ILLINOIS DEPARTMENT OF Healthcare and Family Services

Community-Based Behavioral Services (CBS)
Frequently Asked Questions (FAQ)

Updated: February 17, 2022

This FAQ document is intended to provide guidance and clarification to Community Mental Health Centers (CMHCs), Behavioral Health Clinics (BHCs), and Independent Practitioners (IPs) delivering community-based behavioral health services (CBS services) as outlined in the CBS Provider Handbook. Updates to the FAQ will be posted to the HFS website.

Medical Necessity Standards

1. **What is the medical necessity criteria for CBS services? (new 2/17/22)**

   A. Medical necessity for CBS services is defined at 89 Ill. Adm. Code 140.453 and in the CBS Handbook. Generally, CBS services are considered medically necessary when they are:

      1) Recommended by an LPHA operating within their scope of practice through the completion of an Integrated Assessment and Treatment Plan (IATP) or as otherwise specified and consistent with specific service guidelines outlined in the CBS Handbook;
      2) Provided to a customer for the maximum reduction of mental disability. A mental disability here is defined as having an identified mental health diagnosis or, for children under the age of 21, having more than one documented criterion for a mental disorder outlined in the DSM-5; and,
      3) Provided to a customer for restoration to their best possible functioning level.

      More specific information regarding the medical necessity standards for each service can be found in Sections 207.1 and 208.3 of the CBS Handbook. Providers are responsible for understanding and maintaining compliance with these requirements.

2. **Does an IATP have to be completed with a recommendation for a psychological before IATP: Psychological Assessment services can be provided to a client? (new 2/17/22)**

   A. No. IATP: Psychological Assessment may be delivered prior to the completion of the IATP for a customer. The 10/27/2021 version of the CBS Handbook incorrectly states that IATP: Psychological Assessment must be recommended by an LPHA following the completion of the IATP. This information will be corrected in a future update to the CBS Handbook.

Documentation and Record Requirements

3. **What must be documented to establish medical necessity for CBS services? (new 2/17/22)**

   A. Guidance for documenting medical necessity in compliance 89 Ill. Admin. Code 140.453 has been broken down by service category in Table 1 below. For more specific information regarding the medical necessity standards for each CBS service, please refer to Sections 207.1 and 208.3 of the CBS Handbook.

Table 1. Documenting Medical Necessity for CBS Services

Category	Services	Requirements for Documenting Medical Necessity
Screening, Assessment, and Brief Intervention Services	IATP	A service note supporting the time billed that includes a brief justification for the medical necessity of the service.
	IATP: Review & Update	
	IATP: Psychological Assessment	
	IATP: LOCUS	
	IATP: Clinical Assessment Tool	
	Developmental Screening	
	Developmental Testing	
	Mental Health Risk Assessment	
	Prenatal Care At-Risk Assessment	
	Therapy Counseling: Brief Intervention	
Crisis Services	Crisis Intervention Crisis Intervention Team	A service note detailing the time billed that includes a brief description of the customer's decompensation, loss of role functioning, or inability to deal with immediate stressors that resulted in the behavioral health crisis. For children under the age of 21, this may include events that threaten safety of functioning of the child or disruption from the family or their living situation. The service note must also describe the referral back to their existing treatment provider or the customer driven referral to a community-based provider for follow-up and assessment. If the provider delivering Crisis Intervention is the customer's existing treatment provider, the service note should indicate when and how follow-up will occur.
	Mobile Crisis Response (MCR) MCR Team	A completed Illinois Medicaid Crisis Assessment Tool (IM-CAT). All sections of the IM-CAT must be completed, to the extent possible, for the IM-CAT to be considered complete. The provider must document that a referral back to the customer's existing treatment provider or a customer driven referral to a community-based provider for follow-up and assessment has been made. This can be documented on the IM-CAT under Section 7 (Notes/Comments/Clarifications), on the customer's Crisis Safety Plan, or on the service note. If the clinician delivering MCR is the customer's existing treatment provider, the documentation should indicate when and how follow-up will occur.
	Crisis Stabilization	A Crisis Safety Plan that minimally documents the following: 1. A behavioral health diagnosis, a behavioral health need, and a life functioning need; 2. The agency responsible for delivering Crisis Stabilization as well as the recommended amount, frequency, and duration of services; and, 3. The signature of the authorizing LPHA and signature date.

