

**External Protocols for**

**FY17 Provider Monitoring**

**Scheduling of Reviews**

Post Payment Review (PPR) will be conducted at all community mental health providers who 1) scored below 90% on FY16 PPR and 2) those not reviewed in FY16. Clinical Practice and Guidance (CPG) reviews will be performed by the Collaborative in FY17 only for community mental health providers that receive a PPR. If a provider who receives a PPR scored above 4.0 on CPG reviews in FY16, a CPG will not be required.

Each type of review is a separate review with separate reports and scores. Provider monitoring reviews will not be coordinated with Bureau of Accreditation, Licensure and Certification (BALC) certification reviews. The Collaborative Director of Quality Management is responsible for developing the confidential review schedule which is distributed to DHS/DMH staff and Collaborative staff by the Collaborative Training Coordinator.

The review schedule is very tight and it is not possible to change scheduled review dates, with the only exception being an emergency or unusual situation. Providers may contact the Collaborative Director of Quality Management to discuss the situation. If something comes up after the review has been scheduled that would significantly affect the ability to conduct the review, the Collaborative Quality Management Director must be notified. It will be the responsibility of this person to make the final decision as to whether or not the scheduled review dates will be changed and to notify the Regional Liaison Supervisor, the assigned Regional Liaisons, the DHS/DMH Regional Staff and Management Operations Analyst if a change occurs.

**Provider Notification**

As a courtesy, providers will receive a notification call from the Collaborative Training Coordinator seven calendar days in advance of the scheduled review. Information pertaining to the upcoming review will be related verbally at this time. The Training Coordinator will gather information about the provider for the Regional Liaisons and answer provider questions. Following the phone contact, providers will receive a secure email from the Collaborative Training Coordinator containing a list of consumer names and associated RINs for the records which will be reviewed. In the rare instance that a provider’s review date is postponed and the provider has already been sent a Consumer Name and RIN list, a new list will be developed following established protocols prior to the actual date of the review. As providers are given advance notice of the PPR, the expectation is that all information needed by reviewers will be in consumer records and easily accessible at the time of the review.

**Provider Monitoring Tools**

Provider monitoring tools and ancillary documents are located on the IL Mental Health Collaborative for Access and Choice website. The link to this website is: [www.illinoismentalhealthcollaborative.com](http://www.illinoismentalhealthcollaborative.com) (then “Provider Information”, then “FY17 Provider Monitoring Tools”).

1. Post-Payment Review (PPR) Tool:

Provider clinical documentation for a sample of claims approved for payment is reviewed according to a set tool.  This tool covers aspects of compliance with 59 Ill. Adm. Code 132.

1. Clinical Practice and Guidance (CPG) Tool:

The purpose of this tool is to measure adherence to clinical standards and assess quality items through the provider agency’s clinical documentation and practices. This includes a determination of whether or not there is a clear and consistent inter-connection among the diagnosis, assessed needs, ITP provisions, and actual services and interventions delivered.

**Sampling Methodology and Claim Review Period**

1. Post Payment Review

In order to establish a sampling methodology for PPR for FY17, the Collaborative was given the following guidelines from DHS/DMH: The sampling methodology selected must be reflective of the volume of claims each provider has submitted during the specific identified claim period rather than a flat number of claims per provider. The claim run will only include processed and approved claims.

Based upon these guidelines, the Collaborative will utilize the following sampling methodology for FY17: The claim period will vary from provider to provider: For providers who received a PPR in FY16, the claim period will begin sixty (60) days after their FY16 PPR and end with the date the claim run is developed. For providers who did not receive a PPR in FY16, the claim period will begin twelve (12) months prior to the date the claim run is developed and ends with the date the claim run is developed.

