**Section 132.42 Post-Payment Review**

The Public Payer may conduct post-payment reviews to determine billing amounts subject to recoupment as a result of non-compliance with this Part. The Public Payer, HFS, or their respective agents shall be granted access to all Provider sites. All records shall be made available to the Public Payer, HFS, or their respective agents, on request during any post-payment review for payment of services delivered under this Part. Access to records shall occur in accordance with the Confidentiality Act.

a) The Public Payer shall compare billed services to those listed on the Admission Note, Healthy Kids screen, MHA or ITP in effect at the time service was provided. The Public Payer will determine that a billing will be unsubstantiated for any of the following:

1) Billings for services without a completed Admission Note, Healthy Kids screen, MHA or ITP being in effect, except for mental health assessment; ITP development, review and modification; crisis intervention; case management transition linkage and aftercare; or mental health case management pursuant to Section 132.165(a)(1);

2) Billings for services that the Provider is not certified to provide;

3) Billings for services not listed on the currently effective Admission Note, Healthy Kids screen, MHA or ITP being in effect, except for mental health assessment; ITP development, review and modification; crisis intervention; case management transition linkage and aftercare; or mental health case management pursuant to Section 132.165(a)(1); or

4) Billings that do not comply with the requirements in this Part.

b) The post-payment review must verify compliance with the requirements identified in subsection (a).

c) The Public Payer will report its findings to the Provider within 30 days after the review through a Notice of Unsubstantiated Billings that will identify the billings found to not be documented in compliance with this Part and the dollar amount associated with those bills. The Notice will include:

1) The reason for the Public Payer's findings;

2) A statement of the Provider's right to request a hearing within 20 days after the date of receipt of the notice;

3) A statement of the legal authority and jurisdiction under which the hearing is to be held; and

4) The address where a request for hearing may be filed.

d) The Provider will have 30 days after the date of the Notice of Unsubstantiated Billings to submit a plan to address the compliance problems indentified during the post-payment review as required by the Public Payer.

e) The Public Payer shall verify the Provider's implementation of the plan.

f) If it is determined that less than 50% of the billings reviewed comply with requirements identified in subsection (a), the Public Payer will also submit to the Provider a Notice of Suspension from Billing along with the Notice of Unsubstantiated Billings, within 30 days after the post-payment review.

1) When a Provider receives a Notice of Suspension from Billing, the Provider will immediately stop submitting bills for Medicaid community mental health services under this Part funded by the Public Payer that notified them of the suspension.

2) The Provider will have 60 days to make corrections to its documentation processes to bring them into compliance with this Part.

3) When the Provider notifies the Public Payer in writing that it has made the necessary corrections, the Public Payer will review those corrections for compliance with this Part within 14 days after receiving the notification.

4) If compliant, the Provider will be notified that the suspension from billing has been lifted and that the Provider may resume billing.

5) Once suspension from billing is lifted, the Provider may submit bills that have the required documentation for services provided during the suspension.

6) If corrections are not made within 60 days, the Certifying State Agency may suspend the Provider's certification.

g) The Public Payer shall notify the State Medicaid Agency of the findings from all post-payment reviews.

h) The Public Payer will recover funds based upon the findings of the post-payment review. The Public Payer may use the findings of the post-payment review to extrapolate the amount of funds to be recovered from the total bills from which the sample was drawn when the sample is statistically valid.

i) The Provider may appeal the Public Payer's intent to recover funds as specified in Section 132.44.

j) If the Public Payer finds evidence of suspected Medicaid fraud or abuse, the State agency shall refer such evidence to HFS, Office of Inspector General for further action.

k) Nothing in this Section shall preclude HFS, as the State Medicaid Agency, from conducting post-payment reviews of any bill that is fully or partially reimbursed with federal funds.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)