Final Transcript

STATE OF ILLINOIS: Rule 132

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SPEAKERS

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PRESENTATION

Moderator

Ladies and gentlemen, thank you for standing by. Welcome to the Rule 132 conference call. At this time all participants are in a listen-only mode. Later we will conduct a question and answer session, and instructions will be given at that time.

I would now like to turn the conference over to our host, Ms. Cathy Cumpston. Please go ahead.

C. Cumpston

Thank you, Katia. Welcome, everyone. I am so glad that you all could take time out of your schedules this afternoon to join us. We are going to very briefly go through the changes to Rule 132 that we covered in more detail back in June, on June 5th and June 15th, so it's been a while. We wanted to go over them again today and Kristy Herman from DCFS and I will be doing that. Then we really do want to spend most of our hour and a half with Q&A so that we do our best to make sure that any questions that you may have still, we get answered. If at the end of the hour and a half you have not had your question answered, please send it to us on the DHSMH e-mail address and we will, of course, then respond to that.

Let's just get started. There are some policies within the rule that need to be either created or changed. The policy on performing client record audits, the policy on confidentiality, the policy on reasonable accommodation, the policy on UR. We are going to – let me back up just a little bit. As you probably all know, the official adoption date of the rule was December 13, 2012. The rule was published in the Illinois Register on December 28, 2012. However, because we hadn't had a chance to have this call, because the rule wasn't available to us, or to you, for a period of time, we really are not going to use that December 13th date as the official implementation date for anything.

We have decided that the implementation date that we are going to use, as state agencies, both DMS and DCFS, will be February 1st. So, beginning with February 1st, we are going to grant a thirty day grace period for getting all of these policies changed or created, so we don't expect that you would have those done until March 1st.

Additionally then, moving on – there have been some definition changes. Probably, I mean you've seen all these before; we have not changed them since the proposed rule. We are recognizing a CRSS certification as an MHP and we're also recognizing a Certified Family Partnership Professional, CFPP, as an MHP. We are expecting that people will have either GEDs or high school diplomas.

We have added definitions of Interventions and Activities so that we can distinguish between the two types of services and, therefore, then distinguish between the types of documentation that are required. We did add a definition of Mental Health Setting and a definition of Psychotropic Medication. Those were at the request of providers, so we did that.

There is a new section, 132.27, Provider Qualifying Condition, most of this section is not new even though it is a new number; most of it was moved from 132.145 to this new section. In addition to that, we've clarified what accessibility standards mean and how they apply to a subcontractor.

We have in 132.30 and 132.50, made some changes to allow certification revocation for providers who continually demonstrate inability to comply with the rule with—consistently demonstrate that they are not up to staying in compliance. We don't expect this to be used very often. Our experience shows us that most providers are highly compliant now and those that do have problems are very good at getting them corrected. This isn't something that we expect to begin using frequently.

We have made some changes to post-payment review. We have removed the initial notice of unsubstantiated billing. Providers will continue to get advance notice of post-payment reviews and they will then have no opportunity after the post-payment review to submit additional documentation. The state agencies will have thirty days to get the initial notice – excuse me, to get the notice of unsubstantiated billings out to the providers and then the providers will perhaps, depending upon the score, have to do a corrective action plan and, depending again upon the score, not have to do such a plan. There will be no initial notice.

Organizational Requirements have had some change, minor changes. We have included in this section a requirement that the provider have an active system for determining compliance with this rule. It really is the provider's responsibility to stay compliant with this rule. Most providers have a way already of determining that on their own because it's important to them that they stay compliant rather

than waiting for the state to tell them that they're not. This is really just recording what most providers already do.

We have made some changes to the Personnel Requirements. We have again clarified that providers have to have background checks done if they are required by the Health Care Worker Background Check Act to do those background checks. It's up to the provider to determine if they are one that this applies to. If they are not, then they don't have to do this particular background check. I know, for instance, that DCFS providers have to do an even more thorough background check for staff than required by this Act, it's required by other Acts, and so we don't expect DCFS providers who are already doing the other checks to duplicate that effort with doing this.

The requirement is also in here though for everyone to verify on the Health Care Registry that staff that they employ have not been found to have abused or neglected anyone. This applies to all staff; this is a separate Act, separate from the Health Care Worker Background Check Act, and it is not just for direct care staff, it is for all staff. I'm sure that all of you find – are very serious about assuring that you do not have anybody working for you in any capacity that has abused or neglected someone. I mean we're serving, very often, vulnerable people and it's important that we do not put them in harm's way. So everyone, whether you are a provider that has to do the background checks or different background checks, everyone has to check the Health Care Registry for findings of abuse and neglect.

Under Recordkeeping we have removed some requirements because we found that they were redundant. We thought that somebody else within either DCFS or DHS or HFS or somebody probably already required those and looked at those so we removed them. We're always interested in reducing duplication.

Then under Client Rights we have required that there be an annual explanation by the provider to clients of their rights. We have, again, granted a grace period here because we said that any existing clients who have not had their rights explained to them within the last twelve months, or last year, have to explain those. We have said that that will be a sixty day grace period from February 1st. Basically, by April 1st, existing clients who have not had their rights explained to them within the last year need to have those rights explained to them.

We've also added within that section clarification about restriction of rights. I want to just emphasize here that the rights that we are talking about being restricted are rights granted by the Mental Health Code. I know that from June and the training that we did in June, there were quite a few questions about well, what about this right or this right? If it is not a right that is included in the Mental Health Code then it is not covered by these statements on restriction of rights.

Okay, we're going to hold questions on all of the rule until after the whole review of it is done. I would like at this point to turn it over to Kristy Herman, and she will take us through the changes that have been made to the services and service documentation. Kristy?

K. Herman

Okay, thank you, Cathy. We're going to run very quickly through the Mental Health Assessment, the Treatment Plan, and then the Service Documentation, again just to highlight some of the changes.

In the Mental Health Assessment mostly what has been done is we have consolidated or even removed some of the requirements. For example, the Extent, Nature, and Severity of Presenting Problems is now the Reasons for Seeking Treatment including symptoms. This can be what the client is reporting, the symptoms that they are presenting with. You don't have to hit the Extent, Nature, and Severity of those Presenting Problems. We really just want to know what are the reasons that they're there for treatment.

The Mental Status Exam is now simply that requirement – Mental Status Exam. We are not going to say it has to include all of the different elements, so whatever the LPHA or the QMHP determines to be the proper Mental Status Exam to use – that's the one that we are looking to see in the assessment.

We also added the date of the most recent psychiatric evaluation to another section, and then we changed the requirement to list medications. We really just want to know now if the client is or is not taking psychotropic medication.

We've added employment history and interest activities and hobbies as examples of strengths and resources. We want to know generally what does the client come in with that can be used in treatment as a strength or a resource. We've listed some examples of those. It's not an exhaustive list, so if there are others that you want to include that would be great.

We removed the requirement for inclusion of general physical health and we replaced that with a report by the client on his or her health. We also have removed the requirement that the MHA report contain recommendations for specific Part 132 services, but I want to make a note on this one in particular that if there is going to be a gap between the completion of the Mental Health Assessment and then the completion of the ITP, and you want to do services in between the completion of those two documents, then you do have to indicate on the Mental Health Assessment what services are going to be provided before the treatment plan is completed. So, make sure that you're paying attention to that if you're not doing your Mental Health Assessment and your treatment plan on the same day.

All right, so we'll move on to the Treatment Plan. One of the changes there is that it is now required that a client be given a copy of the treatment plan. You

cannot indicate that there was some kind of contraindication of the client getting a copy. So again there is a grace period here. If you have current clients that did not – were not given a copy of their treatment plan, you'll have sixty days from February 1st to get them a copy of their treatment plan.