* A random sample of all HFS adjudicated claims per specified provider will be selected for post-payment review using the sample calculator within HHS OIG RAT-STATS, 2010 Software to reach a 90% confidence level with a 16% desired precision range (margin of error +/- 8%).
* To guarantee the 16% desired precision range, an anticipated rate of occurrence of 50% will be used when calculating the number of claims to be reviewed per provider.

* The number of claims each provider submitted during the provider’s identified unique claim period (universe size) will be determined using Beacon Health Options’ IntelligenceConnect reporting system.
* Once the sample size has been determined using HHS OIG RAT-STATS, 2010 Software, a provider specific claim run will be developed using the Beacon Health Options’ IntelligenceConnect reporting application.
* New Providers must have submitted 50 or more claims in order to have a PPR. Providers who have not submitted 50 or more claims in two consecutive claim runs will be referred to DMH for determination of needed reviews. The same federal HHS OIG RAT STATS sampling technique will be utilized.
* Claim runs will be developed for each provider approximately two (2) weeks prior to the scheduled review by the Collaborative Training Coordinator.

1. Clinical Practice and Guidance (CPG) Sampling

For each CPG review conducted, ten Medicaid records will be randomly selected from the overall PPR claim run using the statistical tool, Random.org. In the event that the provider’s claim run consists of fewer than ten (10) consumer records, a CPG review will be conducted on all records on the claim run.

**Policy Pertaining to Conflict of Interest**

The Collaborative has a Conflict of Interest policy in place which prevents Collaborative staff from participating in the monitoring of providers for which the staff person has other vested interests or potential conflicts with the provider.

The Collaborative Regional Liaison Supervisor maintains an updated list of providers who would pose a conflict of interest situation for specific Collaborative staff. The Director of Quality Management is responsible for ensuring compliance with this policy, making any adjustments to it and is the final authority in determining whether or not a conflict of interest exists.

**Policy Pertaining to Handling Problem Situations While at the Provider Site**

In the event that a Regional Liaison encounters a problem situation while at the provider site, he/she is to contact the Collaborative Regional Liaison Supervisor who will also notify DHS/DMH Central Office and the Collaborative Director of Quality Management.

**Reviewers’ Guidelines While On-site**

Reviewers will:

1. Arrange (lead will facilitate) a meeting place and time with other team members and enter the provider site together as a group.
2. Carry identification at all times.
3. Maintain the confidentiality of all consumer health care information and provider records, including not leaving consumer or provider records unattended, and ensuring and documenting the return of all records to the provider prior to departure.
4. Document all data on Collaborative forms and/or database.
5. Ensure that handwriting is legible and written in ink when data documentation is done manually.
6. Regional Liaisons document findings on worksheets that are generated through the FY17 Provider Monitoring Access Database. For PPR, there is one worksheet per claim/record being reviewed. Dates of the ITP and MHA that were reviewed specific to the claim will have the date of the LPHA signature recorded on the worksheet. Regional Liaisons are to designate whether the ITP and MHA were initial documents or update/reviews. If the ITP that was in effect at the time of the claim is an initial ITP, PPR Tool item #8 is marked as “N/A”. Regional Liaisons are to note on the worksheet any addendums related to documents that were reviewed. CPG worksheets are used to record information during those reviews.
7. Be responsible for ongoing quality assurance throughout the review, e.g. ensuring that data is being recorded on the most recent and correct document and that reports contain accurate information.
8. Report all mandated abuse and/or neglect allegations immediately to appropriate provider staff, which are then required to file a report with Office of Inspector General, the DCFS Hotline or Department of Aging in conjunction with the Regional Liaison. The Regional Liaison Supervisor needs to be contacted immediately, who will then immediately notify the DHS/DMH Central Office and the Director of Quality Management. If the provider refuses to file a report, the Regional Liaison is required to do so.
9. In the event that Collaborative staff discover potential risk(s) to the immediate life safety of a consumer during the course of a provider monitoring review, Collaborative staff will inform the provider contact of their concerns and relate that as managing the situation is outside of the Collaborative’s authority, the Collaborative staff will be immediately informing the appropriate DHS/DMH regional staff. Collaborative staff will then immediately notify the appropriate DHS/DMH Regional staff. DHS/DMH will then take appropriate steps to mitigate the risk. Following this notification to DHS/DMH, Collaborative staff are to inform the Regional Liaison Supervisor, who will then notify the Quality Management Director and DHS/DMH Central Office.
10. Turn cell phones to mute or vibrate throughout the course of the review. All necessary phone calls must be conducted in a private area away from the review area.
11. Present a professional appearance, attire, and demeanor.
12. Ensure that the least amount of disruption to the provider and the provider’s services occurs throughout the course of the review.

