TITLE 59: MENTAL HEALTH
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES

PART 132
MEDICAID COMMUNITY MENTAL HEALTH SERVICES PROGRAM

SUBPART A: GENERAL PROVISIONS

Section

SUBPART B: PROVIDER ADMINISTRATIVE REQUIREMENTS

Section

SUBPART C: MENTAL HEALTH SERVICES

AUTHORITY: Implementing and authorized by the Community Services Act [405 ILCS 30] and Section 15.3 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705/15.3].

SOURCE: Emergency rules adopted at 16 Ill. Reg. 211, effective December 31, 1991, for a maximum of 150 days; new rules adopted at 16 Ill. Reg. 9006, effective May 29, 1992; amended at 18 Ill. Reg. 15593, effective October 5, 1994; emergency amendment at 19 Ill. Reg. 9200, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16178, effective November 28, 1995; amended at 21 Ill. Reg. 8292, effective June 25, 1997; recodified from the Department of Mental Health and Developmental Disabilities to the Department of Human Services at 21 Ill. Reg. 9321; amended at 22 Ill. Reg. 21870, effective December 1, 1998; emergency amendment at 23 Ill. Reg. 4497, effective April 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 10205, effective August 23, 1999; amended at 24 Ill. Reg. 17737, effective November 27, 2000; amended at 26 Ill. Reg. 13213, effective August 20, 2002; amended at 28 Ill. Reg. 11723, effective August 1, 2004; amended at 31 Ill. Reg. 9097, effective July 1, 2007; emergency amendment at 31 Ill. Reg. 10159, effective July 1, 2007, for a maximum of 150 days.

SUBPART A: GENERAL PROVISIONS

Section 132.10 Purpose

a) The requirements set forth in this Part establish criteria for participation by providers in the Medicaid community mental health services program. The Medicaid community mental health services program shall include the provision of specific mental health services pursuant to this Part supported financially in whole or in part by a public payer, as defined in Section 132.25.

b) These requirements are for the purpose of assuring that clients receiving Medicaid community mental health services shall receive services in accordance with this Part and in accordance with 42 CFR 440 and 456 (2003) for Medicaid-eligible clients.

c) The Department of Human Services (DHS) and the Department of Children and Family Services (DCFS) and the Department of Corrections (DOC), pursuant to an executed interagency agreement with the Department of Healthcare and Family Services (HFS), shall use these requirements to certify, recertify, and periodically review providers participating in the Medicaid community mental health services program, including the certification and recertification of the provider's eligibility for enrollment in the Illinois medical assistance program (89 Ill. Adm. Code 140).

d) The Medicaid community mental health services program is for clients who require mental health services as indicated by a diagnosis contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (Centers for Medicare and Medicaid Services (CMMS) (2003)) or the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (1994) or DSM-IV-TR (2000) (American Psychiatric Association). This shall include services designed to benefit clients:

1) Who require an evaluation to determine the need for mental health treatment; or

2) Who are assessed to require medically necessary mental health treatment to promote growth or maintenance of age appropriate or independent role functioning; or

3) Who are experiencing a substantial change/deterioration in age appropriate or independent role functioning, acute symptomatology, and who require crisis intervention services to achieve stabilization; or

4) Who, because of substantial impairment in role functioning, require multiple coordinated mental health services delivered in a variety of settings.

e) Transition. In order to effectuate a smooth transition from the Part 132 rules as they existed prior to July 1, 2007 revisions and as they existed after that date, the State agencies will, until October 1, 2007, recognize any previous valid documentation presented by a provider that has not been updated to reflect the new requirements effective July 1, 2007. After October 1, 2007, this Part is fully applicable.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.15 Incorporation by reference

Any rules or standards of an agency of the United States or of a nationally-recognized organization or association that are incorporated by reference in this Part are incorporated as of the date specified and do not include any later amendments or editions.

Section 132.20 Clients' Rights and Confidentiality (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.25 Definitions

For the purposes of this Part, the following terms are defined:

"Adult." An individual who is 18 years of age or older or a person who is emancipated pursuant to the Emancipation of Mature Minors Act [750 ILCS 30].

"Applicant." An entity that seeks certification to provide Medicaid community mental health services under this Part.

"Certifying State Agency." Departments responsible for determining and monitoring compliance with this Part: Department of Human Services, Department of Children and Family Services or the Department of Corrections.

"CGAS." The Children's Global Assessment Scale as published in the Archives of General Psychiatry, Volume 40, November 1983, pp. 1228-1231.

"Client." An individual who is Medicaid-eligible and is receiving Medicaid community mental health services.