Okay, so we're going to move on to Service Documentation. We did not add any Service Documentation requirements, but we did reorganize where they show up in the rule. One of the things that we did is put under each of the services what specific requirements we're looking for. For example, under Therapy Counseling you're going to have to do the intervention, the client response, and the progress. Under Psychotropic Medication Administration you will just need a description of the activity.

The Mental Health Assessment and ITP documentation is going to need a description of the time spent with the client or the collateral, gathering information, or developing, reviewing, and modifying the treatment plan. We just wanted to specify under each of the services which specific items were going to need to be documented. We've also changed the mode of service delivery for psychotropic medication monitoring and training. It can now be done by video conference.

Community Support – when you look in the rule it looks like there was a major change to Community Support. It's actually more of a rearrangement than a change in content. We combined Community Support – Individual and Community Support – Group into one service. Then Individual or Group is going to be the modality that the service can be provided in.

You do still have to note in your documentation if you are doing Community Support – Individual or Community Support – Group. And on your treatment plan you do still need to be prescribing individual and group because utilization management requirements will remain the same for your Community Support – Group for your DMH client.

All right, we'll talk quickly about Client-Centered Consultation. We have tightened up the definition of Professional Consultation, and that will be done between staff of your agency or staff of different agencies who you're talking to about the client. Professional communication is defined as: offering or obtaining a professional opinion regarding the client's current functioning level, improving the client's functioning level, discussing the client's progress and treatment, adjusting the client's current treatment, or addressing the client's need for additional or alternative mental health services.

You'll also notice that it is no longer allowable to do client-centered consultation with family members. Now I want to point out that when you are engaging family members in conversations about the client, most of those conversations are going to fit very well under Community Support or possibly even Family

Therapy. So family engagement is still very important and it is still allowable under those other services, but not under client-centered consultation because we are really looking for a professional consultation between staff.

All right, very quickly we'll talk about team members in recovery and this is for ACT and Community Support Teams. ACT must have a certified recovery support professional and CST must either have a certified recovery support professional or a certified family partnership professional. Again, there is going to be a grace period of twelve months from February 1st to get those members on your team.

I'm sorry; Cathy would like to offer a clarification on that.

C. Cumpston — You currently have to have a person in recovery on your team. The grace period is twelve months from February 1st to get that person in recovery already on your team certified. Then, in addition, from the time that you hire anybody, a person in recovery for any of your teams, from the date of hire you will also have twelve months to get them certified. So, you will not have to be finding people who are already certified if you need to hire a new person.

K. Herman — Okay, thank you very much. One other quick change under psychosocial rehabilitation – it removed the minimum amount of time of twenty-five hours per week that that service must be available.

Those are all of the changes that we were planning on highlighting and I believe that we have plenty of time now to move into our Q&A session.

C. Cumpston — Yes, and before we do that I do want to let you know that we will be receiving a transcript of this presentation and the Q&As. That will then, when we get it, be posted onto the website so that anyone that wants to go back and didn't get their notes taken as detailed as they wanted them to, it will be written down and you will be able to go online and see what the responses to questions were.

Katia, we are ready now to begin the Q&A.

Moderator — (Instructions given.) One moment, please, for our first question. Our first question comes from the line of Jennifer Aurand with FHN Family Counseling Center. Please go ahead.

J. Aurand — Hi, I had two questions about the credentialing. One is – I understand that we are allowed to hire a CRSF, or someone who we would like to be certified, and that we have a twelve month grace period. I'm understanding that that is largely due to the amount of time that it takes to get the certifications. First question is – can we bill, can we have that individual bill?

C. Cumpston — Yes.

J. Aurand Okay.

C. Cumpston Because that person would be the person in recovery, designated person in recovery on your team. As a team member, yes, they could bill while they are getting certified. Yes.

J. Aurand The second question is the treatment plan. We have a spot on our current treatment plan that says a copy was given to the client or the guardian/parent, that it was not at this point in time, or that they refused. Are they still allowed to refuse a copy and say I don't want a copy and then we document that?

C. Cumpston No, what you do is you say here is your copy and if they then turn around and throw it away that's up to them.

J. Aurand Okay, so they must physically take a copy no matter what? Okay.

C. Cumpston Yes.

J. Aurand Okay. My other question, and I'm not sure if you can answer this on this call, is that the codes associated with the services have all changed. I'm sure you know – that you're aware of that – the billing codes.

C. Cumpston They have – only one of them has changed and – 90862 or something like that –

K. Herman Med monitoring.

C. Cumpston Med monitoring and it has been changed to M0064 or something like that.

J. Aurand M0064 and the 90862, that's right.

C. Cumpston But that's the only code that has changed.

J. Aurand Okay, so we can still bill the same HCPCS codes for all crises associated because some of the other codes that weren't available to us changed, oddly, that we have to bill.

C. Cumpston You might want to send us that in writing, please.

J. Aurand In writing?

C. Cumpston Because we are not aware of any other codes changing.

J. Aurand Okay, thank you. I'll do that.

C. Cumpston You're welcome. Okay.

Moderator Our next question comes from the line of Rick Germann with Alexian Brothers. Please go ahead.

R. Germann Hi there.

C. Cumpston Hi.

R. Germann Sorry, you got me in mid-egg roll. Sorry.

C. Cumpston That's not fair.

R. Germann Quick question about Client-Centered Consultation. From the description I just heard, that sounds pretty much exactly like what happens when a staff member is in regularly scheduled weekly supervision with their assigned supervisor. Am I to understand that those types of consults during a supervisory relationship can be billed under Client-Centered Consultation?

C. Cumpston No, you can't understand it that way. Kristy, do you want to elaborate on that?

K. Herman Supervision is not billable as Client-Centered Consultation because you are talking about what is going on with the staff person, how they are doing their job, you may be talking about an update of the client. It may be—if you are reviewing the treatment plan, it may be their treatment plan development review and modification, but regular supervision of your staff is not billable as Client-Centered Consultation.

R. Germann Okay, but how about for team meetings then?

K. Herman Team meetings are fine when you're discussing clients and their treatments and doing updates, team meetings around the client are billable as Client-Centered Consultation.

R. Germann Thank you.

Moderator Our next question comes from the line of Julie Darnell with Children's Home Association of Illinois. Please go ahead.

J. Darnell Hi. We were wondering if there is going to be a new cost block or community services reimbursement guide issued?

C. Cumpston We certainly hope so. That's an HFS document, but I understand that Kristy has been working very closely with them on that and we do keep asking about it. We definitely need a new one. We have felt that we've needed a new one for a while. Poor HFS is a little bit overwhelmed by so many other changes that they're going through with the whole SMART Act and Medicaid reform and all of that, that I

don't think it has been their priority. Yes, we believe that there should be an update and we will continue to pursue that.

J. Darnell — Thank you.

Moderator — Our next question comes from the line of Mary Ann Abbott with Rosecrance. Please go ahead.

M. Abbott — Hi. My question is regarding the CRSS credentialing. I was informed yesterday at a network meeting at DMH, a network meeting for Region Two – that it takes all of two years to receive this requirement. There are over 1,000 hours, and this certification is through IAODAPCA. I learned this through the consumer rep from the state who is under Nanette Larson.
So there would be that year time limit from hire wouldn't allow for us – I mean I understand someone in recovery, that's a given, but to receive that actual credential will take a two year period. Now that's what I was informed.

C. Cumpston — Unfortunately, I know that Nanette is actually on the call, but unfortunately we can't have her be a speaker, I don't believe, but I'll tell you what – we gained our guidance on the twelve month grace period from her input. If we need to talk with her further and get further guidance on that we will.