## **Entrance Conference**

Upon arrival at the site:

* The Lead Regional Liaison will identify him/herself to the provider receptionist and ask to speak with the provider contact person.
* The review team will conduct an Entrance Conference with the provider contact person, Program or Clinical Director, and other staff the provider deems important.
* During this conference the review team will utilize the designated Talking Points.

# Final Day

The provider will be given, at minimum, two hours’ notice in order to allow the provider time to notify staff and adjust schedules, if necessary. Review team members will take time prior to the Exit Conference to confer about the findings of the reviews. The Lead Collaborative Regional Liaison will contact the provider’s DHS/DMH Regional staff to inform them of any identified issues/significant findings and to invite them to the Exit Conference.

The Lead Collaborative Regional Liaison is responsible for entering data regarding the reviews, printing the reports and providing the DHS/DMH Regional staff with a copy of the reports prior to the Exit Conference when possible, or upon availability of encrypted e-mail.

In the event that there are significant findings, the Lead Collaborative Regional Liaison will brief the designated provider contact, and if possible, the CEO in advance of the Exit Conference to ensure their understanding. Regional Liaisons will notify the provider contact of missing documents during the course of the review and ask him/her to locate them to ensure all needed documents were assessed during the review. It will be noted on the worksheet if the claim/record had missing documents that needed to be located and the name of the staff person involved in the discussion of missing records. In order to ensure that the review team can complete the assessment in a timely manner, the lead Regional Liaison will give the provider contact a final time that documents can be submitted. .No documents will be allowed to be submitted to the review team following the specified time. As providers are given advance notice of the PPR, the expectation is that all information needed by reviewers will be in consumer records and easily accessible at the time of the review.

# Exit Conference

At the time designated for the Exit Conference, the lead Regional Liaison will utilize the Exit Conference Talking Points.

* All review reports must be signed by the entire review team and the provider. The original signed reports will be returned to the Springfield Collaborative office by the lead Regional Liaison and placed in the provider file. The lead Regional Liaison will leave a copy of all reports with the provider.
* Explain to the provider that a copy of the reports will be forwarded to DHS/DMH for review and that the assigned DHS/DMH Regional staff will be following up with the provider on any required Plans of Improvement (POI). The Collaborative will maintain the confidentiality of the review contents.
* Return all provider materials and have the provider sign off that all provider records were returned to provider at the conclusion of the review.
* Distribute the Provider Monitoring Review Questionnaire and stamped envelope to the provider contact person. This is a survey where providers can give their feedback on the process. Envelopes will be addressed to DHS/DMH who will collect and analyze the data.

**Transportation of Confidential Records**

All Regional Liaisons must comply with the Beacon Health Options policy: CO 403.1 - Physical and Electronic Security of Personally Identifiable Information, revised 10/7/15.

