ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

Post-Payment Review Interpretive Guidelines

Procedural notes:

During the entrance conference when discussing Post Payment Review (PPR), inform the provider that we are looking at the following documents to support the billings being reviewed:

- **Mental Health Assessment/Update*** in effect at the time of the service billed (*If the Mental Health Assessment Update has "No Change" in any area, then we also review the complete prior MHA on which that Update is based),
- **Individual Treatment Plan** in effect at the time of the service billed, and
- **Progress Note** for the service billed.

IMPORTANT: If a document is not in the record provided, ask the provider contact to help you find it. For FY10 reviews, the clinical record must include an annual MHA update that includes all required elements as specified in Rule 132. Reviewers will be using the most current Rule, dated 7/1/08.

For a clinical record (chart) that is not provided to us (they cannot find a record for us to review/ no chart at all): Mark items 19, 20, and 21 to reflect no note, MHA or ITP found.

PPR Tool Reason Codes

1. The Mental Health Assessment report that relates to the claim is not signed and dated by the LPHA.

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

How to handle possible situations found:

- When there is no MHA in the record: Check only item #21 as the reason for the billing not being supported. Also, do so if the full MHA is not in the record, on which the update noting "No Change" is based. 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 providing the face-to-face are the same person, there only needs to be one signature, but this person has to sign LPHA credentials after the name. If they meet credentials as an LPHA, they are also a QMHP so they meet both criteria. They have to do everything the QMHP is responsible for (functioning as a Q). This information doesn't necessarily have to be documented on the MHA but can be found elsewhere in the record, such as in progress notes. If the LPHA didn't have the face to face, would need to see the QMHP signature also.
- In the event that reviewers find a current MHA update that is signed by the LPHA, but the update reflects "no change" on items which results in a review of the mental health assessment that the update is based on and the older MHA does not have an LPHA signature: Go ahead and mark this as in compliance because the current one that is in effect for the claim is signed and dated by the LPHA.
- In the event that the MHA is signed and dated by the LPHA after the ITP is signed and dated by the LPHA, item #1 would be checked as disallowed, but the ITP item #3 would be okay as the ITP does have an LPHA signature and date.

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- It is okay if the signature does not contain the credentials if the signing line has typed credentials underneath or beside the signature.
- Information about electronic signatures:

Rule 132.85 f) Electronic signature or computer-generated signature codes are acceptable as authentication of record content.

1) In order for a provider to employ electronic signatures or computer-generated signature codes for authentication purposes, the provider shall adopt a policy that permits authentication by electronic or computer-generated signature.

2) At a minimum, the policy shall include adequate safeguards to ensure confidentiality of the codes, including, but not limited to, the following:

A) Each user shall be assigned a unique identifier that is generated through a confidential access code.

B) The provider shall certify in writing that each identifier is kept strictly confidential. This certification shall include a commitment to terminate a user's use of a particular identifier if it is found that the identifier has been misused. "Misused" shall mean that the user has allowed another person or persons to use his or her personally assigned identifier or that the identifier has otherwise been inappropriately used.

C) The user shall certify in writing that he or she is the only person with user access to the identifier and the only person authorized to use the signature code.

D) The provider shall monitor the use of identifiers periodically and take corrective action as needed. The process by which the provider will conduct monitoring shall be described in the policy.

3) A system employing the use of electronic signatures or computer-generated signature codes for authentication shall include a verification process to ensure that the content of authenticated entries is accurate. The verification process shall include, at a minimum, the following provisions:

A) The system shall require completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps or obvious contradictory statements appearing within those designated fields. The system shall also require that correction or supplementation of previously authenticated entries shall be made by additional entries, separately authenticated and made subsequent in time to the original entry.

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B) The system shall make an opportunity available to the user to verify that the document is accurate and the signature has been properly recorded.

C) The provider shall periodically sample records generated by the system to verify the accuracy and integrity of the system.

4) Each report generated by a user shall be separately authenticated.

- (Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

2. The Mental Health Assessment does not contain all elements as required by Rule 132, 2008 version.

Definition: All required elements of the MHA identified in Rule 132 need to be addressed on the MHA and MHA Updates. All areas of the MHA need to be completed (not left blank). We cannot assume that an element was assessed if it is left blank. So in the case that the MHA does not identify each element (assuming that if it is not marked it is not a problem) a finding of procedural deficiency would found for item #2. This has been seen at times, especially when provider is using checkmarks for answers. Providers CANNOT insert “unknown”, “consumer refused to answer”, or “does not apply.” Providers CAN respond with “None” in some instances. See attachment of required elements for the MHA report with areas marked where “none” is acceptable.