So, Nanette, you can either e-mail me or give me a call and we can talk about that, but the twelve month grace period was established as a result of input from our Recovery Support Unit.

M. Abbott — Okay, because our whole network was informed of that information yesterday.

C. Cumpston — Okay, thanks for sharing that with us.

M. Abbott — Yes.

Moderator — Our next question comes from the line of Cindy Butler with Mental Health Centers of Central Illinois. Please go ahead.

C. Butler — Hi. Our question is regarding giving the client a copy of their ITP, and we have Recovery Specialists who go out into the field and work with the clients at their home and sometimes complete the ITP with the client in their home. Is it acceptable for – to come back to the office and then make a copy of that document and then document in the record that we have mailed it to them?

C. Cumpston — I have no trouble with that. Kristy, Lee Ann? No, we're fine with that.

C. Butler — Thank you.

Moderator — Our next question comes from the line of Ron Little of Kemmerer Village. Please go ahead.

S. Nagle — Hi, this is Schales Nagle, I'm here with Ron Little. I'm wondering on the MHA changes – aside from the transcript of this meeting will there be any other written materials, and obviously the Rule itself. I'm just wondering because Kristy said a lot of things are combining and what's acceptable now and what's acceptable not. Are there going to be any other written explanations of that expectation?

K. Herman — We will update any sample forms that we have, but other than that you'll have the Rule and then the transcript, so I would just work from those documents.

S. Nagle — Okay. Can I ask a sort of clarifying question then – when you said, Kristy, that it's not really extent and nature – are you implying that there is less expectation for historical documentation? Because we really start basically at birth, or whenever we have the first report of a problem, but what you're really talking about is the focus is more now on maybe the last year to six months.

L. Reinert — This is Lee Ann Reinert, Clinical Policy Specialist with DMH. What we tried to do when we made revisions to the Rule this time related to the Mental Health Assessment was to really move more into strengths-based assessing. So the changes that we made were focused on making it a more strengths-based assessment than it has been before. You are certainly always welcome to add any additional information to your Mental Health Assessment that you believe is pertinent for the operation of your agency. If you add a lot of historical information you are certainly able to continue to do that.

The Rule simply defines the minimum requirement that must be met in order for you to be compliant with the Rule 132 Mental Health Assessment, but you are always able to add any additional information in there that you want.

K. Herman — Well, let me add this too, just really quickly – the requirements for family history and for personal history of mental illness, history of abuse and trauma; those are still in place. We reworked the extent, nature and severity piece, so that's why we wanted to highlight it on the call, but those historical pieces still do need to be addressed. Does that kind of help to give the fuller picture, Schales?

S. Nagle — To some degree. I'm anticipating what will happen is people will be making adaptations to how they're writing their MHAs and then it will come out in the reviews whether or not we're meeting expectations.

K. Herman — Well, you know you may have to go through your forms and actually change some of the prompts that are on there.

S. Nagle — Right, right. I'm just saying in terms of – because ours and other people's MHAs, that extent, nature, and severity section right now is a minimum of four pages.

So, my plan will be to shorten that and come into line with these expectations, but what you're really saying is that until we go through a round of reviews, probably, it's going to be a little bit of a learning process.

C. Cumpston — This is Cathy. I would like to highlight something; that if you have a Mental Health Assessment process now that has been compliant – that you don't necessarily have to change it. We have not added anything to the Mental Health Assessment requirements. We have rearranged, we have clarified, we have moved language to be more strengths-based, and we have designed it so that we feel that we wouldn't be holding you to some of the things that perhaps we had, that weren't really the direction that we wanted it to be going.

If you've got a compliant Mental Health Assessment right now, it will continue to be compliant. Am I off on that, guys?

K. Herman — No, Cathy, I think that's correct. If you're hitting the extent, nature, and severity of all of the problems, you're definitely covering the reasons that the client came into treatment, so I would agree with what you said. Does that help, Schales?

S. Nagle — Yes, thank you.

K. Herman — Okay.

C. Cumpston — You're welcome.

Moderator — Our next question comes from the line of Jim Scarpace with Gateway Foundation. Please go ahead.

J. Scarpace — Hi, I just had a follow-up question on making sure clients get a copy of the treatment plan and how that would be checked in an auditing process. Would it indeed be a box on the form saying the client was given a copy of this plan, or how will you guys be assessing for that?

C. Cumpston — Yes, and we have been accepting that indication on a treatment plan, that the box is checked and then the client signs, so if you continue with that that should continue to be compliant.

J. Scarpace — Okay, and prior to that information being shared there was something, and I might have missed it, about Mental Health Assessments and if they're not done the same day as the treatment plan, if you could just say a little bit more about that because I was confused.

C. Cumpston — Absolutely. What we did is a little bit confusing so let me try and clarify. We removed the requirement from the items in the MHA that all of the services be listed regardless of when you complete it. Okay? So, under the old Rule you always had to include the part 132 services that were going to be provided. What

we did in the new Rule, in these revisions, is we took that requirement out, so you don't have to include the part 132 services as a regular part of the Mental Health Assessment, unless there is going to be a gap in time between the completion of the Mental Health Assessment and the completion of the ITP.

If you want to provide services in between the completion of those two documents, then you do have to include on the Mental Health Assessment what services you are going to provide before the treatment plan is completed. Does that help?

J. Scarpace — It does. Thank you, that's very clear.

C. Cumpston — Okay. You're welcome.

Moderator — Our next question comes from the line of Janine Epsiden with Perry County Counseling. Please go ahead.

J. Epsiden — Hi. You had mentioned organizational requirements that had changed and I – you went through them so quickly I couldn't jot them down. Would you mind going over those again?

C. Cumpston — Sure. We've added a piece in under Organizational Requirements: 132.65, that says that the provider shall have an active system for determining compliance with all client record requirements of this part. So that means that the provider has to have a process in place where they review their own stuff; where they look at their records, they look at what they're doing and they determine that what they're doing is keeping them compliant with Rule 132.

We expect there to be a policy that says how you're going to do that. We believe that this is really just putting into writing what most providers already do – that they've probably already got a way that they're assuring that when the reviewers show up there are no surprises; that they already know that they're compliant with Rule 132. So that's what the change in Organizational Requirement really is.

J. Epsiden — Okay, thank you.

C. Cumpston — Sure.

Moderator — Our next question comes from the line of Cheryl Oseguera with Lutheran Social Services of Illinois. Please go ahead.

K. Kohler — Hi, this is actually Karah Kohler. We have a question regarding the authorizations for the Community Support code. With the combination of the Community Support – Individual with Community Support – Group, will it affect the authorization process at all for Community Support since CSI is not currently part of the 800 units?

L. Reinert — No. You report them separately.

C. Cumpston — No. You still have to report them separately, Community Support – Individual and Community Support – Group, so, no, it does not change the current requirements.

K. Kohler — When they get billed out – I guess that would be a different modifier. Okay.

L. Reinert — Yes, right.

C. Cumpston — Yes, and again just to clarify what we did in the Rule is we just combined Community Support under one service definition instead of having the full service definition for Community Support – Individual and the full service definition for Community Support – Group because it was redundant.

K. Kohler — Okay, great.

C. Cumpston — So we went back. We treated it like Therapy Counseling. Therapy Counseling has two modalities, Individual and Group, so it's just the same theory.

K. Kohler — Okay, that makes sense. Thank you.

C. Cumpston — Okay.

Moderator — Our next question comes from the line of Phyllis Russell with ACMHAI. Please go ahead.

P. Russell — Okay, this is ACMHAI, just a couple of quick questions. You started with a list of – and my note says still to be done – and you started with Client Records and you had reasonable accommodation. Could you just tell me what the other – what the rest of those were?

