



MEDICAID CBS SERVICE COMPLIANCE OVERVIEW

APRIL 2022

HOUSEKEEPING

- Phone lines are in listen only mode.
- Please submit any questions through the chat function. Questions will be addressed at the end of the presentation.
- A copy of the slide deck and a recorded version of the webinar will be posted to the HFS website.
- Questions and answers will be added to a future update of the CBS FAQ.



AGENDA

- Acronyms
- Medicaid Payment Basics
- Historical Perspective
- Overview of the changes to Rule 132/Rule 140
- Key Players and their Role in the Medicaid CBS System
- Audit and Record Requirement Basics
- Guidance on Documentation
- Resources

ACRONYMS

BALC	Bureau of Accreditation, Licensure and Certification
BHC	Behavioral Health Clinic
CBS	Community-based behavioral health services
CMHC	Community Mental Health Center
DCFS	Department of Children and Family Services
DHS-DMH	Department of Human Services, Division of Mental Health
FFS	Fee for service
HFS	Department of Healthcare and Family Services
IMPACT	Illinois Medicaid Provider Advanced Cloud Technology
IATP	Integrated Assessment and Treatment Plan
IM+CANS	Illinois Medicaid Comprehensive Assessment of Needs and Strengths
IP	Independent Practitioner
IPI	Infant Parent Institute
MCO	Managed Care Organization
PPR	Post payment review
SASS	Screening, Assessment and Support Services
TPL	Third Party Liability

