Community-Based Behavioral Services (CBS) Provider Handbook

Illinois Department of Healthcare and Family Services
Issued February 4, 2025

Revision History

Date	Reason for Revisions
Policies and procedures as of October 1, 2018 Published: October 19, 2018	New document
October 1, 2021 Published: October 27, 2021	Changes to Sections 207 and 208 to reflect updates in medical necessity criteria for IATP and Therapy/Counseling services; changes to Section 207 to clarify requirements for reporting Place of Service, diagnosis code, and for notating Telehealth as the service delivery modality on claims for reimbursement; updates to Section 208 to clarify service coding requirements when modifiers are required on claims for reimbursement. Policy effective October 1, 2021.
May 1, 2022 Published: April 28, 2022	Changes to Section 202 to streamline tables 1-3 and to add information about Peer Support Workers (PSWs); changes to Section 203 and the addition of a new Appendix A to add clarity on record requirements; changes to Section 207 to clarify the allowable uses of R codes and to add a new section 207.3.8 regarding the use of modifiers on certain services; changes to all services in Section 208 to better distinguish service requirements vs. claims requirements and to update the medical necessity of IATP: Psychological Assessment. Policy effective May 1, 2022.
July 1, 2022 Published: July 6, 2022	Changes to Section 207 to reflect updates in telehealth billing guidance; changes to Section 208.2.1 to update the activities reimbursable under IATP; a correction to Section 208.3.10 to clarify the staff qualifications for Mobile Crisis Response when delivered by a multidisciplinary team; changes to 208.3.1 to remove obsolete billing guidance. Policy effective July 1, 2022.
February 1, 2025 Published: February 4, 2025	Changes to Section 208.3.5 for the Definition of Client-Centered Consultation Case Management updates the service definition to clarify allowable activities.

Community-Based Behavioral Services Provider Handbook
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201 Basic Provisions

This handbook has been prepared for the information and guidance of providers who provide Medicaid Rehabilitation Option – Mental Health (MRO-MH) and Targeted Case Management (TCM) services, as detailed in 89 Ill. Admin. Code 140.453, to customers in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website on the Provider Notices page. Providers wishing to receive e-mail notification when new provider information has been posted by the Department may register on the website.

Services provided must be in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, General Policy and Procedures, and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein. Providers submitting X12 837P electronic transactions must also refer to the Handbook for Electronic Processing. The Handbook for Electronic Processing identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Department.

Providers should always verify a customer's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the customer's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461 and the Medical Electronic Data Interchange (MEDI) systems are available.

Unless otherwise specified, the billing instructions contained within this handbook apply to customers enrolled in the Department's traditional fee-for-service programs and do not necessarily apply to customers enrolled in a HealthChoice Illinois managed care health plan.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565. Questions regarding the policies or service requirements outlined within this Handbook may be directed to the Bureau of Behavioral Health at 217-557-1000 or HFS.BBH@illinois.gov.

NOTE: Previous rate schedules and provider manuals for community behavioral health providers have been titled, "Service Matrix", "Crosswalk", and/or "Service Definition and Reimbursement Guide" – this guide replaces all other existing documents as the official Handbook for Providers of Community-Based Behavioral Services.

202 Provider Participation

Any provider seeking reimbursement for the MRO-MH or TCM services must be enrolled for participation in the Department's Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Under the IMPACT system, category of service (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a Provider Type Specialty must be selected. A Provider Type Subspecialty may or may not be required.

Consistent with 89 Ill. Admin. Code 140.452, MRO-MH and TCM services may be delivered by enrolled Community Mental Health Centers (CMHCs), Behavioral Health Clinics (BHCs), or Independent Practitioners (IPs). Entities seeking enrollment as a provider of MRO-MH and TCM services may not seek reimbursement from any public payer until the entity's IMPACT application, including any necessary certifications or Program Approvals, has been approved. Please see Sections 207 and 208 of this Handbook for additional information on service delivery requirements, including providers who are qualified to receive reimbursement.

202.1 IP Enrollment

Independent Practitioners (IPs), as defined in 89 Ill. Admin. Code 140.452(a)(3), may receive reimbursement for the delivery of a limited number of MRO-MH services (refer to Section 208.3, Group A services). IPs seeking to provide MRO-MH services must enroll under the appropriate Provider Type for their licensure, consistent with the policies and guidance outlined in the Handbook for Practitioners Rendering Medical Services. Refer to IMPACT Provider Types, Specialties and Subspecialties for additional information.

202.2 CMHC Enrollment

Entities enrolled and certified, pursuant to 59 Ill. Admin. Code 132, as a CMHC may receive reimbursement for the MRO-MH and TCM services described in Section 208. In order to enroll with HFS, CMHC (legacy Provider Type 036) providers must complete and submit a Facility, Agency, Organization (FAO) enrollment application through the IMPACT system, selecting all necessary Specialty/Subspecialty combinations based upon the services the provider intends to provide.

All CMHCs must minimally select a Specialty of 'Outpatient' or 'Residential Services' on their enrollment application. CMHCs selecting the Specialty of 'Outpatient' shall deliver MRO-MH and TCM services on a non-institutional basis to customers in the office, home, or other community settings and shall ensure their facility is open and willing to accept referrals for MRO-MH and TCM services for customers enrolled in one of the HFS full benefit Medical Assistance Programs. CMHCs should select the Specialty of 'Residential Services' to indicate that customers receive room and board as a component of their treatment at the provider's primary practice location, as indicated on the provider's IMPACT application.

Table 1. IMPACT Enrollment Guide – CMHCs

Enrollment Type	Provider Type	Specialty	Subspecialty	Services	Program Approval?
Facility, Agency, Organization (FAO)	Community Mental Health Center	Outpatient	None	• IATP • Crisis Intervention • Therapy/Counseling • Community Support • Med. Admin. • Med. Monitoring • Med. Training • Case Management • Develop. Screening • Develop. Testing • MH Risk Assessment • Prenatal Care At-Risk Assess. • Telepsych: Orig. Site	No
		Residential Services	None	• IATP • Crisis Intervention • Therapy/Counseling • Community Support • Med. Admin. • Med. Monitoring • Med. Training • Case Management • Develop. Screening • Develop. Testing • MH Risk Assessment • Prenatal Care At-Risk Assess. • Telepsych: Orig. Site	No
		Day Treatment	Intensive Outpatient	• Intensive Outpatient	Yes
			Psychosocial Rehabilitation	• Psychosocial Rehabilitation	Yes
		Team Based Services	Assertive Community Treatment	• Assertive Community Treatment	Yes
			Community Support Team	• Community Support Team	Yes
			Violence Prevention Community Support Team	• Violence Prevention Community Support Team	Yes
		Crisis Response	Mobile Crisis Response	• Mobile Crisis Response	Yes
			Crisis Stabilization	• Crisis Stabilization	Yes

202.2.1 CMHC Certification

Entities seeking initial certification as a CMHC pursuant to 59 Ill. Admin. Code 132 must submit a new enrollment request through the IMPACT system.

Under ‘Step 4: Add Licenses/Certifications/Other’ of the IMPACT application, providers must indicate which state agency they are seeking as their certifying body – DCFS or DHS-DMH. Providers who do not know from which state agency they should seek CMHC certification

should default to selecting DHS-DMH. Providers not currently certified as a CMHC must enter a pseudo license number of 'CMHC99999' when enrolling.

The certifying state agency will complete all necessary administrative and on-site reviews, consistent with 59 Ill. Admin. Code 132, prior to notifying the provider and HFS of the certification review outcome. If the provider's CMHC certification application is approved by DCFS or DHS-DMH, the pseudo license number will be replaced by the license number assigned by the certifying state agency. HFS will complete the provider's IMPACT application review following notification from DHS-DMH or DCFS of the CMHC certification outcome.

For additional information on the requirements for becoming a certified CMHC, please contact one of the certifying state agencies:

Department of Human Services
Attn: Division of Mental Health
600 E. Ash, Building 500, 3rd Floor South
Springfield, IL 62703

Department of Children and Family Services
Office of Medicaid Behavioral Health and Care Coordination
2125 S. First Street
Champaign, IL 61820

202.3 BHC Enrollment

Entities enrolled as a BHC, pursuant to 89 Ill. Admin. Code 140.499 and 89 Ill. Admin. Code 140.TABLE O, may receive reimbursement for the MRO-MH and TCM services described in Sections 208.3 and 208.4. To enroll with HFS as a BHC (legacy Provider Type 027), providers must complete and submit a Facility, Agency, Organization (FAO) enrollment application through the IMPACT system, selecting all necessary Specialty/Subspecialty combinations based upon the services the provider intends to provide. All BHCs must minimally select the Specialty of 'BHC Outpatient.'

When completing the IMPACT application to become a BHC, providers should enter a pseudo license number of 'BHC99999' under 'Step 4: Add Licenses/Certifications/Other.' If the provider's BHC enrollment is approved by HFS, this number will be replaced by the license number assigned by the Department.

For additional information on the requirements for becoming a certified BHC, please contact the Office of Medicaid Innovation (OMI) at: OMI.IMPACT@uillinois.edu.