NOTE: The provider must answer all questions on the MHA. Primary method of communication: The method is “verbal”, “sign language”, “ASL”, “ESL”, “communication board”, or other means. Language is not a method, so “English” or any other language is not counted as a method of communication. Simply leaving MHA areas blank that ask about need for sign language, communication board, or other devices is not sufficient… we cannot assume that someone communicates verbally.

If a Mental Health Assessment Update is in the record and has “No Change” indicated on any area, then we also review the most prior complete MHA on which that Update is based. Mental Health Updates must include all required elements, though they may indicate “no change”. Updates do not have to address elements A, D, G, or H. If these elements are the only elements missing from the MHA Update that relates to the claim, the claim would be allowed.

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Information to address Item #2 of the PPR tool:

2008
Rule 132.148 MHA Elements (#2)

A) Identifying information: name, gender, date of birth, primary method of communication. Must respond to all four items. Method means how, not what language. This item is not required to be re-assessed on MHA Updates.
B) Extent, nature, severity of presenting problems.
Must respond to all three items. Extent: How long has the presenting problem been a problem for the person? Severity: How severe is the problem? Has the presenting problem caused any problems or loss of functioning for the person? Nature: What the presenting problem is.

C) DSM-IV or ICD-9-CM diagnosis.
An entire five axis diagnosis must be completed.

D) Family history, including history of mental illness in family. This item is not required to be re-assessed on MHA Updates.

E) Mental status evaluation, including, at a minimum: attention, memory, information, attitudes, perceptual disturbances, thought content, speech, affect, suicidal or homicidal ideation, an estimation of the ability /willingness to participate in treatment. Must respond to all identified items in this section.
Definitions of these items:

Attention: the readiness of the individual to receive information, either through listening or through looking at the interviewer
Memory: recollection of what was experienced or learned in the past and recently; how the individual mentally registers, modifies, stores and retrieves information.
(Fund of) Information: determining, through questioning, the individual's general level of knowledge about the world around him/her.
Attitudes: the manner in which the individual behaves or reacts toward people, objects, institutions or issues.
Perceptual Disturbances: there is deviation from, interruption of or interference with the person's ability to recognize an object or idea.
Thought Content: (also seen as *Cognitive Processes /Cognition):* what is contained in the information the individual discloses.
Speech: talking to convey ideas and thoughts
Affect: the emotional feeling, tone, and mood exhibited whenever a significant experience is recalled.

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Suicidal Ideation: the formulation of thoughts or ideas about killing oneself.
Homicidal Ideation: the formulation of thoughts or ideas about killing another human being.
Estimation of ability to participate in treatment : a determination by the interviewer based on the information gathered and the person's disclosure during the interview whether he/she is able to take an active role in the recommended treatment
Estimation of willingness to participate in treatment: a determination by the interviewer based on the information gathered and the person's disclosure during the interview whether he/she is inclined and motivated to take an active role e in the recommended treatment

F) Client preferences relating to services & desired outcomes.
What does the consumer want to achieve after having received services? What does the consumer prefer in regard to services? Could be location, gender of therapist, hours, race of therapist, religious beliefs incorporated, goals/objectives, family involvement, etc.

G) Personal history, including mental illness and mental health treatment; This item is not required to be re-assessed on MHA Updates.

H) History of abuse/trauma: (childhood sexual/physical abuse, intimate partner violence, sexual assault or other forms of interpersonal violence); Must include trauma and violence, not just abuse/neglect. This item is not required to be re-assessed on MHA Updates.
I) Present level of functioning, including social adjustment and daily living skills;
Must include an assessment of functioning in daily living skill areas and social adjustment. May use a specific assessment tool or may incorporate this information into the MHA itself with a checklist of skills.

J) Legal history and status, including guardianship and current court involvement;
Legal history and current legal status (minor, guardianship, etc.). Has the person ever been involved in the criminal justice system and if so, information needed. Information needed for past and current legal history.

K) Assessment of risk: includes identification of factors that may endanger client or client's family and other immediate threats to client's personal safety (e.g., gang involvement, domestic violence, elder abuse). Risk is future. It has not happened yet. Is there risk or other immediate threats to the consumer or the consumer's family in regard to safety issues?