C. Cumpston — Policies that we expect either to be created or updated.

P. Russell — Right.

C. Cumpston — Policy on performing client record audits, policy on confidentiality of client records, policy on reasonable accommodations.

P. Russell — Okay.

C. Cumpston — Policy on utilization review, and there is a thirty day grace period from February 1st to do the updates of those, but you should just look at the Rule and see what the changes are.

P. Russell Thank you. Then the second piece is where is the transcript going to be posted?

C. Cumpston It's going to be posted on the DMH web page.

P. Russell Thank you.

K. Herman Thank you so much.

Moderator Our next question comes from the line of Norma Miller with Leyden Family Service. Please go ahead.

N. Miller Hello. You've just answered that question, which was what the new policies are that we have to write for the new Rule – utilization review, client record audit, reasonable accommodation, and confidentiality, right?

C. Cumpston Yes.

N. Miller Okay, thank you.

C. Cumpston You're welcome.

N. Miller Anything you wanted me to ask her? Yes, Ruth has a question also.

C. Cumpston Okay.

Moderator Our next question comes from the line of Jill Piper with Union County Counseling. Please go ahead.

J. Piper Hi. I have a question that has to deal with the consent part of the thing – the Rule. It said, it talks about explaining the possible alternative treatments and potential risks and benefits. What, specifically, are you guys looking for there? Can you give some guidance?

C. Cumpston We're going to go to that section of the Rule so that we have all the language right in front of us. Okay, 145A – Informed Consent. I'm just going to read it because that will help me.

Prior to the initiation of mental health services the provider shall obtain written or oral consent for these services demonstrating that the client or guardian is applicable, knows all of the risks and costs involved in the treatment including the nature of treatment, possible alternative treatments, and the potential risks and benefits of the treatment – so that's the part that you're asking about?

J. Piper Yes.

C. Cumpston — Okay. So, one of the easy ones, and this would be medications, and I realize that's not really a Rule 132 service – the prescription of medications, but any time that a physician prescribes medications they have to explain both what the potential benefits, the good effects of taking that medication as well as any side effects – same thing with treatment, with therapy.

If a therapist is sitting down with a person and they're offering to begin individual therapy they should be able to explain to them the potential benefits that they will see from doing therapy, but there could also be some potential negative things that could happen as a result of doing therapy, so you would explain that. I think Kristy might have another – did you have another example or something to add?

K. Herman — Just in more practical terms of how you're going to document that you did that. What you're going to have to have is a staff signature attesting to having explained all of those items to the client and the guardian. You're going to have to have a staff statement that says, "Under the informed consent I explained all of these items to the client/to the guardian." That's going to have to be signed, dated, and in the record.

J. Piper — Okay, now does that have to be a clinical staff or could it be the staff that does the orientation?

K. Herman — It could be the staff that does the orientation. We haven't specified in the Rule what staff it has to be.

C. Cumpston — It has to be somebody that understands what the treatment is and what alternative treatments are.

J. Piper — Sure, sure.

C. Cumpston — I mean, for instance, if somebody says, "You're going – it is our recommendation that you receive therapy counseling and here's why and what we would expect for you to get out of it, but then here are some of the downfalls you may not get this out of it. But if you don't particularly want to do individual therapy counseling, perhaps an alternative to you that might be effective would be community support," and be able to then explain the difference between the two and help the consumer make an informed choice about what they're going to go forward with in treatment to accomplish their own recovery goals.

J. Piper — Sure, sure.

C. Cumpston — Any other questions?

Moderator — Our next question comes from the line of Diane Thurb with Trilogy. Please go ahead.

D. Thurb — Yes, in regards to 132.100, and that's in the Client Records section, saying that if a client does not – potentially if a client does not use verbal English we need to have a statement in the record about what accommodations will be made. I'm just asking for a clarification so if a client speaks primarily Spanish, we just need something in the chart saying the client will meet with Spanish-speaking staff; is that correct?

C. Cumpston — That would be great.

D. Thurb — Excellent. Then one other question –

C. Cumpston — Then also to clarify that any written materials given to them should also be in Spanish if they don't understand written English.

D. Thurb — Okay, cool. That's very easy, thank you. The other question was in regards to 132.150.g-7 about Community Support Team, it states now – when a client is receiving CST, CS and CSR services shall not be provided. We used to be able to provide Community Support – Group to a CST client. Has that been changed now with the change in wording?

C. Cumpston — I don't believe that is a change in wording in this section.

D. Thurb — The wording used to read that it was – when a client is receiving CST, CSI and CSR shall not be provided, was my understanding, because we were allowed to bill Community Support – Group to a client receiving Community Support Team, because team was an individual.

C. Cumpston — So it used to say you could do Community Support – Group and –

D. Thurb — Hold on I've –

L. Reinert — It didn't say that exactly.

C. Cumpston — It didn't say it.

D. Thurb — It was allowed through the question and answer.

C. Cumpston — Okay, so it only says CSI before –

L. Reinert — And CSR.

C. Cumpston — And CSR, and then in our effort to combine things and make Community Support just Community Support, we did not keep that as it had been. We will – I think that we could – I don't think our intent was for it to change.

L. Reinert Right, and there – I don't – we haven't changed any billing modifiers so there shouldn't be any reason it couldn't –

C. Cumpston Lee Ann is saying there have been no billing modifier changes so that it shouldn't cause a problem in billing. Let us get a clarification out on that. I think that that was not our intent. I think we just got a little over zealous in our combination of CSI and CSG. Thank you.

D. Thurb Okay, thank you.

C. Cumpston Thank you for catching that.

D. Thurb No problem.

Moderator Our next question comes from the line of Melissa Box with ABC Counseling. Please go ahead.

M. Box Yes, I have two questions. My first question is we work with a lot of young clients and the requirement that we give them a copy of the ITP – if they're a ward of the state, do we need to give that to – I mean it doesn't make sense to give it to a four year old. Could we give it to the caseworker or the DCFS guardian or do we give it to the foster parent?

C. Cumpston We didn't really specify an age limit on that.

L. Reinert We did say guardian and if the state is the guardian, I mean theoretically it goes to the state.

C. Cumpston Right.

L. Reinert But, I think that that is perhaps something we can put into the guidelines about where that really goes because I'm not sure DCFS –

C. Cumpston Well, if you give it to the four year old they'll use it to color on, which is fine.

M. Box Exactly.

C. Cumpston That's acceptable. I don't think we clarified an age. We do clarify who has to sign it.

M. Box Right.

C. Cumpston But we did not clarify who gets a copy, so who did we say had to sign it for a DCFS ward?

M. Box The guardian.

C. Cumpston Right, if they're under twelve the guardian has to sign. If they're over twelve –

L. Reinert So the guardian is DCFS, right?

M. Box Yes.

C. Cumpston Yes. That is correct, so the DCFS –

L. Reinert Well, it probably still has to be given to the guardian. It does specify the client as well. We can add, if we like, a clarification in the guidelines that says if they're under twelve, you can just give it to the guardian.

M. Box Okay.

L. Reinert We can do that through a guideline. Thanks for pointing that out.

C. Cumpston We will do that.

M. Box Thank you. My second question just to clarify – I understand that the MHA you have to list the services that you're recommending if there is going to be a time span between the MHA and the ITP completion. Are you looking at the date of ITP completion as the date of the signatures on the ITP or the report date that is at the top of the ITP?

C. Cumpston The date of the LPHA signature on both the MHA report and the ITP are the effective date.

M. Box Okay, thank you.

Moderator Our next question comes from the line of Jay Roth with New Foundation Center. Please go ahead.

J. Roth Hi, just had a question about the background checks for the staff. We're just wondering if that applies to contractors who might work at the site as well as the clinical staff?