Table 2. IMPACT Enrollment Guide – BHCs

Enrollment Type	Provider Type	Specialty	Subspecialty	Services	Program Approval?
Facility, Agency, Organization (FAO)	Behavioral Health Clinic	BHC Outpatient	None	• IATP • Crisis Intervention • Therapy/Counseling • Community Support • Med. Admin. • Med. Monitoring • Med. Training • Case Management • Develop. Screening • Develop. Testing • MH Risk Assessment • Prenatal Care At-Risk Assess.	No
		BHC Day Treatment	Intensive Outpatient	• Intensive Outpatient	Yes
		BHC Team Based Services	Community Support Team	• Community Support Team	Yes
			Violence Prevention Community Support Team	• Violence Prevention Community Support Team	Yes
		BHC Crisis Response	Mobile Crisis Response	• Mobile Crisis Response	Yes
			Crisis Stabilization	• Crisis Stabilization	Yes

202.3.1 BHC Approval Process

Following the submission of an application to enroll as a BHC in IMPACT, providers will be required to submit additional documentation to HFS to demonstrate their compliance with the requirements outlined in 89 Ill. Admin. Code 140.TABLE O. HFS will complete both a desk review and an on-site review before approving the provider as a BHC in IMPACT. Providers will be required to demonstrate their compliance with the BHC requirements on an annual basis.

202.4 Program Approval Process

CMHCs and BHCs seeking to provide MRO-MH services that require Program Approval, as detailed in 89 Ill. Admin. Code 140.Table N, must indicate this within IMPACT by adding the appropriate Specialty/Subspecialty combinations (see Table 1 and Table 2). The services of Mobile Crisis Response (MCR), and Crisis Stabilization shall also require a unique Program Approval, consistent with the processes outlined in this section and the service requirements found in 89 Ill. Admin. Code 140.453.

When selecting a Specialty/Subspecialty combination in IMPACT that requires Program Approval, providers will be required to enter a pseudo license number (see Table 3) under 'Step 4: Add Licenses/Certifications/Other.' If the provider's enrollment is approved, the pseudo license number will be replaced by a license number assigned by HFS.

Table 3 below provides a crosswalk of pseudo license numbers that must be utilized for each Specialty/Subspecialty combination requiring a Program Approval.

Table 3. IMPACT Program Approval - Pseudo License Numbers

Provider Type	Specialty	Subspecialty	IMPACT Step 4: Licensing Agency	IMPACT Step 4: Pseudo License Number
CMHC	Day Treatment	Intensive Outpatient	HFS	IOP99999
		Psychosocial Rehabilitation	HFS	PSR99999
	Team Based Services	Assertive Community Treatment	HFS	ACT99999
		Community Support Team	HFS	CST99999
		Violence Prevention Community Support Team	HFS	VPCST999
	Crisis Response	Mobile Crisis Response	HFS	MCR99999
		Crisis Stabilization	HFS	STA99999
BHC	BHC Day Treatment	Intensive Outpatient	HFS	IOP99999
	BHC Team Based Services	Community Support Team	HFS	CST99999
		Violence Prevention Community Support Team	HFS	VPCST999
	BHC Crisis Response	Mobile Crisis Response	HFS	MCR99999
		Crisis Stabilization	HFS	STA99999

IMPACT applications will be pended until all Program Approval reviews are completed.

Following the submission of an application in IMPACT that includes a request for one or more Program Approvals, providers will be required to submit additional documentation to HFS, or its designee, to demonstrate their compliance with the requirements of each respective service requiring Program Approval as outlined in 89 Ill. Admin. Code 140.Table N. Once all necessary documentation has been received, HFS or its designee will review the materials, and HFS will notify the provider of the outcome of the review within 90 days from when HFS received the necessary documentation.

Providers will be required to demonstrate their compliance with the Program Approval requirements on an annual basis, including submitting an attestation of compliance with 89 Ill. Admin. Code 140.453 and 89 Ill. Admin. Code 140.Table N.

All Program Approval on-site review activities, adjudication timelines and decisions are subject to due process as detailed in 89 Ill. Admin. Code 140.Table N. For additional information on Program Approval requirements and processes, please contact the Office of Medicaid Innovation (OMI) at: OMI.IMPACT@uillinois.edu.

202.4.1 Program Approval Review Components

A provider shall develop a specific Program Plan for each service for which the provider seeks Program Approval. The Program Plan will be required as part of the initial and annual

review processes. The Program Plan must specifically address the following core elements of each service, as detailed in 89 Ill. Admin. Code 140.Table N: 1) programming; 2) staffing requirements; 3) targeted population profile; and 4) provider-based utilization management.

Providers must also submit a copy of the provider's policies and procedures, including but not limited to disaster recovery protocols, emergency response protocols, and physical plant site management protocols.

For each service that requires specific staff training, staffing availability, or other specified elements that require individual staff documentation, the provider must submit initially and on an annual basis, the corresponding training records (i.e., training curriculum, trainer name, dates of delivery/receipt, and proof of attendance), staffing schedule (i.e., current and upcoming quarter), and other documents, as requested by HFS.

202.4.1.1 Assertive Community Treatment Review

HFS deems certified and enrolled CMHCs as qualified to provide Assertive Community Treatment (ACT) services upon IMPACT enrollment with the Specialty/Subspecialty combination of Team-Based Services/Assertive Community Treatment. CMHCs are not required to submit the program approval review documentation outlined in Section 202.4.1 of this handbook; however, CMHCs seeking to deliver ACT services shall be required to attest to complying with 89 Ill. Admin. Code 140.453 and 89 Ill. Admin. Code 140.Table N. All necessary documentation will be provided to the provider for completion once the provider has submitted an IMPACT application requesting the Subspecialty of Assertive Community Treatment.

HFS reserves the right to review ACT Programs pursuant to the process outlined in 89 Ill. Admin. Code 140.Table N(b)(2).

202.4.2 On-Site Reviews

The services of Psychosocial Rehabilitation (PSR) and Intensive Outpatient shall require initial on-site reviews prior to Program Approval and annual on-site reviews thereafter.

HFS may, at its sole discretion, elect to perform on-site program review activities, claims review activities, or customer record review activities for any of the services detailed in 89 Ill. Admin. Code 140.Table N, as well as ACT, MCR, and Crisis Stabilization services, regardless of the provider type (CMHC or BHC). Providers will be notified in writing at least ten (10) days in advance of a scheduled on-site review.

202.5 Peer Support Workers

Peer Support Workers (PSWs) delivering services pursuant to 89 Ill. Admin. Code 140.453 and 89 Ill. Admin. Code 140.Table N are not required to be employees of the CMHC or BHC rendering services, so long as the following requirements are met:

- The CMHC or BHC maintains an executed agreement with the entity or individual serving as PSW. The agreement must minimally outline: 1) the scope of services to be delivered by the PSW; 2) PSW service reimbursement; and, 3) supervision of PSWs by staff minimally meeting the requirements of a QMHP.

- The CMHC or BHC ensures and maintains sufficient record of background checks conducted on all PSWs providing direct services to customers, consistent with the requirements outlined in 89 Ill. Admin. Code 140.Table O(c)(3).

202.6 Prohibition on Co-Location

Clinics enrolled in IMPACT that receive reimbursement on an encounter rate basis are prohibited from receiving reimbursement from HFS for the provision of MRO-MH and TCM services in any form other than their established behavioral health encounter rate.

Additionally, a provider may not be dually enrolled as a BHC and one of the clinic provider types outlined in 89 Ill. Admin. Code 140.460(a) at the same site, nor may a provider enroll in IMPACT as both a BHC and as a CMHC at the same site (89 Ill. Admin. Code 140.499(c)).

202.7 National Provider Identification (NPI) Number

Provider enrollment in IMPACT is issued on a site-specific basis – CMHC and BHC applications submitted in IMPACT will only be approved for one primary service location. Providers are required to obtain a unique NPI number for each site they are seeking to enroll with HFS. Each approved provider site is issued a unique Provider ID number from HFS, meaning that providers are required to maintain a unique one-to-one match between NPIs and Provider IDs on file with HFS. Providers that fail to obtain and report a unique NPI for each service location may be subject to claims denial.

202.8 Transfer of Ownership

Participation approval is not transferable. When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims paid to the new owner using the prior owner's assigned Provider ID number may result in recoupment of payments and other sanctions.

202.9 Participation Approval

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, outlining the information associated with the provider's enrollment in HFS' files. The provider is to review this information for accuracy immediately upon receipt.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying

information required is an exact match to that in HFS's files; any inaccuracies found must be corrected and HFS notified immediately via IMPACT.

202.10 Participation Denial

When participation is denied, the provider will receive written notification of the reason for denial. Within 10 calendar days after the date of a participation denial notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which HFS's action is being challenged. If such a request is not received within 10 calendar days, or is received, but later withdrawn, HFS's decision shall be a final and binding administrative determination. HFS's rules concerning the basis for denial of participation are set out in 89 Ill. Admin. Code 140.14. HFS's rules concerning the administrative hearing process are set out in 89 Ill. Admin. Code 104 Subpart C.

202.11 Provider File Maintenance

The information carried in HFS files for participating providers must be maintained on a current basis. The provider and HFS share responsibility for keeping the file updated.

