record corresponding to the specific date and service of the bill. The claim would be disallowed if there is a bill for a specific date and service, but the note with the specified date and service cannot be found in the consumer's record. We cannot assume that a note with a different date or service than those of the claim is one and the same.

Staff providing services are required to sign their notes and specify their credentials after their signature. Staff signature on the note must include legible credentials. If credentials and/or signature are illegible, ask for staff assistance with interpretation. If credentials are missing from the signature or if credentials are illegible to all, only mark #1. Do not also mark off for item #3 unless the person is not qualified. It is okay if the signature does not contain the credentials if the signing line has typed credentials underneath or beside the signature. For information about electronic signatures, refer to Rule 132.85 f).

2. **Note describes a service intervention or activity that is not billable.**

Note describes a service intervention or activity that is not billable. For example, provider bills for transportation only. Note must be reflective of mental health clinical work that is defined as medically necessary, not simply recreational and not something unrelated to a documented mental health need. If marked off for item #2, reviewers should only evaluate the other tool items pertaining to the MHA and ITP because there is no need to assess other items if the service isn't even billable, but feedback on the MHA and ITP could be useful to the provider.

Examples of NOT BILLABLE activities:

a. Watching a movie, shopping, playing basketball, bowling, eating lunch, etc. with no clear skills training or clinical services being provided and clearly documented.
b. Preparing medications without consumer present, picking up medications from the pharmacy without consumer present, or transporting (delivering) medications to consumer.
c. Running errands for consumer (i.e., shopping for consumer without consumer present).
d. Writing out Payee checks or completing paperwork.

3. Service provided by unqualified staff.

See attached grid for definitions of acceptable credentials for qualified staff.

4. No amount of time documented.

The progress note does not include an amount of time. The progress note must include a start time and a duration amount or start time and end time.

5. No valid Mental Health Assessment could be located.

a. The MHA in effect at the time of the claim is required to be in the clinical record. This item would be marked as disallowed if the MHA that should be in effect at the time of the claim could not be located in the record. MHA's need to have annual updates effective 7-1-07. Reviewers will ask for assistance from provider staff in locating documents that could not be found.

b. The LPHA must sign **and date** the MHA report that relates to the claim. Credentials must be legible.

How to handle possible situations found:

- If there is a MHA update in effect that only notes "no change", there must be a full MHA available. You do not have to review each and every MHA in the record, only the one in effect at the time of the claim.
- In the event that the LPHA and the QMHP are the same person, there only needs to be one signature, but this person has to sign LPHA credentials after the name. If they meet credentials as an LPHA, they are also a QMHP so they meet both criteria.
- A current MHA update that is signed by the LPHA that reflects "no change" requires a review of the MHA upon which the update is based. If the older MHA does not have a LPHA signature do not mark off for this item because the MHA in effect at the time of the claim is signed and dated by the LPHA.
- It is okay if the signature does not contain the credentials if the signing line has typed credentials underneath or beside the signature.
- Information about electronic signatures: Refer to Rule 132.85 f).
- If electronic MHA is made up of several components that are located in different screens of the electronic system and are separate from each other, it must be clear that the LPHA reviewed and approved all components of the electronic MHA and that the QMHP was responsible for the completed mental health assessment report as documented by their dated signatures on the mental health assessment. There must be a method that the provider uses consistently to demonstrate this review/approval of all the components of the MHA.

6. No valid Individual Treatment Plan could be located.

a. The ITP that should be in effect at the time of the claim cannot be located in the record. Reviewers will ask for assistance from provider staff in locating documents that could not be found.

b. There is a treatment plan in the record but it is not valid. The dated signature of the LPHA is what puts an ITP into effect. The treatment plan must be approved and signed by a LPHA within 45 days of the Mental Health Assessment. In the instance that the ITP has expired or has not been completed within 45 days, the only services that can be provided are Mental Health Assessment, Treatment Plan Development and Crisis Services. Look for lapses in time between ITP's beyond the required update time span of 180 days. Look for ITP's that do not having a dated LPHA signature.

7. **Specific service does not appear on ITP.**

This item would be marked as disallowed if the service provided and billed for is not included on the ITP. Even when there is a DMH/Collaborative authorization in place, the service must still be included on the ITP.