L) Education, specialized training, vocational skills. All three areas must be addressed. If the consumer is a minor child or someone who has not yet developed vocational skills or received specialized training, specify this information. Simply documenting N/A is not acceptable.

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M) Employment history. History includes past, not just current employment. If the consumer is a minor child document this, for example: "John is a minor child and has never been employed."

N) Interests, activities and hobbies. Leisure activities, interests, hobbies need to be addressed. These three topics are considered one category. Each of the three components of this element do not need to be addressed separately.

O) History of current alcohol or other substance use, abuse or dependence; History is past, current is present. We are looking at both past and present.

P) Name and contact information of clients' primary care physician. For contact information: Could be phone, could be a full address and phone, could be name of clinic/hospital. There needs to be something that would tell another person how to get a hold of the doctor. Best practice would be to have name, address and phone, but this is not required.

Q) Previous and current psychotropic medications, date of most recent psychiatric evaluation. (Date is date last time saw a psychiatrist). Note: If individual was **recently** discharged from a psychiatric inpatient stay the assumption can be made that they received a psychiatric evaluation during the hospital stay.

Providers need to include psychotropic medications (previous and current) and current medications (see R below), including over-the-counter medications on the MHA. These can be broken out into separate sections or combined altogether. Reviewers are not trained to be familiar with all medications that could possibly be prescribed or bought over-the-counter. If it appears to reviewers that all of these areas were assessed than this element would be allowed. If for instance, the provider has only prescription medications listed and it does not appear to include over-the-counter medications, this element would be found to be a procedural deficiency. Each of these components related to medications must be addressed. We cannot assume that the person does not take any over-the-counter medications (for example) if none are listed or if it is not addressed in some manner (i.e., current over-the-counter medications: none).

R) General physical health, including date of last physical examination, any known symptoms or complaints, and current medications not noted in (Q), including over-the-counter medications.
Information is needed about:
1) Current physical health status;
2) Date of last physical exam (last time saw a physician); Note: If individual was **recently** discharged from a medical inpatient stay the assumption can be made that they received a physical exam during the hospital stay.
3) Any current symptoms or complaints; and
4) List of all current medications, including over the counter medications.

The list of medications may be combined in the MHA with (N) and (O) and listed in one area. This is okay, but must also include over-the-counter medications. All four areas need to be provided.

S) Resources such as family, community, living arrangements, religion, personal client strengths. This includes more than simply financial resources. "SUCH AS" means for example and does not mandate each heading being addressed.

T) Summary analysis, conclusions/ recommendation for 132 services. Specific Rule 132 services to be provided means "Community Support Residential, Individual" rather than just Community Support, or Community Support Residential, for example. See item #16 below. As assessment is a continuing process, this information (service recommendations) may be located in additional documents, such as notes, ITP's, etc. as more information is obtained and needs change or become identified.

3. The Individual Treatment Plan (ITP) is not timely/not in effect at time of service.

Definition: The treatment plan must be approved and signed by a LPHA within 45 days of the Mental Health Assessment. Codes allowed without a treatment plan in place include Mental Health Assessment, Case Management-Mental Health, and Crisis Services. Look for lapses in time between ITP's beyond the required update time span of 180 days. Look for ITP's missing, lapsed or not having a dated signed LPHA signature. A consumer signature is required but is not what this item is addressing. The dated signature of the LPHA is what puts an ITP into effect. Reviewers shall not mark off for this item if the only issue is that the consumer signature is missing from the ITP.

4. Time billed is greater than time documented.

Definition: 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.

5. The volume of service activity documented in the note does not support the amount of time billed.

Definition: The documentation must contain a sufficient amount of information demonstrating the volume of service to substantiate/justify the amount of time billed. Billed amounts of times that could be considered as longer than the average time for that service (i.e., over 1 hour for therapy/counseling, over 2 hours for a group service, etc.) need to be even more carefully documented to reflect what occurred during the session. Reviewers need to look at a note that was billed for 1 hour (for example) and be able to see that the service documented most likely took 1

hour. A poorly documented note would appear to reviewers that the service could have occurred in less time than was billed.

Note on information in progress note not relevant to service billed: Ignore other services that may be included in the note and focus on the service that was billed and selected for PPR. If it is clear that the billed service could NOT have taken the entire amount of billed time as it is documented, then address that as item 5 "volume in note doesn't support time billed". If there are clear notations of elapsed time indicating that the billed service was only a part of the entire time billed, then address that as item 4 "time billed greater than time documented".

6. No amount of time or actual time documented.

Definition: 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.