202.11.1 Provider Responsibility

Information contained on the Provider Information Sheet is the same as in HFS's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and HFS notified immediately via IMPACT.

Failure of a provider to properly update IMPACT with corrections or changes may cause an interruption in participation and payments.

202.11.2 HFS Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, HFS will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

203 Record Requirements

HFS regards the maintenance of adequate clinical records as essential for the delivery of quality behavioral health treatment. Providers are required to maintain a clinical record for each customer. The clinical record must include the essential details of the customer's presenting behavioral health condition and of each service provided. Refer to the Handbook for Providers of Medical Services, General Policy and Procedures for record requirements applicable to all providers.

In addition, providers should be aware that treatment records related to service delivery are key documents for post payment audits. It is the responsibility of the provider to maintain sufficient documentation to support payment for the services billed, including but not limited to: personnel records for staff rendering services, a signed service note, and completed copies of the customer's IATP or other medical necessity documentation consistent with Appendix A of this handbook.

In the absence of proper and complete clinical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the Office of the Inspector General (OIG) or other appropriate law enforcement agency for further action.

203.1 Monitoring Activities

All required records are to be available for inspection, audit and copying (including photocopying) by authorized HFS personnel or designees during normal business hours for the purposes of conducting quality assurance or post payment reviews, or to ensure compliance with the policies and procedures outlined in this Handbook.

204 Provider Reimbursement

204.1 Charges

Providers are to submit charges to HFS only after services have been rendered. Charges are to reflect the provider's usual and customary charges to the general public for the services provided. To be eligible for reimbursement, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service, or within 24 months from the date of service when Medicare or its fiscal intermediary must first adjudicate the claim, unless one of the exceptions to the timely filing rule applies. Refer to the Timely Filing Override Submittal Instructions for a list of exceptions to the 180-day rule and billing instructions for each.

Charges for services provided to customers enrolled in HealthChoice Illinois must be billed to the managed care plan according to the provider's contractual agreement with the managed care plan. Please refer to the policies and procedures of each individual plan.

204.2 Payment and Reimbursement

Payment made by HFS for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by HFS. Refer to Handbook for Providers of Medical Services, General Policy and Procedures, for payment procedures utilized by HFS.

HFS is responsible for establishing rates for all eligible services in the Illinois Medicaid Program. The HFS established rate is the maximum allowable rate for each eligible service. Reimbursement of a Medicaid service by a public payer in any amount up to the maximum allowable rate published by HFS shall be considered payment in full and cannot be supplemented in any way. HFS authorized rates for Medicaid-funded MRO-MH and TCM services shall be published on the HFS website.

204.3 Payers of MRO-MH and TCM Services

MRO-MH and TCM services provided to eligible customers may be reimbursed by local government entities, State Agencies, or HealthChoice Illinois managed care plans when rendered consistent with HFS rules and policies, including this handbook, as well as any policies and procedures of the funder.

204.3.1 Funding from HFS

BHCs seeking reimbursement from HFS for services rendered to customers served under the fee-for-service system are required to submit claims to HFS consistent with HFS rules and policies.

204.3.2 Funding from DHS-DMH

CMHCs seeking reimbursement from DHS-DMH are required to comply with all DHS-DMH rules and policies, including those policies issued by its Agent(s). Providers are required to submit claims for reimbursement for all DHS-DMH funded services to HFS consistent with HFS rules and policies. All services funded by DHS-DMH require that eligible customers be enrolled/registered with the DHS/DMH. Information on this process can be found on the DHS website.

204.3.3 Funding from DCFS

Providers seeking reimbursement of MRO-MH and TCM services from DCFS must comply with all DCFS rules and policies. Provider seeking reimbursement for services provided to children and youth under the care of DCFS who are not enrolled with a HealthChoice Illinois Program shall submit claims for reimbursement in a manner specified by DCFS.

204.3.4 Funding for the Screening, Assessment and Support Services (SASS) Program

CMHCs and BHCs that provide MRO-MH and TCM services to customers with an active HFS Social Services Special Eligibility Segment on the date of service shall submit claims for reimbursement directly to HFS.

204.3.5 Funding from Managed Care Plans

Providers delivering MRO-MH or TCM services to customers enrolled in the HealthChoice Illinois Program must comply with the rules and policies of the managed care plan, including any prior authorization requirements and utilization management protocols. Providers seeking reimbursement for services provided to customers enrolled in the HealthChoice Illinois Program must submit claims for reimbursement directly to the managed care plan in a manner specified by the managed care plan.

205 Covered Services

Services covered under the Illinois Medical Assistance Program include only those reasonably necessary medical and remedial services that are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity, or impairment. Covered services are limited to those services that may qualify for federal financial participation under a federal healthcare program, as well as those services recognized by HFS as a core service of one of the HFS Medical Assistance Programs.

A full listing of MRO-MH and TCM services for which payment can be made to participating providers is detailed in Section 208 of this handbook and the accompanying fee schedule.

206 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Adm. Code 140.6 for a general list of non-covered services.

In addition, the following activities are not reimbursable to CMHCs, BHCs, and IPs, either because they are not directly therapeutic and/or because the cost associated with the activity was already considered in the rates paid for billable services:

- Services that do not meet service requirements specified by 89 Ill. Admin. Code 140.453.
- Performance of a billable service in less than one-half billable unit (e.g., services reimbursed in units of 15 minutes cannot be billed if the service is completed in less than 7.5 minutes).
- Preparation required to deliver a billable activity, (e.g., gathering customer files, planning activities, reserving space).
- Activities required to complete a billable service after the billable portion of the episode is concluded (e.g., completing case notes, returning file material, clinical documentation, billing documentation, etc.).
- Unavoidable down-time, including waiting for customers prior to a billable activity or due to failure of a customer to attend billable sessions, regardless of place of service.
- Time spent interacting with or building a relationship with customers when this activity cannot be directly accounted for in a service listed.
- Personnel/management activities (e.g., hiring, staff evaluations, normal staff meetings, utilization review activities, and staff supervision).
- Staff training, orientation, and development.
- Clinical supervision.
- Any travel, with or without a customer in the car, unless performing a service specified in the customer's Integrated Assessment and Treatment Plan (e.g., individual therapy/counseling).

207 Billing and Service Delivery Requirements

207.1 General Medical Necessity Requirements

Providers seeking reimbursement for the provision of MRO-MH and TCM services must adhere to all applicable state and federal laws and rules, including the policies within this handbook, regarding the requirement for medical necessity for every service provided to an eligible customer.

MRO-MH services are considered medically necessary when they are:

1) Recommended by a Licensed Practitioner of the Healing Arts (LPHA) or IP operating within their scope of practice through the completion of an Integrated Assessment and Treatment Plan (IATP) or consistent with the specific service guidelines outlined in Sections 207.1.1 and 207.1.2 of this handbook.

2) Provided to a customer for the maximum reduction of mental disability and restoration to the best possible functional level. A mental disability, for the purposes of receiving MRO-MH or TCM services, shall mean either:

    a) The identification of a diagnosis and a functional impairment; or

    b) For children under age 21 who do not meet the criteria listed above, the identification of more than one documented criterion for a mental disorder listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and a documented impact on the child's functioning in more than one life domain.

3) Provided consistent with any service limitations, utilization controls, and prior authorizations established by the Department.

207.1.1 Integrated Assessment and Treatment Planning (IATP)

IATP services are deemed to be medically necessary when they are provided to a customer for the purposes of assessing or reviewing the need to initiate or continue MRO-MH and TCM services, for the purposes of diagnosis development or confirmation, and to develop, review, or update the customer's' treatment goals, objectives, and recommended treatment services. Consistent with 89 Ill. Adm. Code 140.453(c)(1)(a) and the policies found herein, the completion of an initial IATP to determine the need for MRO-MH and/or TCM services does not require a DSM-5 diagnosis when the IATP is performed by an LPHA or IP operating within their scope of practice.

A customer's IATP may be established by a single service provider for all MRO-MH and TCM service providers. The primary IATP provider is responsible for obtaining the consents and releases of information necessary to share the customer's IATP with other service providers and collaterals that make up the customer's interdisciplinary treatment team. The primary IATP provider shall complete the initial IATP as well as complete a full re-

assessment of the customer's IATP once every 180 days. For medical necessity to be established, each 180-day re-assessment shall incorporate updates and input from the customer's other service providers and collaterals participating as part of the customer's interdisciplinary treatment team.

207.1.2 Medical Necessity Requirements for Specific Services

A subset of MRO-MH and TCM services may be delivered prior to the completion of an IATP. Medical necessity for these services is established when the following are met:

- **Crisis Intervention**. Crisis Intervention services performed for the purposes of treating or ameliorating decompensation, loss of role functioning, or inability to deal with immediate stressors, resulting in a behavioral health crisis are deemed to be medically necessary as long as the Crisis Intervention services include either a referral back to the existing treatment provider for ongoing services, or a customer-driven referral to a community-based provider of MRO-MH services for follow-up and assessment.

- **Mobile Crisis Response (MCR)**. The delivery of MCR services following the receipt of a crisis referral from the Crisis and Referral Entry Service (CARES) Line, a local community resource (e.g., law enforcement, hospital, etc.), or other individual concerned for the mental health and wellbeing of a customer believed to be in a behavioral health crisis is deemed to be medically necessary so long as the MCR service includes either a referral back to the existing treatment provider for ongoing services, or a customer-driven referral to a community-based provider of MRO-MH services for follow-up and assessment.