C. Cumpston I can't say specifically. My inclination – my intuition is, yes, but I would suggest that you go and look – we gave you a connect – I think we gave you information about that Act, what the Act is and pull it up and verify that. If the Act applies to you, you're going to need to look at the Act to verify that it actually applies to you. We will look at that, too, and make sure we get it into the guidelines. So, without going back and pulling up the Act myself, I'm not sure that I can really respond to that question.

J. Roth Okay, thank you.

Moderator — Our next question comes from the line of Steven Cahill of Streamwood. Please go ahead.

S. Cahill — Hi, a couple of quick questions – you mentioned the removal of the initial notice of unsubstantiated billing, which previously allowed you to submit additional documentation. Will you be given the opportunity to submit documentation that the auditors perhaps during a post-payment review were not able to find in the chart during the audit done?

L. Reinert — Yes, during the –

C. Cumpston — Only during the review, not after.

S. Cahill — Right.

C. Cumpston — During the – sorry, during the review you will be – we will be giving you a list of we couldn't find this particular piece of service documentation and we'll keep a list of those as we're going through the client record. If an ITP or an MHA is missing, you're going to be notified right away.

S. Cahill — Okay.

C. Cumpston — You will have the opportunity while staff are still on site to provide that information.

S. Cahill — Okay, and that's what I remembered in the IPI procedures for post-payment review. The IPI procedures for the post-payment review still refer to an initial notice. Will they be revising their post-payment review procedures, too?

L. Reinert — Yes, let me just make one clarification – those are DCFS policies and procedures, okay, that IPI implements –

C. Cumpston — And they are also CHS policies and procedures.

L. Reinert — So –

S. Cahill — You're right. My apologies.

C. Cumpston — As soon as we're done with the call, hopefully by the – well, I'm going to give myself a deadline of tomorrow –

S. Cahill — You're faster than I would be.

C. Cumpston — Well, we're going to update those procedures and get them out.

S. Cahill Okay, and probably a little bit related, but maybe not – the addition of the language regarding extrapolation is kind of non-specific. Have there been procedures created for how extrapolation would be implemented should you decide to do so, and are there any plans for extrapolation from PPR audits?

L. Reinert From a DCFS perspective, we have not moved forward with any plans on extrapolation.

C. Cumpston And from a DMH perspective we have not either.

S. Cahill Okay, wonderful.

L. Reinert And before we ever did there would definitely be procedures in place to assure that we are selecting a statistically valid sample that can stand up under scrutiny and, yes, we would have to do a whole lot more work than we have done so far and there are no plans to do that at this point.

S. Cahill That wouldn't be done tomorrow, too, then?

L. Reinert No.

C. Cumpston No. I can do a lot of things in a day, but not that.

S. Cahill All right; thank you very much.

C. Cumpston You're welcome.

Moderator Our next question comes from the line of Constance Lay with Bobby E. Wright. Please go ahead.

C. Lay My question was already answered.

C. Cumpston Well, good. Thank you.

L. Reinert My, we're efficient.

Moderator Our next question comes from the line of Ann Peterson with Chaddock. Please go ahead.

M. Bainter Hi, this is actually Molly Bainter, my question is in reference to the ITP and the copies. Oftentimes we give our kiddos a modified copy of the ITP, is that still okay or not?

L. Reinert Can you say more of what you mean about a modified copy?

M. Bainter Well, like for instance, an ITP that I received last week had some information in it as far as the client – like he's not aware that he'll be transitioning to another placement, but it had some of that information in there so in order to not pass that information on to him they modified the copy. That's kind of what I'm talking about. Sometimes there is information in the ITP that maybe the parent and the treatment team know about, but the client isn't necessarily privy of.

C. Cumpston Well, first of all, the client or the client's guardian has absolute right to look at their record and any part of their record at any time.

M. Bainter Right.

C. Cumpston So, if you've got things – and then also we've got the whole idea of informed consent and people knowing what the plan is and what is expected of them and what's going to happen with them. Giving the – the idea about giving a plan to someone is to share with them the document that has been created with them, or with their guardian, that everyone has agreed to, that they have consented to, and not have secret stuff and things that are hidden from them.

M. Bainter Well, it's not necessarily secret stuff, the meat of the treatment plan and the goals and all that is in there, but for instance, like if it has – up there it had like a return home goal or something like that and it's not return home. We don't often give our kids a lot of advance notice, especially if it's going to increase their anxiety, especially if an ITP falls during that time. The client is still given the ITP, but information like that may not be on there.

The parents are very aware and the parents sign off on the actual document, but the client may just be given like the treatment plan and goals. If you're saying that's not okay, that's fine. I just want some clarification around that.

C. Cumpston In the Rule it says that the client is supposed to be given a copy of the treatment plan, so I guess I would recommend that if there is something on the treatment plan that you don't want the client to see that you not indicate it on the treatment plan. I mean, I don't know how else to get around that particular requirement, because there isn't any wiggle room to say you can give them part of the treatment plan –

M. Bainter Right.

C. Cumpston – or a different treatment plan than what is in the record, so I would be very careful with that.

M. Bainter Okay, thank you.

C. Cumpston Okay.

Moderator — Our next question comes from the line of Laura …, with … and Robinson. Please go ahead.

B. Donahue — Hi, this is actually Beth Donahue, I'm here with Laura ….

C. Cumpston — Is this my favorite Beth?

B. Donahue — Hi, Cathy; yes, it is.

C. Cumpston — How are you?

B. Donahue — I'm doing good. You didn't actually think I wouldn't be on here. Well, since I've got you on there, one of the questions that we have is regarding the definition of natural setting. We were wondering, it seems like natural setting might exclude a definition – the definition might exclude a CILA or a homeless shelter. Is that correct?

C. Cumpston — Well, definitely a CILA.

B. Donahue — Because the way it's defined now it seems to be where an individual has not been diagnosed with a mental illness typically spends time. It's just come up as a concern because it seems to narrow where a natural setting takes place. Obviously there is a percentage of services that have to be provided in the natural setting, so we want to be clear as to what we can and cannot do.

C. Cumpston — I think you – there is an echo that is driving me crazy here, I hope you guys can't hear it. The – I believe that we have specified at some point or someplace that treatment in certain residential treatment options, such as CILA, are not considered natural settings. However, a homeless shelter or a food pantry or places where people without mental illness do go would be in our minds natural settings.

Basically, it is where you are – where you can possibly find people who do not have mental illnesses, going for whatever that place provides for whatever reason. But if you have a CILA that the only people who are there, besides the staff, are people who have mental illnesses, people with disabilities, then that is not a natural setting.

B. Donahue — Okay. All right, thank you.

C. Cumpston — You're welcome.

Moderator — Our next question comes from the line of Bob Hewitt with Lutheran Social Services of Illinois. Please go ahead.

J. Torderch — This is Joe Torderch with Bob Hewitt. The question I have pertain, I believe, to Rule 132.148. If a Mental Health Assessment is completed and services are provided during that period, then the client drops out of treatment and the treatment plan has not been completed – if I'm remembering right the rule says the treatment plan has to be completed. Is that correct, or can an alternative activity be acceptable? For example, writing a progress note to clearly identify the situation and the status of the client?

C. Cumpston — The rule – go ahead, Kristy.

K. Herman — Oh, I actually just looked at the reference so that's why – in 148.11B it does state that if services are provided prior to completion of the ITP, and the client terminates services before the ITP is completed and signed, the provider must complete the ITP and document that the client terminated services and was unable to sign the ITP. That ITP does still need to be completed and indicated that the client terminated services.