7. Documentation does not identify allowed mode of delivery (group, individual or family).

Definition: Progress note needs to specify what type of modality was used for the intervention. See number 16 below. This may be seen as an activity code that includes modality, i.e., 22 for group therapy/counseling. Was the service provided in a group setting, to an individual, or to several family members?

8. The documentation does not include the setting where services are rendered (on-site vs. off-site).

Definition: The progress note does not identify where the services took place. Documentation is required to identify where services are provided. If off-site, progress note needs to specify where off-site. “Church”, “doctor’s office”, etc. is satisfactory documentation.

The Rule states in section 132.100 (i)(5) that documentation shall include "The specific site or off-site location where the services were rendered." The key words here are ***specific*** and ***location***. If a provider has more than one site, a note of “on site” or “office” is not acceptable because it does not identify where the service actually took place. If the provider has a site on Main Street and a site on Elm Street, it is sufficient to document “Main Street office”. On-site locations would include provider parking lots, provider lounge areas, provider supervised or crisis residential sites, provider office, etc. All telephone calls are considered on-site.

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

Definition: 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. If it is a certified site the service has to be billed as on-site. This item differs from item #8 because it

communicates that the location was noted correctly on the documentation but not billed correctly. 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 who travel from another agency office location must also bill the onsite rate for services that are provided in the office/common area.

10. Documentation must include a description of the interaction that occurred during service delivery, including the consumer's response to clinical interventions and progress toward attainment of the goals in the ITP.

Definition: The progress note needs to include the interactions that occurred during service delivery (what the provider staff did, what consumer did, how the consumer clinically responded to the intervention being provided on that day, any progress made, etc). "As a result of receiving this service, consumer was able to …" Quoting the consumer's own words in the narrative is an excellent documentation practice, though not specifically required by Rule 132.

Note that Section 132.100i)6) requires that there be a client's response to the "clinical interventions and progress toward attainment of the goals in the ITP." Because Rule 132 does not further define "clinical interventions" the following clarification is being made: the definition of clinical interventions is services included in 132.150. Therefore, while there must be a note for each instance of claiming for services listed in 132.148(evaluation and planning) and 132.165(case management) that includes all parts of 132.100i) 1) - 6), we would not expect to see the client's response to the clinical interventions and progress toward attainment of the goals in the ITP for those services.

11. Service provided to ineligible person – service not available for persons in consumer's age category. (Age)

Definition: Service provided is not available for the person's age. For example, individuals must be 14 years or older to receive vocational services, 18 years and older to receive Psychosocial Rehabilitation (PSR), 17 years and younger to receive Individual Care Grant (ICG).

12. Note describes a different service than billing submitted.

Definition: You have a bill with a specified date and service; however the note reflects a different service being provided. This is may be a data entry error on the part of the provider. For example, note may say individual therapy but the billing has the service code for group therapy. Note may

say therapy and bill for therapy but note actually describes provision of case management, for example. This item is correctable through billing because the documentation is valid but was just billed with the incorrect code.

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

Definition: Note describes a service intervention or activity that is not billable. For example, provider bills for transportation only. Watching a movie, shopping, eating lunch with no clear skills training or clinical services being provided are not billable activities. Note must be reflective of clinical work, not simply recreational. If marked off for item #13, reviewers should only evaluate the other tool items pertaining to the MHA and ITP (1-3, 16, 20-21) 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.

14. Service provided by unqualified staff.

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

15. Note not signed by staff providing service, including signature and credentials.

Definition: 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 legibility is an issue for staff, providers may want to include typed signature and credentials with actual written signature. If credentials are missing from the signature or if credentials are illegible, only mark #15. Do not also mark off for item #14 also unless the person is not qualified. If credentials are illegible, ask a staff person to help interpret signature. The preference is for the signature to include legible credentials as part of the signature, but the Rule doesn't specifically require this. If the provider has a list of all the staff persons and their credentials that you could reference, it would be okay if the signature was missing credentials.

16. Specific service not authorized by ITP.

Definition: Service provided and billed for is not included on the ITP. Even when there is a DMH/Collaborative authorization in place, the service must still be included on the ITP.