- **Crisis Stabilization**. Crisis Stabilization services are deemed medically necessary when delivered following an MCR screening event, resulting in the recommendation and authorization of Crisis Stabilization services by a LPHA following the completion of an HFS-approved Crisis Safety Plan.

- **Therapy/Counseling.** For children under the age of 21, Therapy/Counseling services are deemed to be medically necessary when performed for the immediate amelioration of a customer's presenting clinical issues. Therapy/Counseling services may be provided prior to the completion of an IATP so long as they are delivered:

  a) By an LPHA;

  b) For no more than eight (8) clinical sessions not exceeding 90 minutes per session; and,

  c) Billed under Therapy/Counseling using the modifiers TF (LPHA) and TL (Brief Intervention).

- **Mental Health Case Management**. Mental Health Case Management services are deemed to be medically necessary as long as they are performed by staff as approved

by HFS for the purposes of coordination, assessment and direct delivery of case management services to customers with a behavioral health condition, and:

a) Delivered as an adjunct to, concurrently with, or prior to the delivery of other MRO-MH treatment services by the provider; or

b) Result in a customer-driven referral to a community-based provider of MRO-MH services for follow-up and assessment.

207.2 Utilization Management (UM)

Medicaid-funded mental health services are subject to UM consistent with applicable laws, rules and policies of the federal government and Illinois. Providers are subject to review of service delivery and must comply with all Medicaid UM procedures initiated by the funder. Failure to comply with the funder's UM procedures may result in claims denial.

207.3 Claiming Requirements

When billing for services, the claim submitted for payment must include a diagnosis and the coding must reflect the services provided. Any payment received from a third-party payer or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to HFS bearing charges for those services or items. (Exception: HFS co-payments are not to be reflected on the claim. Refer to the Handbook for Providers of Medical Services, General Policy and Procedures, for more information).

207.3.1 Billing NPI

The Billing NPI (formerly referred to as Payee NPI) must be reported in loop 2010AA, Billing Provider. The address associated with the NPI entered into this loop is the address where HFS will send Remittance Advice and Payments.

207.3.2 Rendering Provider

The Rendering Provider must be entered in loop 2310B, Rendering Provider. This data should be a NPI that is connected to a specific provider site / HFS Provider ID number where services were rendered. The Rendering Provider is not required if the provider NPI is the same as the Billing Provider, Loop 2010AA.

207.3.3 Reporting the Preventative Diagnosis Code for Customers under Age 21

Provider may deliver services to any Medicaid-eligible customer under the age of 21 who demonstrates a clinical need, as evidenced by more than one documented criterion for a mental disorder listed in the DSM-5 and a documented impact of the customer's functioning in more than one life domain.

If services are provided to a customer who meets the above criteria, the provider shall report the appropriate ICD-10 diagnosis code for which the customer demonstrates more than one

criterion as the customer's diagnosis code. To identify the preventative nature of the service being performed, the provider must report the following data in the NTE01 and NTE02 segments of the 2300 loop.

NTE 01: Provider must report "DGN"
NTE 02: The provider is allowed an 80 byte field, which should be populated with the word "Prevention" when the provider is serving a customer under the age of 21 who meets the "more than one criterion" standard for medical necessity.

207.3.4 Billing Initial IATP and Therapy/Counseling: Brief Intervention Services

The completion of an initial IATP to establish medical necessity for MRO-MH and/or TCM services, as well as the delivery of Therapy/Counseling: Brief Intervention services, does not require that the customer has an established DSM-5 diagnosis; however, providers are required to include a valid ICD-10 diagnostic code on all claims submitted for reimbursement. For the purposes of billing the initial IATP and Therapy/Counseling: Brief Intervention, providers may include any allowable ICD-10 code, including the Department approved ICD-10 Section R: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, not Elsewhere Classified code (R Codes), as detailed in Table 4. Providers who are unable to identify an ICD-10 code for the purposes of submitting a claim for reimbursement for initial IATP or Therapy/Counseling: Brief Intervention services may utilize an R Code from the listing in Table 4. All other MRO-MH and TCM services, including the delivery of subsequent IATP services and activities, require a documented mental disability as detailed in Section 207.1 of this Handbook, pursuant to 89 Ill. Admin Code 140.453(c)(2).

Table 4. Approved R codes

R45	Symptoms and signs involving emotional state
R45.0	Nervousness
R45.1	Restlessness and agitation
R45.2	Unhappiness
R45.3	Demoralization and apathy
R45.4	Irritability and anger
R45.6	Violent behavior
R45.7	State of emotional shock and stress, unspecified
R45.8	Other symptoms and signs involving emotional state
R45.81	Low self-esteem
R45.82	Worries
R45.83	Excessive crying of a child, adolescent, or adult
R45.84	Anhedonia
R45.85	Homicidal and suicidal ideations
R45.850	Homicidal
R45.851	Suicidal
R45.86	Emotional lability
R45.87	Impulsiveness
R45.89	Other symptoms and signs involving emotional state
R46	Symptoms and signs involving appearance and behavior
R46.0	Very low level of personal hygiene
R46.1	Bizarre personal appearance
R46.2	Strange and inexplicable behavior
R46.3	Overactivity
R46.4	Slowness and poor responsiveness

R46.5	Suspiciousness and marked evasiveness
R46.6	Undue concern and preoccupation with stressful events
R46.7	Verbosity and circumstantial detail obscuring reason for contact
R46.8	Other symptoms and signs involving appearance and behavior
R46.81	Obsessive-compulsive behavior
R46.89	Other symptoms and signs involving appearance and behavior

207.3.5 Reporting Place of Service for a Single Location of Service

Providers must specify the location from which services were rendered on each claim by reporting the appropriate two-digit Place of Service (POS) Code, consistent with HFS billing guidance and national HIPAA guidelines. For dates of service on or after 8/1/2018, all claims for MRO-MH and TCM services must report the true location of services rendered using the appropriate POS Code from the table below:

Table 5. Allowable Place of Service Codes

On-Site	Off-Site
02 – Telehealth provided other than in patient's home 10 - Telehealth provided in patient's home 11 - Office 15 - Mobile Unit 20 - Urgent Care Facility 53 - Community Mental Health Center	03 - School 04 - Homeless Shelter 12 - Home 13 - Assisted Living Facility 14 - Group Home 21 - Inpatient Hospital (Hospital) 22 - On-Campus Outpatient Hospital 23 - Emergency Room – Hospital 26 - Military Treatment Facility 31 - Skilled Nursing Facility (SNF) 32 - Nursing Facility 33 - Specialized Mental Health Rehabilitation Facility 34 - Hospice 51 - Inpatient Psychiatric Facility (Free Standing Psych) 52 - Psychiatric Facility - Partial Hospitalization 54 - Intermediate Care Facility/ Individuals with Intellectual Disabilities (ICF/IID) 55 - Substance Use Disorder (SUD) Residential 56 - Psychiatric Residential Treatment Facility (PRTF) 57 - Substance Use Disorder (SUD) Treatment Site 71 - Public Health Clinic 99 - Other Place of Service

207.3.5.1 Guidance on Selecting the Appropriate POS

<u>On-Site POS Selection</u>

In general, CMHCs should utilize the POS code of 53 – Community Mental Health Center when providing services on-site at the provider's primary practice location. However, if a CMHC is providing services at a site not physically part of the CMHC, but the site is the usual and customary location for the staff member delivering the service (e.g., crisis staff housed in a nearby hospital), the POS code of 11 – Office should be utilized.

Providers whose usual and customary location for staff delivering services is at a residential treatment facility with sixteen (16) or fewer beds should utilize the POS code of 11 – Office.

BHCs providing services on-site at the provider's primary practice location should utilize POS 11 – Office. However, please note that the design and nature of BHCs, pursuant to 89 Ill. Admin. Code 140.Table O, should emphasize service delivery at off-site locations.

Effective with dates of service beginning October 1, 2021, providers delivering services via audio or video communication must utilize the appropriate telehealth POS code, consistent with Section 207.3.7, when billing for services.

Off-Site POS Selection

Community based hospitals that provide psychiatric services should be coded as POS 21 – Inpatient Hospital, while Free Standing Psychiatric Hospitals (i.e., psychiatric services only) should be coded as POS 51 – Inpatient Psychiatric Facility.

POS 03 – School is inclusive of all primary, secondary, post-secondary, preschool, and day care centers but does not include in-home daycare sites.

POS 12 – Home includes the primary residency, usual living space, and in-home daycare sites. Home does not include institutional settings such as a residential treatment facility, group home, or hospital.

The difference between POS 55 – SUD Residential and POS 57 – SUD Treatment Site is the presence of American Society of Addiction Medicine (ASAM) Level III treatment services. All SUD treatment sites that provide ASAM Level III or higher services should be coded as POS 55 – SUD Residential, unless the site would otherwise qualify as a Community based hospital (POS 21) or Free Standing Psychiatric Hospital (POS 51). SUD treatment sites that only provide ASAM Level I and II services should be coded as POS 57 – SUD Treatment Site.