C. Cumpston — Would you read that again, please?

K. Herman — Sure. It is 148.11B: If services are provided prior to the completion of the ITP and the client terminates services before the ITP is completed and signed, the provider must complete the ITP and document that the client terminated services and was unable to sign.

C. Cumpston — Perhaps I heard the question wrong. I thought the question was what if they terminated services before the completion of the Mental Health Assessment?

J. Torderch — No, no that's …. That's correct.

C. Cumpston — Okay, the Mental Health Assessment has been completed?

J. Torderch — That's correct.

C. Cumpston — But then the ITP has not, okay. Then yes, if the Mental Health Assessment has been completed and the person has started treatment, then, yes, they have to complete the treatment plan and indicate the client terminated treatment and was unable to sign. Okay.

J. Torderch — Excellent, very good. Thank you.

Moderator — Our next question comes from the line of Kevin Jesse of Adult Probation Department Mental Health. Please go ahead.

K. Jesse — Hi. When staff do an annual Mental Health Assessment, is that a billable service?

C. Cumpston — Absolutely.

K. Jesse Under Mental Health Assessment, I guess.

C. Cumpston Yes.

K. Jesse Okay, thank you.

C. Cumpston You're welcome.

Moderator Our next question comes from the line of Karen Major with The Baby Fold. Please go ahead.

K. Major Yes, thanks. This is about Client-Centered Consultations and billing with the client present and the foster parent, like, for example, a child and family team meeting.

C. Cumpston Well, if it's a child and family team meeting where there are other professionals that are part of that team, and you're doing a professional communication that would meet the definition of that service, then that is okay.

K. Major Okay.

C. Cumpston Perfect, thank you.

Moderator Our next question comes from the line of Chrissy Anderson with Lutheran Social Services. Please go ahead.

C. Anderson Yes, I was wondering if the e-signature in an electronic health record qualifies under the now original signature that's peppered throughout the rule?

C. Cumpston Yes, it does.

K. Herman Yes, it does, but I want to make one clarification on that – you need to make sure that your electronic signature policies and procedures are all compliant with all of the requirements in 132, including a statement that says that this code that each staff has is only for them and that they are the only one that has access to it. Okay, so all of those statements have to be in place in order for it to be an original signature, to verify that that is the only person that can use that signature code.

C. Anderson All right.

Moderator (Instructions given.) Our next question comes from the line of the Lake County Health Department. Please go ahead.

W Hi, I had a question about informed consent with where it says knows all the risks and costs. Do you expect us to specifically tell them how much out-of-pocket financial cost services are going to be?

C. Cumpston Are there going to be any out-of-pocket costs?

W Well, sure, depending on if they have a spend-down, if there is a $3.65 co-pay; things like that.

C. Cumpston Okay, I don't think there is any co-pay on any of our services, any of the 132 services.

W Okay.

C. Cumpston But yes, there – if they've got a spend-down and you're going to charge them anything for that period of time when you can't bill Medicaid; yes, we would expect you to tell them that.

W Okay. Then, how do we handle existing clients with the new wording for informed consent? Do you want us to have some documentation for all clients with the new wording?

C. Cumpston Yes, we would, but – okay, that would be part of the annual –

W Oh, the rights?

C. Cumpston Yes, explanation of the rights and if they've not had their rights explained to them in the last twelve months, then you have sixty days from February 1st to explain them, including the informed consent. If they have – if there is somebody that's just been in service six months, then six months from now you would be explaining their rights to them again and explaining that.

W Okay, thank you.

Moderator Our next question comes from the line of Lloyd Tramley with Catholic Children's Home. Please go ahead.

L. Tramley My question was answered earlier, thank you.

C. Cumpston Thank you.

Moderator Our next question comes from the line of Sandra Colery with CBHC. Please go ahead.

S. Colery — Hi, I've got a follow-up question on the Client-Centered Consultation. If it can be done within the agency, can it be billed by each person in that meeting, that team meeting, or can it only be billed by one person?

C. Cumpston — It can only be billed by one person.

S. Colery — Okay.

K. Herman — Yes, whenever you have multiple staff that are doing one service, only one person gets to bill it unless there is a specific multiple staff modifier –

C. Cumpston — And there is not for –

S. Colery — Right.

K. Herman — That's just for crisis.

S. Colery — Okay. Then the other thing is the date of the last reimbursement guide – does anybody know which guide is the most current?

C. Cumpston — The 2011 one, I believe.

S. Colery — Which does not have a date on it, correct?

C. Cumpston — Well, when you go online – I think you're right, I think it does not have that date on it, but if you go online there are two links that you can click on and the links have dates on them.

S. Colery — Okay, the one that I found online was the 2007, but I have a printed copy of the 2011 so I know I got it from somewhere. I'll find it. Thank you.

C. Cumpston — Okay, you're welcome.

Moderator — Our next question comes from the line of Gon Ming Mo with KYC. Please go ahead.

G. Mo — Yes, my question is I noticed that on the Mental Health Assessment that you added a few items – I guess added names and the contact information for the client's primary care physician. It had a date for the most recent psychiatric evaluation; also it had employment history and interests, activities, and hobbies as examples of strengths and resources. My question is that when you come – when a survey or auditor comes over to perform the audit, when we look at the assessment – existing assessments – are we going to use the new rules to perform the audit?

These existing assessments does not have this new added items, will they apply the new rules against the existing assessments or they will say they're only looking for the new added items in the new assessments? Those are timeline things – or do you require amendments for all the existing Mental Health Assessments?

C. Cumpston That's a good question and what's going to happen here is we're going to enter into what's called a bridge period between the old rule and the new rule. Any of the documents that were completed while the old rule was in effect will be evaluated according to the old rule standards. As of March 1, any of the documents that are completed after that time – those are going to have to be compliant with the new rule standards.

G. Mo Okay, that's great. Also, that you removed some of the items – I guess for the removed items you actually may not cite for incompliance if they are still in there because you mentioned that agencies are allowed to add additional information.

C. Cumpston That's correct. We're not going to make you take things out that you have been using should you want to keep them there.

G. Mo Okay, great. Thank you very –

K. Herman You can always have more; you just can't have less.

G. Mo Yes, okay. I think Cathy also mentioned that if you have a current process that meets the requirements, you shouldn't have any problems. We have a lot of current templates we are using that we have agencies that have a 98% or even higher on the post-payment review score. So we're actually going to look at the existing templates and add the new added ones, new added items in our existing templates and we'll probably give the users choice to remove the things that you no longer require. That's not a question; that's just telling you what we're going to do.

C. Cumpston Okay.

G. Mo Because you know you did mention that if you're – you really except a few added items, what you really did is not really make substantial changes in terms of the data elements, you just rearranged and reworded things, like, for instance, the presenting problem changed to reasons for seeking treatment.

C. Cumpston Yes. Yes, that was our intent to reword things, to remove some things and offer them as examples rather than requirements –

K. Herman Make things clearer.

C. Cumpston – make things clearer, make things more recovery-focused. So yes, we did not intend that this was going to be any major change to what was already there. As I

said earlier, if you were compliant before you're most likely going to be compliant in the future.

K. Herman — You know there is one item that I want to highlight, though, while we have a chance here. That is around medical necessity – this was actually not new language put into the rule at this revision, it was during the last revision that we clarified what information is needed under Medical Necessity. I just want to point out to everybody to take a look at the rule, the definition of medical necessity, and make sure that your assessment, as part of your summary analysis and conclusions regarding the medical necessity of services, is addressing all of those items. I don't think we're asking for too much additional information, but it may be worded just slightly different.

C. Cumpston — That is, yes, that is language that has been in the rule since May of 2011.

K. Herman — Right, right.

G. Mo — Okay, thank you very much.

Moderator — Our next question comes from the line of Linda Weiss with One Hope United. Please go ahead.