"CMMS." Centers for Medicare and Medicaid Services. A federal agency within the U.S. Department of Health and Human Services with responsibility for Medicare, Medicaid, State Children's Health Insurance (SCHIP), Health Insurance

Portability and Accountability Act (HIPAA), and Clinical Laboratory Improvement Amendments (CLIA).

"Collateral." A person with a relationship to a client and who is important in the treatment or recovery goals of the client or who is a resource to assist the client in meeting treatment or recovery goals.

"Confidentiality Act." The Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110].

"Contract." For purposes of this Part, a written agreement between the applicant/provider and a public payer.

"Co-occurring." Co-existing mental health and substance use disorders or developmental disabilities. Individuals eligible to receive services under this Part must have a diagnosis of mental illness.

"Day." A calendar day unless otherwise indicated.

"DCFS." The Illinois Department of Children and Family Services.

"DHS." The Illinois Department of Human Services.

"DOC." The Illinois Department of Corrections.

"DSM-IV." The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (1994) or DSM-IV-TR (2000), American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, Virginia 22209-3901.

"Enrollment." The official enrollment of a provider in the medical assistance program by HFS on determination of compliance with 89 Ill. Adm. Code 140.11.

"Family." A basic unit or constellation of one or more adults and children, foster or adoptive parents and children, and private individual guardians.

"GAF." The Global Assessment of Functioning Scale contained in the DSM-IV.

"Guardian." The court-appointed guardian or conservator of the person under the Probate Act of 1975 [755 ILCS 5] or a temporary custodian or guardian of the person of a child appointed by an Illinois juvenile court or a legally-appointed guardian or custodian or other party granted legal care, custody and control over a minor child by a juvenile court of competent jurisdiction located in another state whose jurisdiction has been extended into Illinois via the child's legally

authorized placement in accordance with the applicable interstate compact. (The Juvenile Court Act of 1987 [705 ILCS 405]; Interstate Compact on the Placement of Children [45 ILCS 15])

"HFS." The Illinois Department of Healthcare and Family Services.

"HIPAA." The Health Insurance Portability and Accountability Act (42 USC 1320 et seq.) (45 CFR 160 and 164 (2003)).

"ICD-9-CM." International Classification of Diseases, 9th Revision, Clinical Modification (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244-1850 (2003)).

"ITP." Individual treatment plan.

"Level of role functioning." Refers to the client's abilities in critical areas such as vocational, educational, independent living, self-care, and social and family relationships. To assess the severity of the impairment in role functioning, scales approved for use include, but are not limited to, the GAF Scale or the CGAS Scale.

"Licensed clinician." An individual who is either a licensed practitioner of the healing arts (LPHA); a licensed social worker (LSW) possessing at least a master's degree in social work and licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] with specialized training in mental health services or with at least two years experience in mental health services; a licensed professional counselor possessing at least a master's degree and licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] with specialized training in mental health services or with at least two years experience in mental health services; a registered nurse (RN) licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65] with at least one year of clinical experience in a mental health setting or who possesses a master's degree in psychiatric nursing; or an occupational therapist (OT) licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of clinical experience in a mental health setting.

"Licensed practitioner of the healing arts (LPHA)." An Illinois licensed health care practitioner who, within the scope of State law, has the ability to independently make a clinical assessment, certify a diagnosis and recommend treatment for persons with a mental illness and who is one of the following: a physician; an advanced practice nurse with psychiatric specialty licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65]; a clinical psychologist licensed under the Clinical Psychologist Licensing Act [225 ILCS

15]; a licensed clinical social worker (LCSW) licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20]; a licensed clinical professional counselor (LCPC) licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or a licensed marriage and family therapist (LMFT) licensed under the Marriage and Family Therapist Licensing Act [225 ILCS 55] and 68 Ill. Adm. Code 1283.

"Medicaid." Medical assistance authorized by HFS under the provisions of the Illinois Public Aid Code [305 ILCS 5/Art. V], the Children's Health Insurance Program Act [215 ILCS 106] and Titles XIX and XXI of the Social Security Act (42 USCA 1396 and 1397aa).

"Mental health professional (MHP)." An individual who provides services under the supervision of a qualified mental health professional and who possesses: a bachelor's degree; a practical nurse license under the Nursing and Advanced Practice Nursing Act [225 ILCS 65]; a certificate of psychiatric rehabilitation from a DHS-approved program plus a high school diploma plus 2 years experience in providing mental health services; an occupational therapy assistant licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of experience in a mental health setting; or a minimum of 5 years supervised experience in mental health or human services. Any individual meeting the minimum credentials for an LPHA or QMHP under this Part is deemed to also meet the credentialing requirements of an MHP.