207.3.6 Reporting Place of Service for Multiple Units of the Same Service

Providers submitting claims for services with the same procedure code and modifier, RIN, date of service (DOS), and POS combination must "roll up," or combine these units, into a single service line of a claim. However, the HFS system is programmed to recognize only one "on-site" and one "off-site" POS per procedure/modifier and RIN combination per day. Providers needing to submit multiple units of the same procedure/modifier combination rendered to one customer on the same DOS at different locations (e.g., home and school) should use the following table to determine the appropriate POS code for use in claim submission:

	More than one 'On-Site' POS from Table 5, Same Procedure/Modifier Combo, Same Customer, Same Day:	More than one 'Off-Site' POS from Table 5, Same Procedure/Modifier Combo, Same Customer, Same Day:
CMHCs	**53**	**99**
BHCs	**11**	**99**

Telehealth Billing Exception: Providers submitting claims for 'on-site' services that include services rendered both by telehealth and face-to-face must exclude the telehealth services from the "roll up" combination of on-site units. Rather, services delivered via telehealth must

be billed with the appropriate telehealth modifier (GT or 93) and POS (02 or 10) on a service line separate from other 'rolled up' on-site services rendered face-to-face to the same recipient for the same procedure code and modifier combination**.**

207.3.7 Reporting Services Delivered via Telehealth

Effective with dates of service beginning October 1, 2021, providers billing a service that was performed via audio or video communication must append the procedure code with the appropriate modifier and POS to indicate telehealth as the mode of service delivery. This coding is needed for HFS to track the mode of service delivery. The telehealth modifiers and place of service codes are for reporting purposes only and do not affect current payment methodology.

Additional telehealth modifiers and POS have been adopted effective with dates of service beginning July 1, 2022. The table below provides guidance to providers utilizing telehealth on the appropriate telehealth modifiers and POS based upon the date of service.

Table 6. Telehealth Modifiers and POS Descriptions

Date of Service	POS Code and Description	Telehealth Modifier
10/1/2021-6/30/2022	02 - Telehealth	GT - Telehealth delivered via video or audio communications
7/1/2022 and after	02 - Telehealth provided other than in patient's home 10 - Telehealth provided in patient's home	GT - Telehealth delivered via video 93 - Telehealth delivered via audio-only

207.3.8 Reporting Staffing Level on Select Team-Based Services

Claims for Community Support Team (CST), Violence Prevention Community Support Team (VP-CST), and Assertive Community Treatment (ACT) must record the appropriate staffing level for each service provided using a modifier from the list in Table 7 below. Claims submitted without a true staffing indicator will be rejected. For the purposes of billing these services, the modifier '52' must be utilized to indicate services delivered by a Peer Support Worker (PSW), including a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP) when operating in the peer role. If the Multidisciplinary Team (HT) modifier option is utilized to indicate multiple staff involved in the delivery of services, the highest-level staff participating in the intervention should be recorded in addition to the HT modifier.

Table 7. Staffing Level Modifiers for Select Team-Based Services

Modifier	Staffing Level
52	Lower Level of Care
AF	Physician
AH	Psychologist – Masters
HH	Substance Use Disorder Worker
HT	Multidisciplinary Team
HM	RSA
HN	MHP
HO	QMHP

HP	Psychologist – Licensed Clinical
SA	APN
TD	RN
TE	LPN
TF	LPHA

208 Service Delivery Guidance

208.1 General Notes

Section 208 is a companion to 89 Ill. Admin. Code 140.453 for the purposes of providing guidance on the delivery of MRO-MH and TCM services. No detail in this Section shall supplant Illinois law or administrative code in any way.

The services are grouped into sections based on the Provider Types that may render the services. Please note that the field "Service Type" listed under each service indicates the broad authority under which the service can be reimbursed to MRO-MH and TCM providers. Some services include notes on coding requirements for billing the service. Failure to comply with the service delivery requirements and coding structure requirements outlined in the following service pages may result in claims denial. Providers must refer to the accompanying fee schedule for the full listing of Department acceptable HCPCS and modifier combinations.

208.2 Group A Services

Group A services may be provided by CMHCs (Provider Type 036), BHCs (Provider Type 027), and IPs.

208.2.1 Integrated Assessment and Treatment Planning (IATP) HCPC: H2000

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☒ IP

Integrated Assessment and Treatment Planning (IATP): The service of IATP includes the time spent completing the clinical interview; review of documents; discussions with parents, guardians, or other collaterals, including allied professionals; and review of information to formulate a diagnosis and service interventions. The provision of all IATP services should be delivered to support the completion of the Department approved IATP instrument.

The IATP must be completed once every 180 days using the HFS approved instrument, and must be reviewed, approved, and signed by an LPHA. The time spent by the authorizing LPHA clinically reviewing the IATP, including any necessary consultation with the staff who completed the IATP, is reimbursable effective with dates of service on or after July 1, 2022.

The HFS approved IATP instruments must be submitted via the web-based IATP Provider Portal pursuant to the guidelines provided by the Department; submission is required to receive service reimbursement.

The act of documentation, or "completion of the form," is not reimbursable, with the following exceptions:

- Documentation is reimbursable when completed with the customer (direct interaction) as a component of the clinical intervention to enhance engagement.

- Documentation is reimbursable when rating IM+CANS domain or modular items or when prioritizing IM+CANS needs and strengths for treatment planning utilizing the IM+CANS form as a component of the clinician's case formulation.

A copy of the completed IATP shall be provided to the customer, or the customer's parent or guardian, upon completion or revision.

Additionally, IATP includes clinical assessment activities performed by, or under the supervision of, an LPHA using nationally standardized assessment instruments resulting in a written report or documented outcome that includes the identification of a clinical need or diagnosis necessary for the completion of the IATP.

Staff Qualifications: IATP services must be delivered by staff who minimally meet the qualifications of an MHP. Clinical assessment activities must be performed by, or under the supervision of, an LPHA.

Medical Necessity: Medical Necessity for this service is established by the need to assess the customer for the delivery or continuation of community-based clinical services under the MRO-MH or TCM Option. For customers assessed but for whom it is determined that ongoing MRO-MH or TCM services are not medically necessary, the provider may submit their claim for IATP services pursuant to Section 207.3.4 of this handbook.

Lead Provider Responsibility: The lead provider (as identified through the customer's enrollment in a State-administered behavioral health program), or single TCM provider shall be responsible for performing or coordinating all updates/reviews of a customer's IATP. In the instance that a customer does not have an established lead provider but has sought services from multiple providers, each of the providers who are offering services to the customer may utilize the IATP associated with the customer provided that the IATP has a signature of an LPHA that is dated within 180 days of the provision of service and the new provider reviews and updates the IATP as necessary for the provision of services. If the customer has an associated IATP that has a dated LPHA signature that is over 180 days old, then the provider must complete a re-assessment.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Billing Guidance: Initial IATPs and a full re-assessment of a customer's IATP shall only be reimbursed to a single service provider once every 180 days, and cannot be billed using the modifier "SF." Use the modifier "SF" to indicate an update of a customer's IATP that occurs during the 180-day IATP timeframe. Updates of a customer's IATP using the "SF" modifier may be reimbursed at any time during the 180-day IATP timeframe to any service provider delivering MRO-MH and TCM services to a customer.

IATP: Psychological Assessment: The service of IATP: Psychological Assessment includes the time spent performing, reviewing, and interpreting diagnostic assessment activities, including testing for the purpose of needs identification, diagnosis development or confirmation, and service recommendations. IATP: Psychological Assessment activities must be performed with the utilization of nationally standardized psychological assessment instruments.

The act of documentation or report writing is not reimbursable. The act of report review with the customer is reimbursable as a component of the clinical intervention to enhance engagement or with allied professionals for the purposes of developing appropriate service planning. A copy of the completed IATP: Psychological Assessment shall be provided to the customer or the customer's parent or guardian, upon completion, summation, and review with the customer and/or their parent, guardian, and/or caregivers.

Staff Qualifications: IATP: Psychological Assessment services may only be rendered by staff qualified to do so pursuant to the Clinical Psychologist Licensing Act [225 ILCS 15].

Medical Necessity: Medical necessity for this service is established by the need to assess the customer for the purposes of diagnosis development or confirmation and to assist in the development of treatment recommendations on cases that present with complex clinical factors. For customers assessed but for whom it is determined that ongoing MRO-MH or TCM services are not medically necessary, the provider may submit a claim for IATP: Psychological Assessment services pursuant to Section 207.3.4 of this handbook.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

208.2.3 IATP: Level of Care Utilization System (LOCUS) HCPC: H2000

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☒ IP

IATP: Level of Care Utilization System (LOCUS): The service of IATP: LOCUS includes assessing a customer's clinical needs and functional status, and the subsequent matching of those needs to treatment resources in the DHS adult (age 18 and over) service continuum. The act of documentation, or "completion of the form," is not reimbursable, unless the documentation is completed with the customer (direct interaction), as a component of the clinical intervention to enhance engagement. A copy of the completed IATP: LOCUS shall be provided to the customer or the customer's parent or guardian, upon completion.

Staff Qualifications: IATP: LOCUS services must be delivered by staff who minimally meet the qualifications of an MHP.