Note: The following services have specific modalities that must be named specifically:

- Psychotropic Medication Administration, Monitoring, or Training (individual or group).
- Community Support – Individual (CSI)
- Community Support – Group (CSG)
- Community Support - Team (CST)
- Community Support – Residential, Individual (CSR-I)
- Community Support-Residential, Group (CSR-G)
- Psychosocial Rehabilitation – Individual (PSR-I)
- Psychosocial Rehabilitation – Group (PSR-G)
- Therapy/Counseling Individual, Group (two or more), or Family (client need not be present)
- Case Management Mental Health
- Case Management Client Centered Consultation
- Case Management Transition Linkage and Aftercare

Note: "Mandated Follow-up" is a subset of Case Management-Transition, Linkage and Aftercare; just performed for State hospital discharges and documentation may reflect either.

Example: **ITP's** with "Community Support" or "Medication" or "Therapy" do not identify the specific service, so Item 7 would be checked for these instances, as we do not know the modality being used: individual, group, family, etc./ administration, monitoring, training. Documentation does **not** have to include the word 'Psychotropic' before Medication.

Services may be provided concurrently with ITP development if they are recommended by the LPHA as medically necessary on the MHA and are included in the completed ITP within required time lines. If the ITP was not yet completed and the service is not on the MHA, mark off for this item because the MHA served as the ITP at this point.

8. ITP review does not demonstrate a review of progress towards goals or an evaluation of needed services (NEW for FY12).

Rule 132.148 c.5 requires that the ITP reviews should include a determination of whether the ITP goals are being met and whether services have contributed to meeting the goals. For the purpose of PPR, reviewers will be looking for the specific service of the claim and for evidence that the ITP review documents progress toward goals and which services should be offered.

a. If the ITP review states that services in the ITP will continue, there is no need to restate specific services. Wording of "continue all services" may vary. Providers need to consider progress towards goals and either make changes to the treatment plan or have services continue because consumer is making progress. If the only thing that is documented is for example, "This is 6 month ITP, continue all services" with no review of progress, this is not sufficient. Documentation has to demonstrate a review of ITP goals and progress.

b. It is not necessary for ITP review to be attached to ITP to ensure original ITP was reviewed.

c. Progress toward goals may be documented in a progress note that is specific to the treatment plan review (same date as the signatures on the ITP review). This note must contain a review of progress toward each goal of the ITP that is being reviewed and cannot be just a summary of overall progress. Merely stating "met", "not met", "achieved", "change", "inactive", "continue", etc. does not meet the expectation for documentation of progress.

9. Time billed is greater than time documented.

The progress note states one time and the billing states a longer period of time (example: progress note states 15 minutes for the billed service, while the billing states 30 minutes). This item is correctable through billing because the documentation is valid but was just billed with the incorrect time.

10. Location of service not correctly noted on-site vs. off-site.

Services provided at a certified site must be billed as on-site. If it is a provider site (owned or leased by the provider) the provider is required to have the site certified. This item is correctable through billing because the documentation is valid but was just billed with the incorrect code.

Note: Services provided in a supported residential site may be billed as either onsite or offsite, depending on where the services are provided. Those provided in the consumer's apartment/home may be billed as offsite. Any service rendered in other certified locations at a site, such as an office, conference room or activity area, should be billed as onsite. Staff that travels from another agency office location must also bill the onsite rate for services that are provided in the office/common area.

11. Note describes a different service than billing submitted.

This item is marked as disallowed if there is a bill with a specified date and service; however the note reflects a different service being provided. This is may be a data entry error on the part of the provider. For example, note may say individual therapy but the billing has the service code for group therapy. This item is correctable through billing because the documentation is valid but was just billed with the incorrect code.

In the event that the bill was submitted at a higher credentialed level (bill says service provided by QMHP but signature on note reflects an MHP, for example) than documentation notes, check off for this item if the credential is one that is allowed to provide the service billed (an MHP providing therapy/counseling but billed as a QMHP, for example). This item is correctable through billing because the documentation is valid but was just billed with the incorrect staff credentials. However, if the staff person does not have required credentials for providing the service, mark off for #3 (Service provided by unqualified staff).