"Mental illness." A mental or emotional disorder diagnosis contained in the DSM-IV or ICD-9-CM, authorized by the public payer funding the services under this Part and the condition that will be the main focus of treatment for services under this Part. Mental illness does not include organic disorders such as dementia and those associated with known or unknown physical conditions such as hallucinosis, amnestic disorder and delirium; psychoactive substance induced organic mental disorders; and mental retardation or psychoactive substance use disorders.

"Off-site." Locations other than provider sites, as described in this Part, where community mental health services are provided and that require the staff to travel from their usual office base in order to deliver the service. A place of residence that is owned or operated by a provider and occupied by a client will be considered an off-site location unless there is an office on-site that is the usual office base of the staff delivering the services.

"Part 132 services." The community mental health services described in this Part.

"Physician." A physician licensed under the Medical Practice Act of 1987 [225

ILCS 60] to practice medicine in all its branches.

"Provider." An entity certified to provide Medicaid community mental health services in accordance with this Part.

"Public payer." HFS, a State agency or a unit of local government that is responsible for payment for services under this Part provided to a client pursuant to a contract with the provider.

"Qualified mental health professional" or "QMHP." One of the following:

A licensed social worker (LSW) possessing at least a master's degree in social work and licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] with specialized training in mental health services or with at least 2 years experience in mental health services;

A licensed professional counselor possessing at least a master's degree and licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] with specialized training in mental health services or with at least two years experience in mental health services;

A registered nurse (RN) licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65] with at least one year of clinical experience in a mental health setting or who possesses a master's degree in psychiatric nursing;

An occupational therapist (OT) licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of clinical experience in a mental health setting; or

An individual possessing at least a master's degree in counseling and guidance, rehabilitation counseling, social work, vocational counseling, psychology, pastoral counseling, or family therapy or related field, who has successfully completed a practicum or internship that included a minimum of 1,000 hours of supervised direct service, or who has one year of clinical experience under the supervision of a QMHP.

Any individual meeting the minimum credentials for an LPHA under this part is deemed to also meet the credentialing requirements of a QMHP.

"Rehabilitative services associate (RSA)." An RSA must be at least 21 years of age, have demonstrated skills in the field of services to adults or children, have

demonstrated the ability to work within the provider's structure and accept supervision, and have demonstrated the ability to work constructively with clients, treatment resources and the community. Any individual meeting the minimum credentials for an MPH, QMHP or LPHA under this Part is deemed to also meet the credentialing requirements of an RSA.

"SASS." A program of intensive mental health services provided by an agency certified to provide Part 132 services and under contract to provide screening, assessment and support services to children with a mental illness or emotional disorder who are at risk for psychiatric hospitalization.

"Specialized substitute care living arrangement." A living arrangement providing services to a client supervised by a provider licensed under the Child Care Act of 1969 [225 ILCS 10] or any comparable Act in another state when the provider is under contract to the State agency.

"State agency." Department of Healthcare and Family Services, Department of Juvenile Justice, Department of Human Services, Department of Children and Family Services or the Department of Corrections.

"Unit of local government." A county, municipal corporation, or other local government entity organized under the laws of the State of Illinois that, pursuant to an executed intergovernmental agreement with HFS, has agreed to pay for Medicaid community mental health services.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.30 Application, Certification and Recertification Processes

a) A State agency, subject to an executed interagency agreement with HFS in its capacity as the Medicaid State agency for Illinois, is authorized to perform the functions ascribed under this Part.

b) Any entity having a contract with a State agency for the provision of mental health services, other than hospital inpatient or hospital outpatient psychiatric services, with DCFS for the provision of child welfare services, with DCFS or DHS for the provision of youth services, or with DOC for the provision of youth treatment, rehabilitative or transitional services may apply for certification as a provider. Applicants who meet the requirements of this Part will be certified by one of the State agencies and enrolled as a provider in the Illinois medical assistance program by HFS pursuant to 89 Ill. Adm. Code 140.11. Providers will be certified by, and subject to, Medicaid certification review by only one State agency. Providers who are certified to provide comparable Medicaid services in

other states may apply to a State agency for reciprocity consideration and enrollment. Providers applying for reciprocity consideration and enrollment will be subject to the same standards as those providers applying for certification under this Part.

c) Applications may be obtained by submitting a request in writing to:

Illinois Department of Human Services
Bureau of Accreditation, Licensure and Certification
401 North Fourth Street
Springfield, Illinois 62702

or

Illinois Department of Children and Family Services
Office of Medicaid Certification
406 East Monroe Street
Springfield, Illinois 62701

or

Illinois Department of Corrections
Office of Medicaid Certification
1301 Concordia Court
Springfield, Illinois 62794-9277

d) The applicant shall submit to DHS, DCFS or DOC a completed "Application for Certification of Medicaid Community Mental Health Services Programs" with all of the required accompanying components, as specified on the application form. An applicant shall submit its application to the Certifying State Agency that it intends to contract with for Part 132 services.