Medical Necessity: Medical Necessity for this service is established by the need to assess the customer for determining eligibility for admission to DHS treatment programs.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

208.2.4 Crisis Intervention — HCPC: H2011

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☒ IP

Crisis Intervention: The service of Crisis Intervention includes the short-term delivery of interventions that may be provided prior to, or without, an established IATP, in direct response to a customer who, in the course of treatment or intervention, appears to need immediate intensive intervention to achieve crisis symptom reduction and stabilization. Crisis Intervention includes specific crisis intervention, de-escalation, and response techniques, as well as all MRO-MH services that an MHP-level staff member can provide, excluding services that require prescriber authorization or a Program Approval within IMPACT.

Staff Qualifications: Crisis Intervention services must be delivered by staff who minimally meet the qualifications of an MHP. If services are delivered by an MHP, the MHP must have immediate, direct access to a QMHP.

Medical Necessity: Medical Necessity for this service is established when, during the course of treatment or intervention, the MHP, QMHP, or LPHA identifies a customer's decompensation, loss of role functioning, or inability to deal with immediate stressors, resulting in a behavioral health crisis and the need for the immediate delivery of crisis intervention services. The Crisis Intervention services must also include either a referral back to the existing treatment provider for ongoing services, or a customer-driven referral to a community-based provider of MRO-MH services for follow-up, assessment and ongoing service delivery. For children, a behavioral health crisis may also include events that threaten safety or functioning of the customer or disruption from the family or their living situation.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Restrictions on Delivery Mode: The delivery modes of phone and video may only be utilized for customers already engaged and established as a client with the provider. The usage of phone or video should be documented as an acceptable delivery mode either on the customer's IATP or Crisis Safety Plan.

Allowable Service Delivery Types: Individual

208.2.5 Therapy/Counseling — HCPC: H0004

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☒ IP

Therapy/Counseling: The service of Therapy/Counseling includes all treatment modalities and clinical techniques, with an emphasis on evidence-informed practices, used by the

therapist/counselor to promote positive and/or pro-social emotional, cognitive, behavioral, or psychological changes with the customer.

Staff Qualifications: Therapy/Counseling services must be delivered by staff who minimally meet the qualifications of an MHP.

Medical Necessity: An IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Therapy/Counseling.

For customers under the age of 21, Therapy/Counseling services performed for the immediate amelioration of a customer's presenting clinical issues are deemed to be medically necessary prior to the completion of an IATP so long as they are: a) delivered by an LPHA; b) delivered for no more than eight (8) clinical sessions not exceeding 90 minutes per session; and c) submitted for reimbursement using the appropriate modifiers of TF (LPHA) and TL (Brief Intervention).

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual, family/couple, and group.

208.3 Group B Services

Group B services may be provided by CMHCs (Provider Type 036) or BHCs (Provider Type 027).

208.3.1 Community Support — HCPC: H2015

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Community Support: The service of Community Support includes the facilitation of illness self-management techniques, identification and use of natural supports, development of functional, interpersonal and community-based coping skills, and other clinically informed efforts to support the recovery of the customer. Additionally, Community Support includes efforts to increase targeted strengths or reduce targeted needs, as identified in the customer's IATP.

Staff Qualifications: Community Support services must be delivered by staff who minimally meet the qualifications of an RSA.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Community Support interventions.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual and group.

208.3.2 Medication Administration HCPC: T1502

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Medication Administration: The service of Medication Administration includes the time spent preparing the customer (including drawing blood, as necessary) and medication for administration, the actual administration of the medication and observation for possible adverse reactions.

Staff Qualifications: Medication Administration services must be delivered by staff that hold a valid Illinois license and are legally authorized under state law or rule to administer medication, so long as that practice is not in conflict with the Illinois Nurse Practice Act or the Medical Practice Act of 1987 (i.e., a physician, a psychiatrist, advanced practice nurse, registered nurse or a practical nurse).

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Medication Administration performed as an adjunct to a medication prescribed related to either the customer's behavioral health condition or general health and wellbeing, but the medication or condition has a direct impact on the customer's behavioral health condition creating a complex medical condition.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

208.3.3 Medication Monitoring HCPC: H2010

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Medication Monitoring: The service of Medication Monitoring includes observation, evaluation and discussion of target symptoms, responses, and adverse effects of medications. Additionally, the service provides for the review and explanation of laboratory results to customers and provider activities to investigate and identify new target symptoms from medications, such as performing screens for tardive dyskinesia.

Staff Qualifications: Medication Monitoring services must be delivered by staff who minimally meet the qualifications of an RSA and who have been designated in writing to provide the service by staff that hold a valid license in the state of practice and are legally authorized under state law to prescribe medication pursuant to the Illinois Nurse Practice Act or the Medical Practice Act of 1987.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Medication Monitoring performed as an adjunct to a medication prescribed related to either the customer's behavioral health

condition or general health and wellbeing, but the medication or condition has a direct impact on the customer's behavioral health condition creating a complex medical condition.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Restrictions on Delivery Mode: The delivery mode of phone may only be utilized when a phone consultation is necessary to consult with another professional in direct response to a customer experiencing adverse symptoms. The provider's documentation should indicate the adverse symptoms the customer experienced and the name of the professional with whom the provider consulted via phone.

Allowable Service Delivery Types: Individual

Billing Guidance: Use the modifier 52 (Lower Level of Care) on claims for services performed by an RSA, MHP, QMHP or LPHA, as designated in writing to provide the service by staff that hold a valid license in the state of practice and are legally authorized under state law to prescribe medication pursuant to the Illinois Nurse Practice Act or the Medical Practice Act of 1987.

208.3.4 Medication Training — HCPC: H0034

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Medication Training: The service of Medication Training includes a provider training clients on self-administration and safeguarding (adverse reactions, storage, etc.) of medication and communication with other professionals, family or caregivers on medication usage, potential issues, and means to actively seek assistance in the event of an issue or emergency.

Staff Qualifications: Medication Training services must be delivered by staff who minimally meet the qualifications of an RSA and who have been designated in writing to provide the service by staff that hold a valid license in the state of practice and are legally authorized under state law to prescribe medication pursuant to the Illinois Nurse Practice Act or the Medical Practice Act of 1987.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Medication Monitoring performed as an adjunct to a medication prescribed related to either the customer's behavioral health condition or general health and wellbeing, but the medication or condition has a direct impact on the customer's behavioral health condition creating a complex medical condition.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Billing Guidance: Use the modifier 52 (Lower Level of Care) on claims for services performed by an RSA, MHP, QMHP or LPHA, as designated in writing to provide the service by staff that hold a valid license in the state of practice and are legally authorized under state law to prescribe medication pursuant to the Illinois Nurse Practice Act or the Medical Practice Act of 1987.

208.3.5 Client-Centered Consultation Case Management HCPC: T1016

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Client-Centered Consultation Case Management (CM): Client-Centered Consultation CM includes client-specific professional communications among provider staff, including professional communications between supervisors and supervisees, or between provider staff and staff of other providers, who are involved with service provision to the customer. Professional communications must fall under one of the following categories: offering or obtaining a professional opinion regarding the individual's current functioning level or improving the customer's functioning level; discussing the customer's progress in treatment; adjusting the customer's current treatment; or addressing the customer's need for additional or alternative mental health services.

Staff Qualifications: Client-Centered Consultation CM must be delivered by staff who minimally meet the qualifications of an RSA.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Client Centered Consultation CM along with concurrent delivery of one or more of the following services: Community Support, Intensive Outpatient (IO), Medication Administration, Medication Monitoring, Medication Training, Psychosocial Rehabilitation, or Therapy/Counseling.

Prohibition Against Duplication of Service: Customers may only receive Case Management services or care coordination services from a single service provider, regardless of the underlying diagnosis or reason for the provision of Case Management/care coordination services. Care management delivered by an MCO or other administrative function similar in nature is not considered to be duplicative of TCM services as outlined in this Handbook.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Limitations on TCM Services: HFS shall not fund more than 240 total hours of TCM services (inclusive of Client Centered Consultation CM, Mental Health CM, and Transition Linkage and Aftercare CM) per State fiscal year per customer.

208.3.6 Mental Health Case Management HCPC: T1016

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Mental Health Case Management (CM): The service of Mental Health CM includes the following: assessment, planning, coordination and advocacy services for customers who need multiple services and require assistance in gaining access to and in using behavioral health, physical health, social, vocational, educational, housing, public income entitlements and other community services to assist the customer in the community. Mental Health CM may also include identifying and investigating available resources, explaining options to the customer, and linking the customer with necessary resources.

Staff Qualifications: Mental Health CM services must be delivered by staff who minimally meet the qualifications of an RSA.

Medical Necessity: Medical Necessity for this service is established when the customer has a clinical presentation consistent with a behavioral health condition to be addressed by the provider via service delivery or intervention. Mental Health CM services may be provided prior to IATP.

Prohibition Against Duplication of Service: Customers may only receive Case Management services or care coordination services from a single service provider, regardless of the underlying diagnosis or reason for the provision of Case Management/care coordination services. Care management delivered by an MCO or other administrative function similar in nature is not considered to be duplicative of TCM services as outlined in this Handbook.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Limitations on TCM Services: HFS shall not fund more than 240 total hours of TCM services (inclusive of Client Centered Consultation CM, Mental Health CM, and Transition Linkage and Aftercare CM) per State fiscal year per customer.