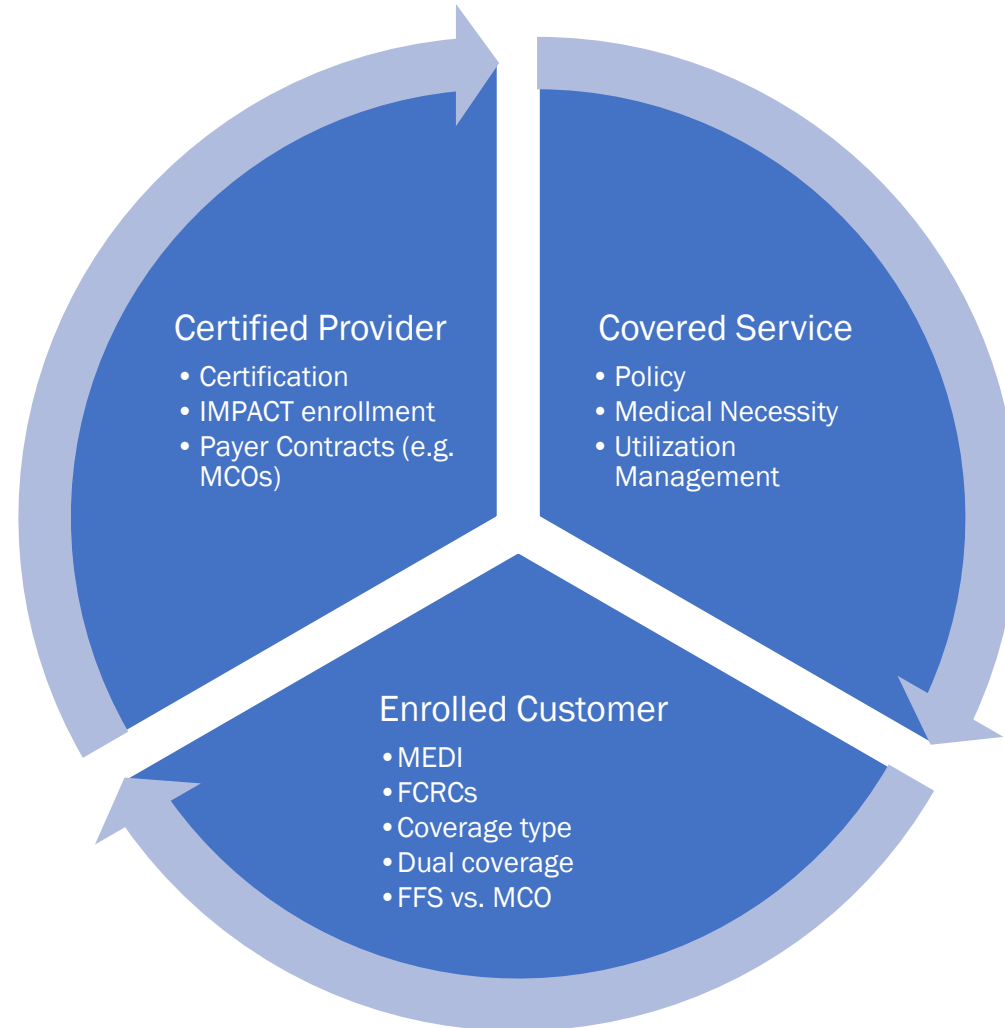
MEDICAID PAYMENT BASICS

For Medicaid to pay a claim, there must be:

1. A **covered service**,
2. Provided to an **enrolled customer**,
3. By a **certified provider**.

If any one of these is missing on the date of service, Medicaid will not pay.

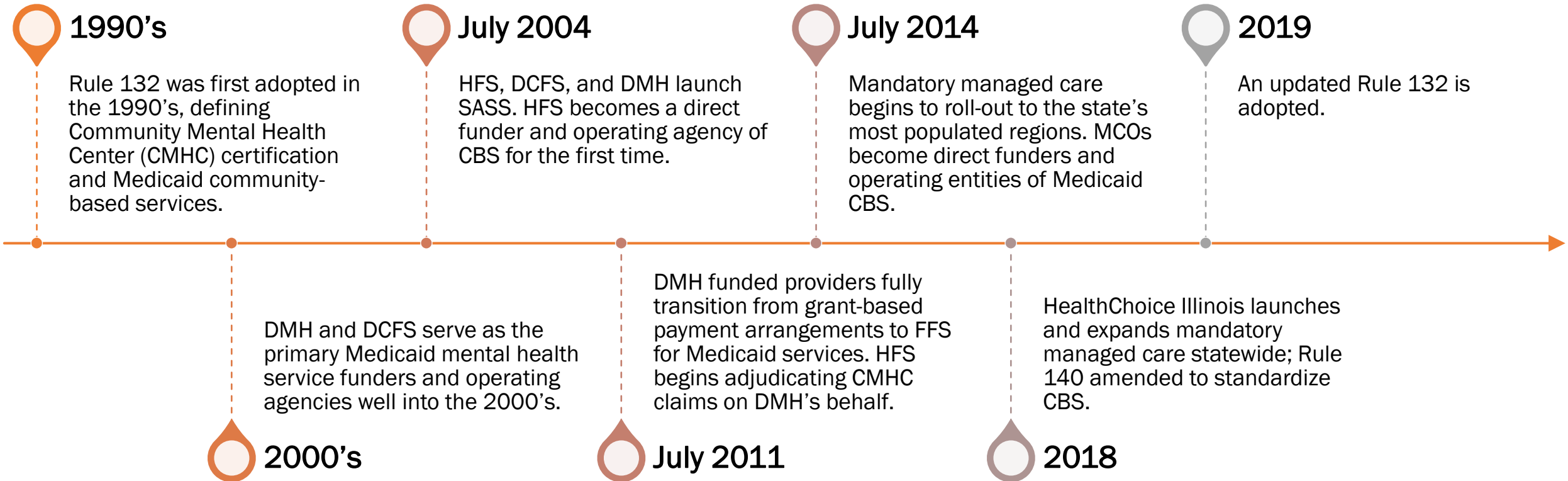
When we think about Medicaid compliance, we are often referring to some aspect related to one of these three fundamental components.



RULE 140

- [89 Ill. Admin. Code 140](#)
- Rule 140 is the broad administrative rule governing most aspects of the Illinois Medical Assistance Programs, including:
 - Who can provide services,
 - What services are covered, and
 - How they will be paid.
- Rule 140 sets the requirements (e.g. record requirements, audits, provider enrollment, payment of claims) that every provider must adhere to as condition of participation in the Medicaid program.
- Rule 140, Section 453 (140.453) is where CBS services are defined.
- Rule 140, Table N outlines additional requirements for providers seeking program approval to deliver certain intensive/team-based CBS services.

