ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

DHS/DMH POST-PAYMENT REVIEW INTERPRETIVE GUIDELINES

FY14 PPR Tool Items

1. **No valid note documenting the service could be located** - Rule 132.100 (i); 132.100 (i) (4).

   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.

   Bills submitted for mental health assessment must have a progress note which includes a description (narrative) of the time spent with the client or collateral gathering information [132.148(a)(13)]. The Mental Health Assessment itself does not function as a progress note. A progress note for this service that states "completed mental health assessment" is not sufficient documentation and will be marked as disallowed for this item.

   Specific documentation of delivery of treatment plan development, review and modification service must include a description of the time spent with the client or collateral developing, reviewing or modifying the ITP [(132.148(c)(12)]. The ITP itself does not function as the progress note. A progress note for this service that states only "updated ITP" or "completed ITP" is not sufficient documentation and will be marked as disallowed for this item.

   Likewise, all treatment services outlined in Rule 132 include requirements regarding documentation of service provision. If progress notes do not meet these requirements for the claim billed, the claim will be disallowed.

   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, reviewers will ask for staff assistance with interpretation. If credentials are missing from the signature or if credentials are illegible to all, this item will be marked as disallowed. Item #3 will not be marked as disallowed unless the person signing the note 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** - Rule 132.100 (i) (1); Rule 132.100 (i) (6).

   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 activities which are NOT BILLABLE:

   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** - Rule 132.42 (a) (4); Rule 132.150.

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

4. **No amount of time documented** - Rule 132.100 (i) (3).

   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 (MHA) could be located** - Rule 132.148 (a).

   The MHA, Admission Note (residential or ACT) or HFS approved Healthy Kids mental health screen (for persons under age 21) 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, Admission Note or Healthy Kids screen that should be in effect at the time of the claim could not be located in the record.

   An Admission Note must be completed within 24 hours of admission and is effective for a maximum of 30 days [132.148 (a)(1)]. A **dated signature of a QMHP** must be on the Admission Note [132.148 (a)(1)(C)].

A Healthy Kids mental health screen remains effective for the **initiation of services** for 60 days from the date of the **physician's dated signature**. A Healthy Kids mental health screen may be used for a maximum of 30 days while the mental health assessment is being completed. [132.148 (a)(2)].

Per 132.148 (a)(3), a mental health assessment is not required prior to the initiation of psychological evaluation, crisis services [132.150(b)] and case management services [132.165 (a)(1)].

The provider designates what is the first face to face that initiates treatment. If the provider does not indicate the first face-to-face date that initiates treatment, the reviewer will assume the first appointment is that date. If the MHA was not completed within 30 days of that appointment or what the provider designated as the first face to face AND there is no explanation of the delay, then reviewers would indicate that as a deficiency.

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 -132.148 (a) (10). The LPHA must sign **and date** the MHA report that relates to the claim. Credentials must be legible - 132.148 (a) (9).

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 is the same person, this person needs to sign only once, but this person has to sign with 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. For information about electronic signatures see 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** - Rule 132.42 (a) (1); 132.100 (d).

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

   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 and the signature and/or date is missing from the ITP. The treatment plan must be approved and signed by a LPHA within 45 days of the dated LPHA signature on the Mental Health Assessment.

   In the instance that the ITP has expired or has not been completed within the required time period, the only services that can be provided are mental health assessment service, ITP development, review and modification, crisis intervention, case management transition, linkage and aftercare and mental health case management.

   Services may be provided concurrently with ITP development if they are recommended by the LPHA as medically necessary on the signed and dated MHA and are included in the completed ITP within required time lines.

   When an Admission Note or Healthy Kids mental health screen was completed to initiate service the ITP shall be developed, following the completion of a mental health assessment, within 30 days after the client's date of admission [(132.148(c)(1)].

7. **Specific service does not appear on ITP** - Rule 132.42 (a) (3); Rule 132.148 (c) (2) (C); 132.148 (c) (7).

   This item would be marked as disallowed if the specific 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 are examples of "specific services":
   - Psychotropic Medication Administration
   - Psychotropic Medication Monitoring
   - Psychotropic Medication Training (Individual or Group)
   - Community Support (Individual or Group)
   - Community Support Team (CST)
   - Community Support Residential (Individual or Group)
   - Psychosocial Rehabilitation (Individual or Group)
   - Therapy/Counseling (Individual, Group, or Family)
   - Case Management- Mental Health
   - Case Management-Client Centered Consultation
   - Case Management -Transition Linkage and Aftercare
   - ACT or ACT Group

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.

Services may be provided concurrently with ITP development if they are recommended by the LPHA as medically necessary on the signed and dated 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.

Services may be provided concurrently with ITP development if the mental health assessment report is completed, signed and dated by the LPHA or the Admission Note is signed and dated by the QMHP or a Healthy Kids mental health screen completed by a physician is in the client record, is recommended as medically necessary and are included in the completed ITP within required time lines.

8. **ITP review does not demonstrate both a review of progress towards goals and an evaluation of needed services** - Rule 132.148 (c) (5).

Rule 132.148 (c) (5) requires that 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.

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.

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

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** - Rule 132.100 (i) (3).

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 - Rule 132.100 (i) (5).

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.

"On-site" includes the surrounding provider owned, leased or controlled property and buildings and adjacent parking areas. Additionally, any service that is provided via telephone or video or that is provided to a client in a staff person's office in a certified site is considered on-site.

11. Note describes a different service than billing submitted - Rule 132.100 (i) (1).

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 may be a data entry error on the part of the provider. For example, note may say individual therapy but the claim was billed with 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).

QUALITY INDICATORS

The following indicators are to be completed for each claim reviewed in PPR**.** Quality indicators are scored as "Yes" or "No" and do not affect the substantiated percentage score for the provider. These items are on the post-payment review tool for quality improvement purposes and identification of training needs.

A. Documentation is sufficiently detailed corresponding to time billed.

High quality documentation will have enough meaningful details about the service provided that it is clear how the time was spent. Documentation that needs improvement has one of the following issues:

- Service provided is unusually lengthy for the nature of the service and the narrative does not provide more details than notes for services of less time.
- Narrative of note reflects a small portion of billable services but the note also contains a large portion of non-billable services.

For example, Provider staff takes a group shopping at the mall. Staff provides skills training on the way to the mall and on the way home from the mall. During the course of the shopping trip, the consumer shopped independently or shopped with peers while staff observed. If the narrative of the note for billable activities does not provide as much details as one would expect to see for the time billed, note it here as an issue.

If the service is not a billable service as described, note the issue in #2. "**Note describes a service intervention or activity that is not billable."** In that case there is no need to complete this item.

B. MHA contains sufficiently detailed information to guide clinical treatment.

A high quality Mental Health Assessment contains enough meaningful details to help clinicians planning treatment and performing services that will actually meet the individual's needs. For example, if the usual clinician providing services left the agency, would someone stepping in be able to understand how to proceed, having a good grasp on the treatment history, needs and goals of the individual? If another agency working with the consumer requested a copy of the mental health assessment, would the requesting agency have sufficient information to guide their treatment well?

If the MHA is missing or is so insufficient that it could not be considered a valid assessment, note the issue in #5, "**No valid Mental Health Assessment (MHA) could be located."** In that case there is no need to complete this item.