208.3.7 Transition, Linkage and Aftercare Case Management — HCPC: T1016

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Transition, Linkage and Aftercare Case Management (CM): The service of Transition, Linkage and Aftercare CM is inclusive of efforts to assist in the effective transition in living arrangements, consistent with the customer's welfare and development. This includes discharge from institutional settings, transition to adult services (transition age), and assisting the customer or the customer's family or caretaker with the transition.

Staff Qualifications: Transition, Linkage and Aftercare CM services must be delivered by staff who minimally meet the qualifications of an MHP.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Transition, Linkage and Aftercare CM.

Prior Authorization Requirements: Pursuant to 89 Ill. Admin. Code 140.40 and 140.453(e)(1)(C)(iii), Transition Linkage and Aftercare CM may be subject to Prior Authorization as established by HFS, or under the authority and approval of HFS.

Prohibition Against Duplication of Service: Customers may only receive Case Management services or care coordination services from a single service provider, regardless of the underlying diagnosis or reason for the provision of Case Management/care coordination services. Care management delivered by an MCO or other administrative function similar in nature is not considered to be duplicative of TCM services as outlined in this Handbook.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Limitations on Transition, Linkage and Aftercare CM Services: HFS shall not fund more than 40 hours of Transition, Linkage and Aftercare CM services per State fiscal year per customer.

Limitations on TCM Services: HFS shall not fund more than 240 total hours of TCM services (inclusive of Client Centered Consultation CM, Mental Health CM, and Transition Linkage and Aftercare CM) per State fiscal year per customer.

208.3.8 Crisis Intervention – Team HCPC: H2011

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Crisis Intervention: The service of Crisis Intervention is the short-term delivery of interventions that may be provided prior to, or without, a completed IATP, in direct response to a customer who, in the course of treatment or intervention, appears to need immediate intensive intervention to achieve crisis symptom reduction and stabilization. Crisis Interventions include specific crisis intervention, de-escalation, and response techniques, as well as all MRO-MH services that an MHP-level staff member can provide, excluding services that require prescriber authorization or a Subspecialty Authorization within IMPACT.

Staff Qualifications: Crisis Intervention Team services must be delivered by multiple staff or a multidisciplinary team. All team members must minimally meet the qualifications of an MHP. MHPs delivering Crisis Intervention Team services must have immediate, direct access to a QMHP.

Medical Necessity: Medical Necessity for this service is established when, during the course of treatment or intervention, the MHP, QMHP, or LPHA identifies a customer's decompensation, loss of role functioning, or inability to deal with immediate stressors, resulting in a behavioral health crisis and the need for the immediate delivery of crisis intervention services. For children, a behavioral health crisis may also include events that threaten safety or functioning of the client or extrusion from the family or their living situation.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

Limitations on Place of Service: Crisis Intervention Team services may only be provided at off-site locations.

Billing Guidance: The utilization of multiple staff or of a multidisciplinary team in the crisis intervention must be documented by the provider through the usage of the modifier 'HT' on claims.

208.3.9 Crisis Stabilization — HCPC: T1019

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Crisis Stabilization: The service of Crisis Stabilization includes observing the customer in their natural environment during periods of high stress, providing coaching to the customer in the usage of their crisis safety plan; modeling positive coping skills and response patterns to the customer's parent/caregiver; redirecting a customer's behaviors when they begin to escalate; educating the customer on responding and reducing environmental stressors and stimuli when the client is feeling overwhelmed, providing crisis de-escalation, and providing a crisis response in the event the customer experiences a behavioral health crisis. Crisis Stabilization Services target periods of high stress and transition with the goal of reducing crisis episodes and institutionalizations.

Staff Qualifications: Crisis Stabilization services must be delivered by staff minimally meeting the qualifications of an MHP. MHPs delivering Crisis Stabilization must have immediate, direct access to a QMHP

Medical Necessity: Following an MCR event, Crisis Stabilization services are authorized by a LPHA following the completion of an HFS authorized Crisis Safety Plan. The Crisis Safety Plan must include the following: 1) a behavioral health diagnosis, demonstrated clinical need, or functional impairment; 2) the agency responsible for delivering Crisis Stabilization service as well as the amount, frequency, and duration of services; and 3) LPHA signature and date authorizing services.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

208.3.10 Mobile Crisis Response — HCPC: S9484

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Mobile Crisis Response (MCR): The service of MCR requires a mobile (i.e., responding to the location of the crisis), face-to-face crisis response, crisis intervention services, the initiation of an individualized Crisis Safety Plan, and the completion of the Illinois Medicaid –

Crisis Assessment Tool (IM-CAT) and all of its elements. MCR services are event based, not to exceed one hour.

Staff Qualifications: MCR services must be delivered by staff who minimally meet the qualifications of an MHP. MCR services may also be delivered by multiple staff or a multidisciplinary team; at least one team member must minimally meet the qualifications of an MHP. MHPs delivering MCR services must have immediate, direct access to a QMHP.

Medical Necessity: Medical Necessity for this service is established by direct referral from the Crisis and Referral Entry Service (CARES) Line or acceptance of a crisis referral from a local community resource (law enforcement, hospital, etc.), stakeholder or other entity or individual concerned for the mental health and wellbeing of someone believed to be in a behavioral health crisis, so long as the MCR service includes either a referral back to their existing treatment provider for ongoing services, or a customer-driven referral to a community-based provider of MRO-MH services for follow up, assessment and ongoing service delivery.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

Billing Guidance: MCR services are event based, not to exceed one hour. Services required to stabilize a crisis after one hour may be billed as Crisis Intervention, Crisis Stabilization, or Mental Health Case Management so long as medical necessity for the service is met.

208.3.11 Community Support Team — HCPC: H2016

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Community Support Team (CST): The service of CST is provided under the direction of a full-time QMHP, is available to the customer 24 hours a day, every day of year, and is intended to decrease institutional and behavioral health crisis episodes while increasing community functioning to achieve rehabilitative, resiliency and recovery goals. CST includes all MRO-MH services that an MHP-level staff can provide, except for Mobile Crisis Response, Crisis Stabilization, Mental Health CM, other services that require prescriber authorization, and other services that require a Program Approval within IMPACT.

Staff Qualifications: CST services are to be delivered by one or multiple members of a multidisciplinary team. Requirements for CST team member qualifications are outlined in 89 Ill. Admin. Code 140.Table N.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Community Support Team and continued compliance with CST Program Approval as detailed in 89 Ill. Admin. Code 140.Table N.

Prior Authorization Requirements: Pursuant to 89 Ill. Admin. Code 140.40 and 140.453(d)(4)(B)(iii), CST may be subject to Prior Authorization as established by HFS or under the authority and approval of HFS.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Billing Guidance: Claims for CST services must record the appropriate staffing level for each service provided consistent with Section 207.3.8.

208.3.12 Violence Prevention Community Support Team — HCPC: H0037

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Violence Prevention Community Support Team (VP-CST): The service of VP-CST is provided under the direction of a full-time QMHP, is available to the customer 24 hours a day, every day of year, and is intended to reduce traumatic stress symptoms and increase community functioning for individuals who have experienced chronic exposure to firearm violence. VP-CST services use evidence-informed, trauma-specific interventions and techniques to engage customers in the service delivery and trauma recovery process, develop strategies and plans to increase safety and community stabilization, and assist customers in the development of functional, interpersonal, and community coping skills. VP-CST includes all MRO-MH services that an MHP-level staff can provide, except for Mobile Crisis Response, Crisis Stabilization, Mental Health CM, other services that require prescriber authorization, and other services that require a Program Approval within IMPACT.

Staff Qualifications: VP-CST services are to be delivered by one or multiple members of a multidisciplinary team. Requirements for VP-CST team member qualifications are outlined in 89 Ill. Admin. Code 140.Table N.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of VP-CST and continued compliance with VP-CST Program Approval, as detailed in 89 Ill. Admin. Code 140.Table N.

Prior Authorization Requirements: Pursuant to 89 Ill. Admin. Code 140.40, VP-CST may be subject to Prior Authorization as established by HFS or under the authority and approval of HFS.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual, family/couple, and group.

Billing Guidance: Claims for VP-CST services must record the appropriate staffing level for each service provided consistent with Section 207.3.8.

208.3.13 Intensive Outpatient — HCPC: S9480

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Intensive Outpatient (IO): The service of IO includes scheduled, group therapeutic sessions, made available for a minimum of at least four hours per day, five days per week. Services are designed to target the specific needs of participating customers and should focus on evidence-informed practices and interventions, when possible.

Staff Qualifications: Staff delivering IO services must minimally meet the qualifications of a QMHP.

Medical Necessity: Medical Necessity for this service is established when a customer is at risk of, or has a history of, institutionalization services, has had an IATP completed within the last 180 days that was reviewed and signed by an LPHA identifying a clinical need for services with a treatment recommendation of IO.