HISTORICAL PERSPECTIVE



SO, WHAT CHANGED?

- The amendments to Rule 132 and Rule 140 in 2018/2019 significantly changed the regulatory landscape for Medicaid community-based behavioral health.
- CMHC certification and CBS service definitions were split:
 - Rule 132 maintains the requirements and process for organizations to be certified as a CMHC.
 - Rule 140 (Section 453) maintains the CBS service definitions and staff qualifications.
- BHCs (140.499 and 140.Table O) introduced as a new Medicaid provider type qualified to deliver most CBS services.
- Certain Independent Practitioners (IPs) became eligible for reimbursement of a subset of CBS services.
- Program approvals for the delivery of certain CBS services introduced (140.Table N).

WHAT HAVE THESE CHANGES MEANT FOR PROVIDERS?

- Both Rule 132 and Rule 140 updates significantly streamlined requirements, reducing administrative overhead for providers.
- CMHC certification requirements and processes streamlined.
- CBS service definitions were streamlined and brought in line with the Medicaid State Plan.
- BHCs provide additional options for smaller organizations, satellite offices, and providers delivering a specialized set of services to participate in the Medicaid program, expanding access to services for more customers.
- Post-payment reviews (PPR) are no longer specifically defined for CMHCs above and beyond audit requirements for other Medicaid providers.

KEY PLAYERS WITHIN THE MEDICAID CBS SYSTEM

HFS	DHS-DMH	DCFS	MCOs
<ul style="list-style-type: none"> • IL Medicaid Authority • Administers and oversees Medical Assistance Programs, including MCOs • Maintains Rule 140, the CBS Handbook and fee schedule • Enrolls Medicaid providers via IMPACT • Certifies BHCs (OMI) • Conducts CBS Program Approvals (OMI) • Funder of FFS CMHC claims for SASS, BHCs, and IPs • Adjudicates DMH-funded CMHC claims 	<ul style="list-style-type: none"> • IL Mental Health Authority • Issues and administers the MH Block Grant and other grants to establish a continuum of mental health services in the state • Maintains Rule 132 • Certifying body for CMHCs (BALC) • Funder of FFS CMHC services 	<ul style="list-style-type: none"> • IL Child Welfare Authority • Establishes state-funded or IV-E funded contracts for additional MH services, child welfare supports, and residential treatment • Certifying body for CMHCs (IPI) 	<ul style="list-style-type: none"> • Organizations contracted with HFS to administer the Medicaid benefit to enrollees • Establishes a Provider Network via contracts of enrolled Medicaid providers • Provide care coordination to high-risk and special population enrollees • Largest funder of Medicaid CBS services

HFS RECORD REQUIREMENTS

- Record requirements, including documentation required for certain services, used to be defined in Rule 132.
- Documentation requirements for CBS services were streamlined in the updates to both Rule 132 and Rule 140.
- Record requirements for CBS services are now defined in HFS policy:
 - [89 Ill. Adm. Code 140.28](#)
 - [HFS Handbook for Providers of Medical Services, General Policies and Procedures](#) (Chapter 100, Section 110)
 - [Handbook for Providers of Community-Based Behavioral Services](#) (CBS Handbook)
 - [Community-Based Behavioral Services Frequently Asked Questions](#) (CBS FAQ)

AUDITS

- [89 Ill. Adm. Code 140.30](#)
- In the context of Medicaid, an audit refers to ensuring provider reimbursement was appropriate (Medicaid basics). Audits may occur as a result of standard program oversight or due to suspected fraud, waste, and abuse.
- May include pre or post payment reviews of services.
- The payer of services, HFS, and the federal government all have a right to audit Medicaid payments made to a provider.
- Things that are NOT a Medicaid audit:
 - CMHC/BHC certification reviews;
 - HFS Program Approvals;
 - Accreditation reviews;
 - Contract or program monitoring and compliance activities.

WHAT'S NEEDED FOR AN AUDIT?