Mental Health Case Management	Mental Health Case Management+ *+Applicable to Mental Health Case Management services delivered prior to the completion of the IATP, consistent with Section 207.1.2 of the CBS Handbook.*	A service note supporting the time billed that includes brief justification for the medical necessity of the service. The service note must also describe the referral back to their existing treatment provider or the customer driven referral to a community-based provider for follow-up and assessment. If the provider delivering Mental Health Case Management is the customer's existing treatment provider, the service note should indicate when and how follow-up or assessment will occur.
General Medicaid Rehabilitation Option (MRO) Services	Therapy/Counseling Community Support Client-Centered Consultation Case Management Case Management: Transition Linkage and Aftercare Mental Health Case Management* **Applicable to Mental Health Case Management services recommended following the completion of the IATP.*	A customer's IATP must document the following: **1.** The presence of a behavioral health need, represented on the IM+CANS by at least one rating of 2 or 3 on an item from the Behavioral/Emotional Needs domain (IM+CANS Section 3a). **2.** The presence of a life functioning need, represented on the IM+CANS by at least one rating of 2 or 3 on an item from the Life Functioning domain (IM+CANS section 3b). **3.** Brief narrative information must be documented in the appropriate Supporting Information section to provide additional information about behavioral health needs identified as well as the impact of those needs on the customer's life functioning. **4.** Identification of a behavioral health diagnosis. The IM+CANS Section 11, Diagnosis, must be completed, identifying a diagnosis, or symptoms of a diagnosis for children under age 21 (see CBS Handbook, Section 207.3.3), from the DSM-5. **5.** The Mental Health Assessment summary (IM+CANS Section 12) must be completed, providing an overall summary analysis and conclusion regarding the medical necessity of services. This section should tie together all key information about the customer's mental health needs and diagnosis. **6.** Identification of at least one goal and one treatment objective (IM+CANS Section 16). **7.** A recommendation for the service being delivered that is tied to a documented treatment objective (IM+CANS Section 17). **8.** Signature by the authorizing LPHA and the signature date.
Medication Services	Medication Training Medication Administration Medication Monitoring	In addition to all the requirements for General MRO Services, the IATP must document the prescribed medication(s) the service is being delivered in conjunction with and identify the condition(s) the medication is intended to address. *Note: while not a component of medical necessity, please note that some medication services require additional written authorization from a licensed prescriber for the service to be delivered by lower level staff. Please refer to Section 208.4 of the CBS Handbook for more information.*