L. Weiss — Yes, my question is about 132.100.i, where services shall support the amount of time claimed and how that is going to be determined.

C. Cumpston — 132.100.i – That is not a change, really. I mean we have always expected that your documentation would be sufficient to support whatever time you were claiming you provided the service. If you're claiming that you're providing Community Support for three hours to somebody, we need to see documentation that actually describes three hours' worth of intervention.

L. Weiss — True, and I understand that, I just didn't know if there was going to be some clarification on how that would be determined, if it's going to be determined any differently – what an auditor might say, that doesn't support four units, or that doesn't support six units.

C. Cumpston — It's not going to be determined any differently than it is determined right now.

L. Weiss — Okay, thank you.

C. Cumpston — So no additional guidance.

Moderator — Our next question comes from the line of Amy Faron with University of Illinois. Please go ahead.

A. Faron — Thank you. I wonder if you could clarify whether there are any changes in UR or billing procedures that are related to the Medically Necessary definition for use

under age 21, specifically that children don't need to have a complete diagnosis to receive services.

C. Cumpston — Well, we do have, in the rule the language is that a Healthy Kid Screen may be used to initiate services while a Mental Health Assessment is actually being completed. That language is all in the rule, but then a Mental Health Assessment must be completed and services must be medically necessary; they are Medicaid services so they must be medically necessary. They can be initiated using a Healthy Kid Screen from a physician.

A. Faron — Are there any changes to the UR or billing procedures related to those, to that change with the Health Kid Screen?

C. Cumpston — No, it's treated just like you had a Mental Health Assessment already done or like an admission note.

A. Faron — Admission note.

C. Cumpston — No, it's just – a kid can start getting services based on that screen and it would be billed just the same as the services would be billed once the treatment plan is done.

A. Faron — Great, thank you.

C. Cumpston — Sure.

Moderator — Our next question comes from the line of Michael Freda with Robert Young Center. Please go ahead.

M. Freda — Yes, our question is about nursing assessment or health risk assessment done for clients, for example, prior to seeing a physician for medication and they're asking a lot of questions related to behavioral health functioning, medical comorbidity, medications, problems with medications, those kinds of things – we're wondering if that's allowable to be billed under the code of Mental Health Assessment?

C. Cumpston — I would prefer that you put that one in writing and send it to us so that we have more time to think about that cautiously.

M. Freda — Okay.

C. Cumpston — Thank you.

Moderator — Our next question comes from the line of Scott Burgess with Alexian Brothers. Please go ahead.

S. Burgess — Hi, thank you. Actually a lot of my question was resolved when Gon Ming asked his question. I did want to note, though, that it appears to us in the review that the updated mental health allows – it indicates that there are several areas that are historical areas that are no longer required on the updated MHA, which is terrific to see. I think a number of years ago historical information was not needed to be repeated every year, then it kind of morphed at some point that it was required again, and now it appears that that's no longer required. We just appreciate that you've addressed that.

C. Cumpston — Well, thank you very much, but I don't think we can really take credit because that wasn't something that we changed. In the last version of the rule we said that historical information did not need to be updated in the annual review unless something – unless somebody's history suddenly changed. Thank you.

S. Burgess — Okay, yes, and I don't know if that was maybe then a Joint Commission requirement for –

K. Herman — Probably, yes. Let's blame it on them.

S. Burgess — We'll just send them your way for the recommendation.

K. Herman — Tell them this is the way DMH does it.

L. Reinert — Mention Cathy Cumpston.

S. Burgess — I've got it written down and I've got it on audio tape, thank you.

Moderator — Our next question comes from the line of Marci Kresin with Heartland Health Outreach. Please go ahead.

J. Lantham — Yes, we were wondering, this is Joan Lantham, from Heartland Health Outreach, and I was wondering why are we taking away a participant's choice to choose whether or not he or she wants a copy of the treatment plan?

C. Cumpston — We're not. You hand them a treatment plan, if they don't want it they can throw it out. We're not saying that you must insist that they keep it and put it anyplace, they can do whatever they choose with it.

K. Herman — I would just – the only part that I would add is that is bringing this requirement in line with the Mental Health and Developmental Disabilities Confidentiality Act.

C. Cumpston — Which requires that you give them a copy.

J. Lantham — Okay. Thank you.

C. Cumpston — You're welcome.

Moderator — Our next question comes from the line of Brenda Bowe with Webster-Cantrell Hall. Please go ahead.

G. Weeks — Hi, this is actually Gabi Weeks from Webster-Cantrell Hall. I have a question about the Mental Health Assessment. I understand that the language was changed from extent, nature, and severity of presenting problem; however, I was also told that we need to cover each element of this component of medical necessity. The information I was given is that one of those components is severity, type, and chronicity of client's symptoms. I wanted to get clarification on that.

K. Herman — Okay, sorry, I just want to get to the actual wording. That is true, under Medical Necessity it does state that the L needs to consider and document whether there is medical necessity based on the type, severity, and chronicity of the client's symptoms. That in the Mental Health Assessment piece we've taken out extent, nature, and severity, right, and we've indicated you need the reasons for treatment, so when you're going to establish that there is medical necessity for those services, you do need to at least address the type, severity, and chronicity.

C. Cumpston — That's what the L has to do. The L has to do these considerations before they sign off that the client is acceptable.

K. Herman — Right.

C. Cumpston — It does not have to then list or have a section in the assessment that says – that talks about those things; it's what the L has to do to make a determination about medical necessity.

G. Weeks — So the same thing with severity of impairment in client work functioning and such, right? I have another component I was wondering about – it is the expected short-term and long-term outcome of service needed by the client. Again, even ... those can be addressed so the services are prescribed and then there has to be some type of an explanation what those short- or long-term outcomes for each service would be?

C. Cumpston — Right, what is the expectation of the progress, if you will, that the client is going to make based on receiving those services.

G. Weeks — Okay, so –

C. Cumpston — We haven't really defined short-term and long-term, so you've got to look at the immediate benefit that the client is going to get and then long-term are they going to stay out of residential treatment? Are they going to be able to step down to a less restrictive placement; those kind of questions.

G. Weeks — Okay, so all the six components have to be covered – they don't have to be covered in one place, I would assume, but they can be covered in different parts of the Mental Health Assessment, is that correct?

K. Herman — I'm sorry, could you say that last part again? The connection isn't very good.

G. Weeks — Oh, I'm sorry. I understand that the six components – do they have to be all addressed in one section of the Mental Health Assessment or certain components can be in, I don't know, section one or section two, because there are six components we do, is that correct?

C. Cumpston — If those components are covered in other sections of the Mental Health Assessment that is okay.

G. Weeks — Okay.

C. Cumpston — Generally, we would see this in the Summary, Analysis, and Conclusion sections, but if it is addressed throughout the assessment then that is fine. You just need to make sure that it is addressed at some point.

Wow, we've got some really bad feedback.

Moderator — Our next question comes from the line of Bill Schaefer with Thresholds. Please go ahead.

C. Mesdorf — Hi, I have a question, but this is Carrie Mesdorf. I have a question about the changes to the on-site/off-site and so if an agency owns or leases a building, but there is no staff on-site, has there been a change whether or not that needs to be certified?

C. Cumpston — So, for instance, if somebody has a residential site –

C. Mesdorf — Correct.

C. Cumpston — That the provider owns –

C. Mesdorf — Correct, but there is no staff office.

C. Cumpston — But there is no service – there are no staff housed there?

C. Mesdorf — Correct.

C. Cumpston — So any time, for instance, if it's a Community Support – Residential and they – staff go on-site to provide services there –

C. Mesdorf — It really wouldn't be under – the CSRs would be – would have staff on site. It would be more an individual condo the agency owns – the member is leasing it from the agency, the staff, so Thresholds owns it, and we've got staff going out and doing either CST or CSI at that site. Would those individual sites need to be certified?