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

- Psychotropic Medication Administration, Monitoring, or Training (individual or group).
- Community Support – Individual (CSI)
- Community Support – Group (CSG)
- Community Support - Team (CST)
- Community Support – Residential, Individual (CSR-I)
- Community Support-Residential, Group (CSR-G)

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- Psychosocial Rehabilitation – Individual (PSR-I)
- Psychosocial Rehabilitation – Group (PSR-G)
- Therapy/Counseling Individual, Group (two or more), or Family (client need not be present)
- Case Management Mental Health
- Case Management Client Centered Consultation
- Case Management Transition Linkage and Aftercare

Example: **ITP's** with "Community Support" or "Medication" or "Therapy" do not identify the specific service, so Item 16 would be checked for these instances, as we do not know the modality being used: individual, group, family, etc./ administration, monitoring, training. Documentation does **not** have to include the word 'Psychotropic' before Medication.

Therapeutic Behavioral Services and Rehabilitation Stabilization are terms no longer used effective 2007 Rule 132: Effective 7-1-07 these old terms are not to be on ITP's.

17. The specific service is authorized by the ITP but is not based on a clinical need as identified in the mental health assessment or any additional evaluations.

Definition: The service associated with the billing is included on the ITP and is authorized by the LPHA, however the MHA or additional evaluations do not reflect a clinical need for that particular service. Clinical need may be found in additional documents in the clinical record and may not be found on the MHA. Note that this item is not evaluated by simply looking at the recommended services in section T of the MHA – it requires an assessment of demonstrated need for a service. If you are having trouble locating this information please ask provider staff for assistance. For example, it is questionable to provide ACT to someone who is functioning well in the community and has the skills to independently manage symptoms associated with his/her illness, ie, no clear need for these services. When writing report, PLEASE GIVE SPECIFIC EXAMPLES FOR THIS ITEM as this item may be subjective in nature.

Note 1: Clinical assessment is ongoing, and therefore, a treatment plan may include services to address needs that are identified after the mental health assessment is completed. These assessments may be documented in a number of ways depending on the agency's practice, such as, MHA addendums, as an assessment portion within a review of the treatment plan, or a clinical progress note. Any of these would be acceptable to documenting an assessed need that could be included in an ITP. If you cannot find documentation of an assessed need, request assistance from provider staff.

Note 2: Rule 132.145.e includes: "The public payer, or his or her designee, may provide additional clinical direction in determining whether services are medically necessary. If the public payer or its designee and the LPHA do not concur on medical necessity, an appeal may be initiated in writing or by phone in accordance with the Service Authorization Protocol located on the DHS website at http://www.dhs.state.il.us/page.aspx?item=33244.

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If the service (such as ACT, CST, or ICG) has been authorized by the Collaborative and there is documentation in the record reflecting this, medical necessity has been demonstrated.

18. Service provided to an ineligible person – a) Diagnosis in the clinical record is not a covered diagnosis and/or does not match the diagnosis on the billing; or b) insufficient documentation of functional impairment to establish medical necessity. (Diagnosis/Medical Necessity)

Definition: The diagnosis is not eligible for these services, such as 303.90 Alcohol Dependence with no other diagnosis documented. An example of insufficient documentation of functional impairment to establish medical necessity is for a consumer receiving CST services is that the consumer's record does not contain evidence that the consumer exhibits at least three of the eligibility items in Rule 132.150.h.4.A-M, or if receiving ACT services with no evidence of meeting eligibility criteria in Rule 132.150.i.4.A. LOCUS or Ohio scales may be used to demonstrate impairment.

Co-Occurring Disorders must have an eligible mental health diagnosis, but the mental health diagnosis does NOT have to be the primary diagnosis. Documentation must clearly reflect that services being provided are addressing the mental health issues.

If the service has been authorized by the Collaborative and there is documentation in the record reflecting this, medical necessity has been demonstrated.

19. No note to match date of service on billing submitted.

Definition: You have a bill for a specific date and service, but can not find a note with the specified date and service in the consumer's record.

20. The Individual Treatment Plan in effect at the time of the claim could not be located in the clinical record.

Definition: The ITP that should be in effect at the time of the claim could not be located in the record. Reviewers will ask for assistance from provider staff in locating documents that could not be found. This item would be checked if the ITP could not be located - only check off here and do not reflect in other tool ITP items. Item #3 would be checked if it is in
the record but lapsed/expired or does not have the required signatures and dates.

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21. The Mental Health Assessment in effect at the time of the claim could not be located in the clinical record.

Definition: The MHA that should be in effect at the time of the claim could not be located in the record. MHA's need to have annual updates effective 7-1-07. Reviewers will ask for assistance from provider staff in locating documents that could not be found. If the MHA cannot be located, only check off here and do not reflect in other tool MHA items.