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Date: January 21, 2010
To: DHS/DMH Community Mental Health Providers
From: Jacqueline Manker, DHS/DMH Associate Director for Community Services
Subject: Summary of Major Trends and Clarifications on FY10 Provider Monitoring

The purpose of this communication is to provide a summary of trends relating to FY10 provider monitoring and to offer a few clarifications. The Post Payment Review (PPR) Interpretive Guidelines have recently been updated on the Collaborative website (www.illinoismentalhealthcollaborative.com). The interpretation of items has not changed but further clarifications and examples have been added to the document.

Beginning in FY10, DHS/DMH began performing Clinical Practice Guidance (CPG) reviews only at those providers who received a score below 4 (out of 5) in the FY09 review. So far this fiscal year the CPG reviews have gone very well, with an average overall score of 4 out of 5.

All providers continue to receive annual Post Payment Reviews (PPR). So far this fiscal year the average substantiated score is 72.8%. Following is a few noteworthy best practices and clarifications, including the areas most often found unsubstantiated in Post Payment Reviews.

Please look for information in the near future relating to enhancements to the Division's quality improvement procedures following Post Payment Reviews. DHS/DMH already has policies in place related to performance on specific items of Post Payment Review and will be further clarifying our policies related to aggregate performance.

Best Practices

- As part of the Mental Health Assessment (MHA) and/or Individual Treatment Plan (ITP) process, some providers ask consumers to complete written forms that are attached to the MHA and/or ITP, giving the consumer the opportunity to document their history, preferences, needs, goals and objectives in their own words. These providers then verify that the information is complete to ensure there are no elements missing.
- Similar to this, some providers ask Psychosocial Rehabilitation (PSR) participants to document what they gained from the PSR class in their own words and then incorporate this information into the progress note.
- In one record keeping system, documents of the chart are color-coded (i.e., the MHA is on yellow paper and ITP is on blue paper) and clear sheet protectors separate information by categories and/or dates. This makes it easier for staff of the agency to navigate charts and locate documents.
- Some providers are updating ITP's as needs and goals change rather than waiting until the required 6-month mark.

Clarifications

Mental Health Assessments

- The most common issue found in Post Payment Reviews continues to be missing elements from the Mental Health Assessment (item #2). Please refer to Rule 132.148.a.3 A-T for all of the required elements. The specific elements that were missing from the records reviewed are noted in a report that each provider receives after the review.
- Note that an item left blank or marked as “N/A” is considered a missing element. If the client does not remember a piece of information, it is acceptable to note, “Client does not remember”. If the item does not appear relevant to the client (like vocational skills or employment history for a child), it is acceptable to note, “None because client is a child”. “N/A” is never an acceptable response.
- Method of communication is not solely language spoken; it is the actual method a person uses to communicate. This could be spoken language, sign language, written language, language board, etc. It is relevant to the assessment because it should guide how provider staff communicates with the individual. E.g. if a person cannot read, the provider should be providing information verbally.
- Mental Health Assessment updates may indicate “no change” for specific items. When this occurs, reviewers refer back to the prior MHA to locate the information. If the older MHA does not include any information related to the required element, it is noted as missing.
- Mental Health Assessments must be updated annually.

Volume of service documented in the note does not support the amount of time billed (item #5)

The documentation must contain a sufficient amount of information demonstrating the volume of service to substantiate/justify the amount of time billed. Billed durations 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 be able to read a note that was billed for 1 hour (for example) and see that the service as documented most likely took 1 hour.

Location of Services

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 you have more than one office location, you must document which office, such as “Main Street Office”. For off-site, you must document the specific location, for example, "Library" or "Lincoln Park."

Specific Service Not Authorized by ITP (item #16)

The Individual Treatment Plan must list which specific services are to be provided, including the modality of the services. This is most commonly an issue with community support services, which could be community support individual, community support group, community support team, community support residential–individual or community support residential–group. See the Interpretive Guidelines for a list of services with possible modalities.

PPR Correctible Items

Three items on the PPR tool are considered “correctible” items. It should be noted that these items are correctible ONLY under specific circumstances. First, the error made must be with the data entry/billing of the service. I.e., the note as written documents the service provided, but the billing was either submitted for the wrong amount of time or for the wrong service. Second, there can be no other errors for that claim. The items considered correctible are:

- Item #4 - Time billed is greater than time documented
- Item #9 - Location of service not correctly noted on-site vs. off-site
- Item #12 - Note describes a different service than billing submitted

If an item is noted as correctible, then the provider must void the original claim and submit a new claim for the correct amount of time and/or correct service. **Providers must never change the documentation in the record.**

PPR Supporting Documentation:

- Providers have thirty (30) days after the receipt of the *Initial Notice* to submit any additional supporting documentation that was not available during the on-site review that will offer substantiation for the billings in question to the Collaborative.
- Before an unsubstantiated claim can be re-determined allowable, each reason noted for that claim to be disallowed must be addressed by this supporting documentation. **It is important to note that documentation submitted may not include anything produced following the on-site review** [See Rule 132.42 (e)]. In order to avoid confusion, please wait to send supporting documentation until after receiving the *Initial Notice*.
- The Collaborative will review any additional documentation or any requests to reconsider Post Payment Review findings within fourteen (14) days after receipt. A *Final Notice of Unsubstantiated Billings* will be sent to your organization after this review. **The *Final Notice of your Post Payment Review* will indicate if your organization is required to submit a Plan of Improvement.**

I hope you find this information helpful as together we continue to enhance compliance. Please let your regional staff know if you have any questions or comments.

JM:BH