Prior Authorization Requirements: Pursuant to Title 89 Ill. Adm. Code, Sections 140.40 and 140.453(d)(2), IO may be subject to Prior Authorization as established by HFS or under the authority and approval of HFS.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Group

208.3.14 Developmental Screening — HCPC: 96110

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Developmental Screening: Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

Staff Qualifications: Developmental Screening must be delivered by an LPHA.

Medical Necessity: Service is deemed to be medically necessary upon clinical judgement of the LPHA.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

208.3.15 Developmental Testing — HCPC: 96112

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Developmental Testing: Developmental testing includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments with interpretation and report.

Staff Qualifications: Developmental Testing must be delivered by an LPHA.

Medical Necessity: Service is deemed to be medically necessary upon clinical judgement of the LPHA.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

208.3.16 Mental Health Risk Assessment — HCPC: 96127

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Mental Health Risk Assessment: Brief emotional/ behavioral assessment (e.g., depression inventory, attention-deficit/ hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.

Staff Qualifications: Mental Health Risk Assessment must be delivered by an LPHA.

Medical Necessity: Service is deemed to be medically necessary upon clinical judgement of the LPHA.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

208.3.17 Prenatal Care At-Risk Assessment — HCPC: H1000

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Prenatal Care At-Risk Assessment: Administration and interpretation of health risk assessment instrument to be used for a prenatal depression screening if the customer is pregnant.

Staff Qualifications: Prenatal Care At-Risk Assessment must be delivered by an LPHA.

Medical Necessity: Service is deemed to be medically necessary upon clinical judgement of the LPHA.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

208.3.18 FSP: Application Assistance — HCPC: G9012

Service Type: ☐ Medicaid ☒ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Application Assistance: The service of Application Assistance includes the completion of the Family Support Program Application as well as the compiling and submission of all the necessary documentation, in conjunction with the family and/or youth, to determine the youth's clinical eligibility for the Family Support Program (FSP).

Staff Qualifications: Application Assistance must be delivered by staff who minimally meet the qualifications of an MHP.

Service Approval: The service is only approved for youth who are not enrolled in one of the full benefit healthcare programs administered by HFS and who require assistance in the completion of an FSP application for the purposes of determining FSP eligibility. If the youth is enrolled in a full benefit healthcare program, the appropriate case management service should be used for billing this service.

Usage of Pseudo RIN: HFS has established a unique nine-digit pseudo-RIN to be used for billing this service. This service should only be billed for non-Medicaid customers, consistent with HFS policy. The pseudo-RIN for FSP Application Assistance is detailed in the table below:

RIN	First Name	Last Name	DOB	Program Usage/Description
212771711	ICG	Application	4/21/2000	ICG Application Assistance

Registration Number: Providers must enter a youth-specific identifying registration number into the Patient Control Number field (Loop 2300) on the claim for this service. The registration number consists of the youth's name – first initial of the first name and up to 11 characters of the last name and date of birth. The entry should not exceed 20 characters in total and must be alpha and numeric characters, consistent with the following example:

FSP Applicant Youth Name:	John Smith
FSP Applicant Youth Date of Birth:	9/8/2005
FSP Application Assistance Registration No.:	09082005JSMITH

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Service Limitation: 8 units per unique application.

208.3.19 FSP: Case Participation — HCPC: T1016

Service Type: ☐ Medicaid ☒ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Case Participation: The service of Case Participation includes the FSP Coordinator's participation in individual customer-specific case meetings to discuss case or clinical issues,

with or without the customer present, and should only be utilized when the Medicaid eligible Targeted Case Management service codes are not appropriate for the service.

Staff Qualifications: Case Participation must be delivered by staff who minimally meet the qualifications of an MHP.

Service Approval: The service is only approved for youth who are FSP eligible, not enrolled in one of the full benefit healthcare programs administered by HFS, and who requires case coordination services.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

208.3.20 FSP: Family Support Services HCPC: T1999

Service Type: ☐ Medicaid ☒ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Family Support Services: Family Support Services includes funding for the Department's provider of FSP services for activities that are intended to promote stabilization in the community and support the goals of the treatment plan.

Prior Authorization: Prior authorization is required for all Family Support Services. See FSP Program guidance regarding Family Support Services. The prior authorization number must be entered into the PA field (Loop 2400) on the claim.

Annual Family Support Services Reimbursement Limit: $1500 per eligible FSP youth per State Fiscal Year.

208.3.21 FSP: Therapeutic Support Services HCPC: H0046

Service Type: ☐ Medicaid ☒ FSP/SFSP **Eligible Providers:** ☒ CMHC ☒ BHC ☐ IP

Therapeutic Support Services: Therapeutic Support Services includes funding to the Department's provider of FSP services for time-limited, therapeutic intervention targeted to support and stabilize a child/youth in their home or home-like setting. This service is designed to support the child/youth and family in implementing therapeutic interventions, skills development, and behavioral techniques that are focused on symptom reduction.

Prior Authorization: Prior authorization is required for all Therapeutic Support Services. See FSP Program guidance regarding Therapeutic Support Services. The prior authorization number must be entered into the PA field (Loop 2400) on the claim.

Annual Family Support Services Reimbursement Limit: $3000 per eligible FSP youth per State Fiscal Year.

208.4 Group C Services

Group C services may be provided by CMHCs (Provider Type 036).

208.4.1 Telepsychiatry: Originating Site — HCPC: Q3014

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☐ BHC ☐ IP

Telepsychiatry: Originating Site: The use of a telecommunication system to provide medical services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications. The Originating Site is the site where the customer is located.

Staff Qualifications: Telepsychiatry: Originating Site must be delivered by staff who minimally meet the qualifications of an MHP.

Medical Necessity: Used in conjunction with a standard CPT code and appropriate telehealth modifier billed by the distant site provider; medical necessity for service predicated upon the CPT/modifier determination.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual

208.4.2 Assertive Community Treatment — HCPC: H0039

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☐ BHC ☐ IP

Assertive Community Treatment (ACT): ACT is the integration of crisis intervention, treatment services and rehabilitative supports focused on skill building and stabilization to promote and maintain community living. ACT services are available to the customer 24 hours a day, every day of year, are provided by a multidisciplinary team under the direction of an allowable team lead as detailed in 89 IL Admin. Code 140.453(d)(4)(A)(iv), and include the following: 1) all MRO-MH services that an MHP-level staff member can provide, 2) all MRO crisis services, 3) all MRO-MH medication services, and 4) all Case Management services. Services that require a Subspecialty Authorization within IMPACT, unless authorized above, are excluded.

Staff Qualifications: ACT services are to be delivered by one or multiple members of a multidisciplinary team. Requirements for ACT team member qualifications are outlined in 89 Ill. Admin. Code 140.Table N.

Medical Necessity: For customers age 18 and older, an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of Assertive Community Treatment.

Prior Authorization Requirements: Pursuant to Title 89 Ill. Adm. Code, Sections 140.40 and 140.453(d)(4)(A)(iii), ACT may be subject to Prior Authorization as established by HFS, or under the authority and approval of HFS.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual and group.

Billing Guidance: Claims for ACT services must record the appropriate staffing level for each service provided consistent with Section 207.3.8.

208.4.3 Psychosocial Rehabilitation HCPC: H2017

Service Type: ☒ Medicaid ☐ FSP/SFSP **Eligible Providers:** ☒ CMHC ☐ BHC ☐ IP

Psychosocial Rehabilitation (PSR): The service of PSR is provided under the direction of a full-time QMHP who engages in direct provision of services, and includes cognitive-behavioral interventions, development of problem-solving skills, interventions to reduce or ameliorate symptoms of a co-occurring disorder and other interventions provided through individual and group sessions delivered on-site via organized programming and active treatment. The focus of treatment interventions includes capacity building to facilitate stability, adaptation, problem solving, coping skills, and independent living when age appropriate.

Staff Qualifications: PSR services must be delivered by staff who minimally meet the qualifications of an RSA.

Medical Necessity: Medical Necessity for this service is established by an IATP completed within the last 180 days, reviewed and signed by an LPHA, identifying a clinical need for services and a treatment recommendation of PSR services.

Prior Authorization Requirements: Pursuant to Title 89 Ill. Adm. Code, Sections 140.40 and 140.453(d)(3)(F)(ii), PSR may be subject to Prior Authorization as established by HFS, or under the authority and approval of HFS.

Allowable Service Delivery Modes: Face-to-face

Allowable Service Delivery Types: Individual and group.

Limitations on Place of Service: PSR services may only be provided on-site at a CMHC.

Questions regarding the policies or service requirements outlined within this Handbook may be directed to the Bureau of Behavioral Health at 217-557-1000 or HFS.BBH@illinois.gov.

Appendix A

Guidance for Documenting Medical Necessity of MRO-MH and TCM Services

Category	Services	Requirements for Documenting Medical Necessity
Screening, Assessment, and Brief Intervention Services	IATP, IATP: LPHA Review, 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	A service note supporting the time billed that includes a brief justification for the medical necessity of the service.
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) or the Risk Behaviors domain (IM+CANS Section 4a). **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), Violence Prevention Community Support Team (VP-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: *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) or the Risk Behaviors domain (IM+CANS Section 4a).

		Note: It is acceptable and anticipated that the Behavioral/Emotional Needs and/or Risk Behaviors 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.