Team-Based and Day Treatment Services	Community-Support Team (CST) Assertive Community Treatment (ACT) Intensive Outpatient (IOP) Psychosocial Rehabilitation (PSR)	A customer's IATP must document the following: **1.** Adherence to the Target Population Profile outlined for the service in the corresponding section of 89 Ill. Admin. Code 140.TABLE N: • CST: 89 Ill. Admin. Code 140.TABLE N (c)(1)(C) • IOP: 89 Ill. Admin. Code 140.TABLE N (c)(2)(C) • PSR: 89 Ill. Admin. Code 140.TABLE N (c)(3)(C) • ACT: 89 Ill. Admin. Code 140.TABLE N (e)(1)(D) *Note: HFS does not strictly define for any of these services how the Target Population Profile must be documented on the IM+CANS, as many of the factors could vary in how they are documented based upon the presentation of the customer. The clinical documentation must be sufficient to demonstrate that the predominant population of customers receiving the service meet the Target Population Profile.* **2.** The presence of multiple behavioral health needs, represented on the IM+CANS by more than one rating of 2 or 3 on an item from the Behavioral/Emotional Needs domain (IM+CANS Section 3a). *Note: It is acceptable and anticipated that the Behavioral/Emotional Needs item ratings will also serve as documentation for those factors required under item 1.* **3.** The presence of multiple life functioning needs, represented on the IM+CANS by more than one rating of 2 or 3 on an item from the Life Functioning domain (IM+CANS section 3b). *Note: It is acceptable and anticipated that the Life Functioning item ratings will also serve as documentation for those factors required under item 1.* **4.** Brief narrative information must be documented in the appropriate Supporting Information section to provide additional information about behavioral health needs identified as well as the impact of those needs on the customer's life functioning. **5.** Identification of a behavioral health diagnosis. The IM+CANS Section 11, Diagnosis, must be completed, identifying a diagnosis or symptoms of a diagnosis for children under age 21 (see CBS Handbook, Section 207.3.3) from the DSM-5. **6.** The Mental Health Assessment summary (IM+CANS Section 12) must be completed, providing an overall summary analysis and conclusion regarding the medical necessity of services. This should tie together all key information about the customer's mental health needs and diagnosis. **7.** Identification of at least one goal and one treatment objective (IM+CANS Section 16). **8.** A recommendation for services that is tied to a documented treatment objective (IM+CANS Section 17). **9.** Signature by the authorizing LPHA and signature date.

4. **What must be documented on the IM+CANS for it to be considered complete? (new 2/17/22)**

   A. An IM+CANS is considered complete once the authorizing LPHA has reviewed, approved, and signed the IM+CANS. The completed IM+CANS should minimally document medical necessity for the recommended services (see Table 1 in this FAQ) as well as have a completed IM+CANS Section 1, General Information. The General Information section should be filled out the extent the customer is willing to disclose information. Data fields in this section may be left blank, but only if the information is unknown or if the customer is uncomfortable disclosing this information and not solely for the convenience of the provider. The demographic information included in Section 1 is required for federal Mental Health Block Grant reporting and is also critical at the agency, program, and system level for examining trends in service delivery, including being able to examine if any disparities exist across populations.

5. **Is it acceptable to leave fields blank on the IM+CANS? (new 2/17/22)**

   A. Not every data field on the IM+CANS must be "filled in" for the IM+CANS to be considered complete or to be in compliance with 89 Ill. Admin. Code 140.453.

   From a Medicaid compliance standpoint, the IM+CANS must minimally have sufficient documentation to establish medical necessity for recommended services (see Table 1 in this FAQ). If there is no evidence of a need/strengths, the core domain items and the items in any modules that been triggered for the customer must be scored a '0' for needs or a '3' for strengths rather than left blank. The use of the checkbox "N/A" on items is reserved for usage only when the item is not age appropriate for the customer.

   From a clinical appropriateness and quality of care standpoint, a comprehensive assessment process should be exploring the areas outlined on the IM+CANS. The IM+CANS is purposely designed to be reflective of the clinical standards of best practice for a comprehensive assessment, ensuring the relevant factors that could impact a customer's treatment trajectory are considered, including trauma exposures, social determinants of health and co-occurring disorders such as developmental disabilities, substance use, and other medical complexities. It is understood and expected that the initial IM+CANS will not provide as complete of a clinical picture of a customer as subsequent IM+CANS will, as new information and history will be discovered as the therapeutic relationship between customer and clinician develops.

6. **What is required for an "Update" of the IM+CANS? (new 2/17/22)**

   A. An update is any change made to the IM+CANS that occurs during the 180-day period between assessment/reassessments. Updates should be used to capture additional information relevant to the customer's behavioral health needs and circumstances as the customer is able to provide additional information through the therapeutic engagement process. Best practice dictates that the IM+CANS be used as part of active treatment with a customer and that updates be made regularly as the therapeutic engagement process and clinical interventions unfold.

   Updates only require new signatures from the customer and authorizing LPHA if a change to the treatment plan or recommended services (IM+CANS Sections 16 or 17) is required.