**PPR Formal Notification to** **Providers Scoring 50% and Above**

Providers will continue to receive results of the PPR at the Exit Conference. Providers scoring 50% and above will receive a letter by email within 30 days of the PPR entitled: *Notice of Unsubstantiated Billing*. This email will also include PPR reports which include protected information. As a result, this email notification will be sent encrypted. This *Notice* is sent to the provider’s CEO and one other provider contact person of the provider’s choosing. The Collaborative Training Coordinator will obtain the name of this second person when the provider notification call is made prior to the review. In addition, the DHS/DMH Regional staff and Central office staff are also copied on this email. The Collaborative will track receipt of the *Notice* through the Outlook “read receipt” function. In the event that the Collaborative does not receive a return read receipt by the third day after it was sent, the Collaborative Training Coordinator will notify DHS/DMH Central Office and appropriate DHS/DMH Regional staff for follow-up. The Collaborative prepares and sends this email *Notice* to providers as an administrative support function for DHS/DMH.

**PPR Follow-Up with Providers Scoring 50% and Above**

Providers are required to submit a PPR POI to their DHS/DMH Regional staff within 30 days of the PPR if established thresholds are not met for each of the eleven items of the PPR Tool. Thresholds for items 1: valid note, 5: valid MHA, and 6: valid ITP are set at 90%. Thresholds for items 2 – 4 and 7-11 are set at 80%. In addition to thresholds for specific PPR Tool items, a threshold of 70% has been established for the total PPR substantiated score.

The purpose of the POI is to document the steps the provider has taken to correct all issues identified during the recent PPR that resulted in scores below threshold. DHS/DMH Regional staff are responsible for approving and monitoring compliance of the POI. Additional follow up, including a return review may be enacted if a provider has a significantly low overall score. Providers are asked to send a courtesy copy of the POI to the Collaborative. Providers have the option of using their own format for the POI report if all of the specified elements on the DMH POI template are addressed or using the DHS/DMH template that is sent along with the *Notice.* The POI template can also be found on the IL Mental Health Collaborative website along with the FY17 provider monitoring tools.

**PPR Formal Notification to Providers Scoring Below 50%**

Following notification that a provider scored below 50%, the Director of Quality Management will have a discussion with DHS/DMH Central Office to decide which type of follow-up review will occur. The joint decision will be based upon whether it was one or two specific issues that are easily correctible and can easily be assessed by a desk audit or if wide spread issues were identified that would require looking at the clinical record in greater detail.

DHS/DMH Central Office sends the provider a *Notice of Unsubstantiated Billings/Notice of Suspension from Billing* (one letter) within 30 days of the PPR. This *Notice* relates important information regarding findings, voiding unsubstantiated claims, how to file an appeal, steps needed to be lifted from suspension, required timelines and whether the follow-up review will take place by desk audit or return visit and should be read carefully. Questions regarding this Notice should be directed to DHS/DMH Regional staff.

Copies of this *Notice* are sent via email to the Collaborative Quality Management Director, the DHS/DMH Associate Director Region Services, DHS/DMH Regional Director, DHS/DMH Regional staff, DHS/DMH Provider Access Specialist, DCFS, and HFS.

The provider immediately stops transmitting billing to HFS upon being informed to do so by Collaborative Regional Liaisons at the provider monitoring Exit Conference.

As required by 59 Ill. Admin. Code pt. 132, the Provider submits a POI to the DHS/DMH Regional staff within 30 days of the Notice of Suspension from Billing. Of the eleven (11) items on the PPR Tool, thresholds for items 1: valid note, 5: valid MHA, and 6: valid ITP are set at 90%. Thresholds for items 2 – 4 and 7-11 are set at 80%. In addition to thresholds for specific PPR Tool items, a threshold of 70% has been established for the total PPR substantiated score. The POI needs to address all areas that were below threshold on the PPR. The provider is asked to send a courtesy copy of the POI to the Collaborative. Providers have the option of using their own format for the POI report if all of the specified elements on the DMH POI template are addressed or using the DHS/DMH template that is sent along with the *Notice.* The POI template can also be found on the IL Mental Health Collaborative website along with the FY17 provider monitoring tools.

The DHS/DMH Regional staff reviews the POI and either approves it as submitted or works with the provider until it is approved. It is the responsibility of the DHS/DMH Regional staff to monitor compliance and progress of the POI.