- During an audit, a reviewer needs to be able to see sufficient documentation to reasonably conclude that services:
 - Were actually provided;
 - Were provided at the level billed;
 - Were delivered consistent with applicable policy; and,
 - Were medically necessary.
- It is the responsibility of the provider to maintain sufficient documentation to support payment for the services billed. This should include:
 - Personnel records for staff rendering services;
 - A signed service note (amount, duration, scope);
 - Completed copies of the customer's IATP or other medical necessity documentation consistent with HFS policy
- Any audit on a Medicaid funded service must be conducted in line with policies applicable to the service as defined and interpreted by HFS.

COMPONENTS OF A SERVICE NOTE

1. Date;
2. Service name;
3. Start and end time;
4. Mode of service delivery;
5. Participants;
6. Location;
7. Description of treatment or interventions;
8. Description of the customer's response to treatment and any clinical observations;
9. Signature of the rendering staff including date signed and staff's credentials;
10. If the service note is establishing medical necessity consistent with guidance in the CBS FAQ, appropriate medical necessity details must also be documented.

DOCUMENTATION OF MEDICAL NECESSITY

- Medical necessity for CBS services is defined in Rule 140 and further detailed in the CBS Handbook.
- Generally, CBS services are medically necessary when:
 - 1) Recommended by an LPHA through the completion of an IATP or as otherwise specified in the CBS Handbook;
 - 2) Provided to a customer for the maximum reduction of mental disability; and
 - 3) Provided to a customer for restoration to their best possible functioning level.
- Providers must maintain records documenting the medical necessity of each service billed.
- The CBS FAQ dated 2/17/22 provides guidance for documenting medical necessity for Medicaid CBS services.

IM+CANS DOCUMENTATION

- The Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) serves as the HFS-approved instrument used in the delivery of IATP services.
- Medical necessity for most CBS services requires that a completed IM+CANS, completed or reviewed and authorized by an LPHA, identifies a need and recommendation for services.
- To be considered complete, an IM+CANS must minimally have:
 - A completed Section 1, General Information;
 - Documentation of medical necessity (see guidance in the CBS FAQ); and
 - Signature of the authorizing LPHA, including date signed.
- The LPHA signature establishes medical necessity for recommended services for 180-days.
- A reassessment of the IM+CANS must be completed every 180-days to reestablish medical necessity, meaning an LPHA has reviewed all documented information on the IM+CANS, ensuring all updated clinical information has been considered in the development of the treatment plan and recommended services (i.e., the golden thread).

DEMONSTRATING MEDICAL NECESSITY ON THE IM+CANS

To establish medical necessity for most CBS services a customer's IM+CANS must document the following:

- 1) A behavioral health need (multiple needs for team-based and day treatment services);
- 2) A life functioning need (multiple needs for team-based and day treatment services);
- 3) Brief narrative information in the appropriate Supporting Information section;
- 4) A behavioral health diagnosis;
- 5) A completed Mental Health Assessment summary;
- 6) At least 1 goal and 1 treatment objective;
- 7) A recommendation for services tied to a documented treatment objective; and,
- 8) Signature and date by the authorizing LPHA.

*Medical necessity documentation guidance specific to individual CBS services can be found in the CBS FAQ.

COMPLIANCE QUALITY

- Understanding policy changes and expectations is just one piece of the puzzle as we collectively work to improve the lives of Illinois children and adults with behavioral health needs.
- Training, coaching, and technical assistance on the appropriate usage of the IM+CANS and on incorporating the principles of collaborative-based assessment and care is available through the Provider Assistance and Training Hub (PATH) at the University of Illinois' School of Social Work.
- Be on the lookout for more training and educational opportunities from HFS and PATH!

RESOURCES

- [HFS Provider Notices](#)
- [HFS Provider Handbooks](#)
- [IMPACT](#)
- [CBS Fee Schedule](#)
- [Rule 132](#)
- [Rule 140](#)
- [CBS Services FAQ](#)
- [Provider Assistance and Training Hub \(PATH\)](#)
- [IM+CANS Workgroup Information](#)

THANK YOU!

HFS.BHCOMPLIANCE@ILLINOIS.GOV