

ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

FY15 POST-PAYMENT REVIEW TOOL

A. PROVIDER NAME:		B. REVIEW DATE: Dates of on-site review
PROVIDER #: Collaborative provider/NPI		
C. Time Period Covered: Date span for bills reviewed. All claims reviewed will have been processed and approved by HFS. If the provider was not reviewed in FY14, the claim review period is the 12 month period prior to the claim run being developed. If the provider was reviewed in FY14, the claim review period begins 9-12 months from the last review (up to the date the claim run is developed).		
CONTRACT AND RULE COMPLIANCE		
Reason Codes:		
1	No valid note documenting the service could be located.	
2	Note describes a service intervention or activity that is not billable.	
3	Service provided by unqualified staff.	
4	No amount of time documented.	
5	No valid Mental Health Assessment could be located.	Date:
6	No valid Individual Treatment Plan could be located.	Date:
7	Specific service does not appear on ITP.	
8	ITP review does not demonstrate both a review of progress towards goals and an evaluation of needed services. <i>No ITP review is required for this claim.</i>	
9	Time billed is greater than time documented.	
10	Location of service not correctly noted on-site vs. off-site.	
11	Note describes a different service than billing submitted.	
COMMENTS:		
Reviewer comments of any other positives or concerns identified during the review		

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	Quality Indicators	Yes / No
A.	Documentation is sufficiently detailed corresponding to time billed.	
B.	MHA contains sufficiently detailed information to guide clinical treatment.	
	COMMENTS: Reviewer comments of any other positives or concerns identified during the review.	

Reviewer: _____

Date_____

Reviewer: _____

Date_____

Results verbally reviewed with provider and copy of summary provided to:

Name: _____

Date_____

Signature of Provider Representative

A copy of this summary document is left with the Provider.