After the DHS/DMH Regional staff has approved the POI, and the provider believes that they have implemented the POI sufficiently for a follow-up review, the **provider must notify the Collaborative, in writing**, they are ready for the follow-up review as specified by 59 Ill. Adm. Code pt. 132.  If preferred, written notification may also be sent by electronic mail to:

[QualityMgmtDept@beaconhealthoptions.com](mailto:QualityMgmtDept@beaconhealthoptions.com).

The **provider must follow the direction provided in the *Notice******of Unsubstantiated Billings/Notice of Suspension from Billing*** letter regarding whether or not additional items must be sent in along with the written notification. The mailing address for the Collaborative can be found in the *Notice* letter that was sent to the provider. If a provider chooses to send notification and clinical records to the Quality Management mailbox, the email must be encrypted.

**Desk Audit as Follow-up Review**

* The *Notice of Suspension from Billing* letter specified that the follow-up review will be a desk audit and states that the provider must submit the following items to the Collaborative:
  + Written notification that they are ready for the follow-up review.
  + Documents that demonstrate that corrections have been made to address the items that scored below the established threshold during the recent PPR. Sample documents that can be submitted to verify that corrections have been made include, but are not limited to: staff training rosters and training agendas, examples of compliant progress notes, treatment plans and reviews, and mental health assessments dated after implementation of improvement steps, etc. Clinical records need to be actual documents, not blank templates.
* Provider submits required documents and notification to the Collaborative.
* Upon receipt of the provider’s written notification and required additional documentation, the Collaborative Director of Quality Management will send a copy of the provider’s written notification and documentation to the Collaborative Regional Liaison Supervisor, and the DHS/DMH Management Operations Analyst and the LCSW at the Central Office for review.
* Documentation is reviewed by DHS/DMH Regional and Central Office and the Collaborative Quality Management department.
* DHS/DMH and Collaborative Quality Management department staff meet with DHS/DMH Regional and Central Office staff to discuss the provider’s documentation.

**Return Visit as Follow-up Review**

* Upon receipt of the provider’s written notification, the Director of Quality Management will notify DHS/DMH Regional and Central Office staff of its receipt. The DHS/DMH Regional staff will contact the provider and arrange a date and time for the follow-up review. The DHS/DMH Regional staff will inform the provider that this visit is a focused visit, focusing on the PPR Tool items that did not meet established thresholds. It is not a second PPR.
* During this call, the DHS/DMH Regional staff will inform the provider that the provider needs to have ten (10) clinical records available for review. If there were fewer than ten (10) clinical records on the PPR claim run, the appropriate DHS/DMH Regional staff will make the decision as to how many clinical records to review during the follow-up review when coordinating for the follow-up review with the provider. The provider will select the records. These records must include documentation that demonstrates that the provider has made the necessary corrections. The DHS/DMH Regional staff person will coordinate with the Collaborative in preparation of the Follow-up review.
* Collaborative Regional Liaisons will conduct the follow-up review. DHS/DMH Regional staff may be present during the follow-up review.
* Entrance and Exit Conferences will occur during the follow-up review. Attendance sheets will be signed and collected. During the Exit Conference, the Collaborative will not leave a written report with the provider, but will give a verbal report of findings. DHS/DMH Regional staff may participate during the conferences, if they are not present during the follow-up review. Conference. Providers will be asked to sign a Return of Records form at the Exit Conference.
* Regional Liaisons will inform the provider that:
  + The Collaborative will submit information regarding the follow-up review to DHS/DMH;
  + A decision will be made as to whether or not the suspension should be lifted; and
  + The provider will receive a *Suspension Determination Notice* from DHS/DMH, along with a copy of the *Suspension of Billing* *Follow-up Review report*.
* The Collaborative submits a written report of findings to DHS/DMH Central Office. This is a narrative report, different than PPR reports left during the PPR.