C. Cumpston — No, they would not.

C. Mesdorf — Okay, so if there is – basically, if there is no staff office there, certification is not required?

C. Cumpston — Right.

C. Mesdorf — Okay, thank you.

C. Cumpston — You're welcome.

Moderator — Our next question comes from the line of Cheryl Stenzel with Allendale. Please go ahead.

C. Stenzel — Hi, I had a follow-up question regarding the Strengths and Resources. It looks like it's basically a list – because I know in the past when we hadn't addressed every one of those items when they were ... that that was an issue. I just wanted to check to understand that basically now it's an area and it looks like it's saying that these are strengths to be listed, but it doesn't look like if we don't address every single one that that's going to be a deficiency.

K. Herman — Right, I want to point out that it says in the parentheses e.g. –

C. Stenzel — Right.

K. Herman — That means examples – these are some examples of what you could cover. Any time it says that in the rule, those are just examples; we are not going to look for each individual one. If it says i.e. – that is, then those do need to be listed, but in there it is e.g. and so those are just examples of items you may want to cover.

C. Cumpston — You may have others you want to cover.

K. Herman — Right.

C. Cumpston — They're just examples.

C. Stenzel — Okay, thanks for clarifying that. Then also, just still trying to get some clarification on the Summary, Analysis, and Conclusions regarding the Medical Necessity. Can you give an example because I'm just wondering what is going to be looked at for that? Is it the therapist, this is what the diagnosis, like a summary

of the diagnosis from all the symptoms that are listed in the presenting problem or?

C. Cumpston — I would like for us to put some further guidance in writing when we've had some time to talk more about this, because this is really a process that the L uses. This is not part of the Mental Health Assessment. This is a typical – the L has to sign off on everything saying yes, these services that we are recommending are medically necessary. That guidance has – that we include under the Medical Necessity guidance is what an L would typically go through in their thought process for – is this going to be medically necessary for this person? When we look at any utilization management and we're then considering whether something is medically necessary those are the thought processes, the review processes we will go through to say yes, this is medically necessary.

We really want that to be something that the L thinks about, that the L then can make a statement that says yes, I have looked at this from these perspectives and yes, these services are medically necessary. Then, if we ever question it, if we ever have a disagreement about is this really medically necessary, the L would be able to support why the decision was made from the L's perspective that the service was medically necessary.

Now, what the documentation needs to be is something I think we would like to internally discuss and put out on the Q&As to make sure that everybody then has access to what we really mean there. It's always important for all 132 services to have been determined medically necessary. That is really the role of the L when the L signs anything.

We don't want you to be thinking of this as something else that the Q or somebody assisting the Q has to put into a Mental Health Assessment. This is something, really guidance for the L in their sign off on things that this is what the thought process they've gone through to determine medical necessity. So, we will have some more internal discussions and we will get something out on the Q&As about this.

C. Stenzel — You know, it's kind of an interesting distinction, I don't know if maybe when that comes out if you could kind of clarify this distinction more between the L and the Q, because in terms of training staff, I think I want them to be thinking about medical necessity if they're doing a Mental Health Assessment and the severity of the problem, the symptoms, so I mean I understand in terms –

C. Cumpston — Certainly, yes, you're right. That's a very good idea to have staff thinking about it and understanding what it all means, but still it comes down to the L is the person responsible for signing off and saying yes, these are services that are medically necessary.

C. Stenzel — Sure, yes. I mean I understand, I just think it's an interesting distinction because, I mean, I would want the Q to be thinking about that because in terms of who writes it, I guess, I'm not sure that it matters so much who writes it as much as that is what's being reviewed for the client and certainly as an L signing off I'm thinking about that. I guess my concern is kind of the other side that if it's something that's sort of put in a category for the L to do, then the Qs aren't thinking about it so much, so I just want to offer that input.

C. Cumpston — Sure. You can have your Qs; I think it's a very good idea to have your Qs thinking along the same lines.

C. Stenzel — Yes, and it's just that the documentation is like okay, this section is for the Ls then you know how in practice people just feel like, okay well that's for my supervisor to think about or integrate versus as a practice level we would basically want them to do that also so that they're not just saying okay, well, the L will think about it and pull it all together.

C. Cumpston — We understand, thank you.

C. Stenzel — Okay and then one other question about the annual review of the Client Rights – If I'm understanding it correctly that that should be a new copy of the Client Rights being put in the file? So I know we reviewed in terms of copies, a new copy would need to be given to the client and the progress notes, but in terms of in the file, if it's kind of the same document, do we need to put a new signed copy in there or can they sign the first one that was done the year before?

C. Cumpston — Hang on just a second, I'm getting to the Client Rights section so that I can tell you exactly. Okay, what we're looking for is a signed and dated statement by the staff person that explain the rights, okay, so if that is on the Client Rights form then that full form has to go into the record. If that is a separate statement signed by the staff and dated, then that is fine, too, so you don't have to have a copy of the Client Rights in the form. If you do just have the signature page with the statement of the staff saying I explained the rights to the client, you need to indicate on that statement which version of the Client Rights you are – they explained to the client. Does that make sense?

K. Herman — If you have one Client Rights Statement and you haven't updated it, and it's still good to go, and you explain it this year, and you don't make changes to it and you explain it again next year, you could have a form that has a staff signature on it that says, "I explained it February 1, 2013. I explained it – there were no changes. I explained it February 1, 2014." But if you change your Client Rights Statement, then you'll have to have the new version in there with the sign off from the staff that said they explained it.

C. Stenzel — Okay. Are you going to – I think you had mentioned earlier in the call that you're going to update the example documents and we could get them through IPI so that it might have an example of that?

K. Herman — Yes, all of those sample documents will be updated.

C. Stenzel — Okay, because I'm not sure if I'm understanding – I'm trying to translate what you're saying to how we would modify ours. I'm not quite sure.

C. Cumpston — Well, we're just trying to say to you that you don't need to have extra paper in your file.

C. Stenzel — Okay.

C. Cumpston — If you have a Client Rights Statement in there and you don't change it, then you just need to be able to refer back to it and say we explained it to them again.

C. Stenzel — Right and that's the part to me that if you have a statement that says explained to the client and then – do we have to go in and say have that printed out again and the signature under it or can you just sign under that statement again? Do you know what I mean?

C. Cumpston — You can just sign under the statement again.

C. Stenzel — Okay. Thank you, that's helpful.

C. Cumpston — Okay. Katia, we're over our time, so I would like to take one more question. Then those of you who are still in the queue, if you would send us on the DHSMH e-mail address we would gladly respond to the additional questions that we haven't gotten to.

Moderator — Our last question comes from the line of Donald Dill with HASI. Please go ahead.

W — Yes, you had mentioned earlier about the – that you could bill for services under the provided by CRSS until that person becomes certified. My question is where – what reference do we use to understand what services are allowable for a CRSS?

C. Cumpston — A CRSS is defined in Rule as an MHP.

W — MHP, all right. Thank you.

C. Cumpston — You're welcome. Okay. Thank you all for participating today. Again, if you still have questions get those to us in writing and we will respond back to you. We will begin the implementation of the Rule changes February 1st. There are some

things out there that have grace periods; thirty days, sixty days, twelve months, but we suggest that you make sure that your staff have copies of the Rule; that they understand any changes that have been made to the Rule, and that you promptly address those. Again, thank you for participating.

Moderator — Ladies and gentlemen that does conclude our conference for today. Thank you for participating and for using AT&T Executive Conferencing.