7. **The CBS Handbook indicates a full reassessment of the customer's IATP must be completed every 180 days. What does a "full" reassessment mean? (new 2/17/22)**

   A. A full reassessment means an LPHA has reviewed all documented information on the IM+CANS, ensuring all updated clinical information has been considered in the development of the treatment plan and recommended services (i.e., the golden thread). The signature of the LPHA following this review reestablishes the medical necessity of recommended services for an additional 180-day period. A reassessment of the IM+CANS is considered complete when it has met the standards detailed in the response to question 4 in this FAQ.

8. **When is a service note required? (new 2/17/22)**

   A. A service note is required anytime a billable service is provided to a customer. The service note serves as the provider's "receipt" of service delivery, accounting for the time spent and billable activities conducted.

9. **What are the core components that must be included in a service note? (new 2/17/22)**

   A. Service notes must be specific and individualized to the customer. The following items must be included in every service note for CBS services:

      i. Date of service.
      ii. Name of service. It is recommended this match the service name in the CBS Handbook for consistency.
      iii. Start and end time of service delivery.
      iv. Mode of service delivery (face to face, phone, video, individual, group, family).
      v. Participants. This should reflect all parties present during the service intervention (e.g. customer, parent/guardian, other service provider). If the customer was not present consistent with allowable CBS Handbook policy, this should be noted.
      vi. Location of service delivery. The specific location should be documented and should correlate to the Place of Service code identified on a claim.
      vii. Description of treatment or interventions utilized. This should be consistent with the service definition outlined in the CBS Handbook.
      viii. Description of the customer's response to treatment interventions and any clinical observations.
      ix. Signature of the rendering staff including date signed and staff's credentials (RSA, MHP, QMHP, LPHA).

      If the service note is being used to establish medical necessity for a service consistent with Table 1 in this FAQ, the appropriate medical necessity details must also be documented.

10. **What documentation is needed for a Medicaid service audit? (new 2/17/22)**

    A. The purpose of a Medicaid service audit is to ensure that payments to providers for the delivery of Medicaid services were accurate and appropriate. During an audit, reviewers must see sufficient documentation to reasonably conclude that services were provided at the level billed, were delivered consistent with applicable policy, and were medically necessary.

It is the responsibility of the provider to maintain sufficient documentation to support payment for the services billed. This must minimally include: 1) personnel records for the staff rendering and authorizing services to verify qualifications (RSA, MHP, QMHP, LPHA); 2) service notes for all billable and non-billable activity; and 3) a completed copy of the customer's IATP or other appropriate medical necessity documentation consistent with Table 1 in this FAQ.

Team-Based Services

11. **When a staff member who is part of an Assertive Community Treatment (ACT) team or Community Support Team (CST) leaves a provider agency, does the provider have to replace that staff member on the team within 30 days?** (9/16/21)

    A. No, there is no requirement that providers delivering ACT or CST replace team members who leave the provider agency within a certain timeframe. Providers should make efforts to replace team members who leave the agency as soon as possible to meet the minimum staffing requirements for CST and ACT teams as outlined in 89 Ill. Admin. Code 140.Table N. Providers unable to fill minimum team staffing requirements within 180 days should reach out to the Department for additional technical assistance and guidance by emailing HFS.BHCompliance@illinois.gov.

12. **89 Ill. Admin. Code 140.Table N(e)(1)(C)(ii) states: "Psychiatric Resource. ACT services are directly supported by a treating psychiatrist and/or Advance Practice Nurse at a ratio of 10 hours per week for each 60 participating individuals. An ACT team must have access to at least 5 hours of dedicated treatment and consultation time from the participating psychiatrist on a weekly basis." Can you please clarify this requirement? Can an Advance Practice Nurse provide the 5 hours of dedicated treatment and consultation time?** (9/16/21)

    A. Yes, the 5 hours of dedicated treatment and consultation time may be provided by either a psychiatrist or an Advance Practice Nurse. This will be clarified in future updates to 89 Ill. Admin. Code 140.