**Next Steps after a Follow-up Review (applies to both desk audits and on-site follow-up reviews)**

DHS/DMH Central Office and Regional staff will discuss with the Collaborative Director of Quality Management and the Regional Liaison Supervisor whether or not the provider has made sufficient corrections and next steps.

If, during this meeting, DHS/DMH determines that **the provider has not made sufficient corrections** to have the suspension lifted, DHS/DMH Regional staff will contact the provider to arrange a date and time for a teleconference. Upon notification of this date and time, the DHS/DMH Management Operations Analyst will send a meeting invite to the provider, the DHS/DMH LCSW, Regional staff and Regional Director, the Collaborative Director of Quality Management and the Regional Liaison Supervisor. The purpose of this meeting is to discuss concerns and provide technical assistance regarding the provider’s documentation and 59 Ill. Adm. Code 132 compliance. DHS/DMH Central Office will lead this call.

* If, after this meeting, DHS/DMH determines that the provider clearly doesn’t understand and/or isn’t capable of making the needed changes, DHS/DMH Medicaid Officer at the Central Office will clearly inform the provider during this meeting that:
* The provider’s suspension from Medicaid billing will continue.
* As specified in 59 Ill. Adm. Code 132, the provider has 60 days from the date of the *Notice of Unsubstantiated Billings/Notice of Suspension from Billing* letter to make corrections. The DHS/DMH LCSW will give the provider the specific date (60-day mark) during this meeting.
* That, if corrections are not made by this date, the provider’s Medicaid certificate may be subject to revocation. The DHS/DMH LCSW will clarify for the provider that this would result in the provider not being able to provide services.
* The DHS/DMH LCSW contacts the Bureau of Accreditation, Licensure and Certification (BALC) and internal discussions would occur. The Collaborative is no longer involved at this point.

When DHS/DMH has determined that t**he provider understands the needed changes clearly and/or has made sufficient corrections** to have the suspension lifted, DHS/DMH will send a *Suspension Determination Notice* to the provider. Copies of this *Notice* will be sent to the Collaborative Quality Management Director, the DHS/DMH Associate Director Region Services, DHS/DMH Regional Director, DHS/DMH Regional staff, DHS/DMH Provider Access Specialist, DCFS (if applicable), and HFS. DHS/DMH will send the *Suspension of Billing Follow-up Review report* to the provider along with the *Suspension Determination Notice.*

When DHS/DMH is notified by DCFS that they have suspended a provider that DHS/DMH also funds, the DHS/DMH Medicaid Officer will send a letter that notifies the provider that they are also suspended from billing DHS/DMH.  When DCFS lifts the suspension, the DHS/DMH Medicaid Officer will also send a letter lifting the suspension from DHS/DMH billing and distribute copies.

In the event that the FY17 suspension is the second consecutive suspension for the provider, DHS/DMH is notified by the Collaborative and a decision will be made regarding whether or not the provider’s Medicaid certificate should be revoked.

If the decision is made to **not revoke** a provider’s Medicaid certificate:

* Provider will receive a Notice entitled *FY17 Post-Payment Review Notice of Unsubstantiated Billing/Notice of 2nd Consecutive Suspension from Billing.*
* This *Notice* will be prepared by the Collaborative as an administrative support service for DHS/DMH Central Office, who will then sign and send to the provider on DHS/DMH letterhead.
* This *Notice* will inform the provider that although their Medicaid certificate is not being revoked at this time, failure to comply with Rule 132 requirements could result in revocation at a later date. This *Notice* further informs the provider of the appeal process, and information about submitting a POI, voiding of unsubstantiated claims and the follow-up review process.
* The same process will be used for the follow-up review as is used for a provider that received their first suspension.

If the decision is made to **proceed with revocation** of the Medicaid certificate:

* Provider will receive a Notice entitled *FY17 Post-Payment Review Notice of Unsubstantiated Billing/Notice of Intent to Revoke*
* This *Notice* will be prepared by the Collaborative as an administrative support service for DHS/DMH Medicaid Officer, who will then sign and send to the provider on DHS/DMH letterhead.
* This *Notice* will inform the provider that DHS/DMH is instructing the Bureau of Accreditation, Licensure and Certification (BALC) to begin the revocation process of the provider’s Medicaid certificate. This *Notice* will also describe the appeal process, and the need to void unsubstantiated bills.
* Provider may appeal PPR findings and revocation of the Medicaid certificate. These are two separate appeals and result in different outcomes. The outcome for an appeal of PPR findings (59 Ill. Adm. Code 132.44) may result in claims that were initially disallowed becoming allowed, if the final administrative decision issued by the Director of Healthcare and Family Services is positive for the provider. The outcome for an appeal of Medicaid revocation (59 Ill. Adm. Code 132.55), may result in the provider retaining their Medicaid certificate,if the final administrative decision issued by the Director of Healthcare and Family Services is positive for the provider.

**CPG Formal Notification**

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Providers will be sent a Notification of Findings letter by email within 30 days of completion of the CPG review. This email will also include the CPG report which includes the provider’s FEIN. As a result, this email notification will be sent encrypted. This Notice is sent to the provider’s CEO and one other provider contact person of the provider’s choosing. The Collaborative Training Coordinator will obtain the name of this second person when the provider notification call is made prior to the review. In addition, the DHS/DMH Regional staff and Central office staff are also copied on this email. The Collaborative will track receipt of the Notice through the Outlook “read receipt” function. In the event that the Collaborative does not receive a return read receipt by the third day after it was sent, the Collaborative Training Coordinator will notify DHS/DMH Central Office and appropriate DHS/DMH Regional staff for follow-up. The Collaborative prepares and sends this email *Notice* to providers as an administrative support function for DHS/DMH.

**CPG Follow-up**

A formal POI is required to be submitted to the DHS/DMH Regional staff within thirty (30) days from the date on the DHS/ DMH Notification letter if established thresholds (scores of “4.0” for CPG) are not met for any items of the tools. The purpose of the POI is to document the steps the provider has taken to correct all issues identified during the recent review that resulted in a score below threshold. The DHS/DMH Regional staff is responsible for approving and monitoring compliance of the POI. Providers must submit the POI to their DHS/DMH Regional staff with a courtesy copy to the Collaborative. Providers have the option of using their own format for the POI report including all of the specified elements or using the DHS/DMH format. DHS/DMH Regional staff may request a revised plan and will monitor progress.

**Appeal Process**

Providers have the right to appeal findings of the post-payment review (PPR). For additional information regarding what an appeal entails, please review 59 Ill. Admin. Code 132.44: Appeal of Post Payment Review Findings.

Appeal hearings are formal hearings conducted in Chicago by the Department of Healthcare and Family Services with attorney representation required. The sole issue at the hearing shall be whether the Provider is in compliance with requirements set forth in 59 IL Admin. Code 132.

If, after reviewing Part 132.44, the provider would like to proceed with a formal hearing, the provider must submit the written request to Collaborative Director of Quality Management within twenty (20) days after the receipt of the *Notice*. The appeal request shall specify the grounds for the appeal.

Upon receipt of an appeal request, the Collaborative Director of Quality Management will forward all documents related to the PPR and appeal request to the Illinois Department of Healthcare and Family Services Vendor Hearings Section within five days. A copy of the appeal packet is also sent to the DHS/DMH LCSW and Management Operations Analyst for review.

An Administrative Law Judge will conduct appeal hearings. If an appeal is filed, claims do not need to be voided until the Administrative Law Judge has made a final administrative decision. The provider will be required to void unsubstantiated claims if the final administrative decision concludes that the provider is not in compliance with 59 Ill. Admin. Code 132.