1) If an applicant intends to contract for Part 132 services with more than one State agency, the applicant shall submit its application to the State agency that provides the most funding for those Medicaid community mental health services.

2) If the funding from the Certifying State Agencies is equal, the applicant shall submit the application to DHS.

3) The application shall request information including, but not limited to:

A) Applicant name and corporate status;

B) List of services the applicant is requesting be certified;

C) Description of how each service to be certified fits into the programs of the applicant and other evidence of compliance with specific service definitions (see Section 132.150);

D) List of sites to be certified;

E) Fire, electrical and plumbing clearances for each site, pursuant to Section 132.90;

F) The address of all accessible sites;

G) A staffing roster including staff qualifications and supervisory responsibilities;

H) Policies on confidentiality and third-party payments;

I) Utilization review plan; and

J) Medicare certification status.

e) If the application form and all of the required components are in compliance with this Part, the State agency shall issue to the provider a certificate for the Medicaid community mental health services program.

1) An applicant that submits an application that is not in compliance with this Part shall receive a Notice of Deficiencies. The Certifying State Agency shall issue the Notice of Deficiencies within 30 days after receiving the application. If the applicant intends to proceed with applying for Medicaid certification, the applicant shall submit corrected documentation to address all of the deficiencies. The applicant shall submit the corrected documentation to the Certifying State Agency that received the application and issued the Notice of Deficiencies.

2) The State agency shall issue the certificate within 30 days after the Certifying State Agency receives the completed application and all required components, including corrected documentation, if applicable. The effective date of certification shall be the date that the application or, if required, corrected documentation was approved. The Certifying State Agency shall also send the Medicaid enrollment forms to the provider.

The provider shall complete the enrollment forms for each certified site to enroll those sites in the Illinois medical assistance program.

f) Certification shall be for a 3-year period.

1) Any changes during the certification period that affect the ability of the provider to deliver services in compliance with the requirements of this Part shall be reported to the Certifying State Agency.

2) A provider shall deliver only mental health services under this Part for which it is certified.

g) Within 12 months after the date of initial certification, the Certifying State Agency shall conduct a review.

1) At the review, the Certifying State Agency shall evaluate the provider's compliance with this Part.

2) If no deficiencies are noted at the review, the Certifying State Agency shall notify the provider of the results within 30 days after the completion of the review. Compliance reviews for recertification shall be conducted on or about the expiration date of the current certification period.

3) If deficiencies are noted at the review, the Certifying State Agency shall report those deficiencies to the provider during an exit conference. The Certifying State Agency shall also issue a Notice of Deficiencies, return receipt requested, to the provider within 30 days after the completion of the review.

4) If the Certifying State Agency issues a Notice of Deficiencies to the provider, the provider shall respond with a Plan of Correction pursuant to Section 132.45(a). The Plan of Correction shall address all of the deficiencies listed on the Notice of Deficiencies. The Plan of Correction must identify the actions that have been, or will be, taken to comply with this Part and the timeframes for implementing the corrective actions. Unless otherwise specified, the timeframes for implementing corrective actions must follow the requirements specified in Section 132.45. The provider must submit this Plan of Correction to the Certifying State Agency within 30 days after the return receipt of the Notice of Deficiencies.

A) Providers that submit a Plan of Correction approved by the Certifying State Agency shall be notified of the approval. The

Certifying State Agency shall notify the provider of the approval within 30 days after the Certifying State Agency receives the provider's Plan of Correction. The Certifying State Agency shall verify the provider's implementation of the Plan of Correction at the next review. If a Plan of Correction was required, the next review shall occur within 12 months after the date the Plan of Correction was approved.

i) If the findings at the next review indicate that a provider has failed to implement a Plan of Correction, the Certifying State Agency may revoke the provider's certification.

ii) Compliance reviews for recertification shall be conducted on or about the expiration date of the current certification period.

B) If a provider submits a Plan of Correction that does not address the deficiencies noted during a review pursuant to subsection (g)(4), the Certifying State Agency shall notify the provider within 30 days after receipt of the provider's Plan of Correction. The provider shall submit a revised Plan of Correction that addresses the deficiencies within 10 days after receiving notification. The Certifying State Agency may revoke the provider's certification if the provider fails to submit an acceptable revised Plan of Correction within 10 days after the return receipt date.

C) The Certifying State Agency may revoke a provider's certification if the provider fails to submit a Plan of Correction for deficiencies noted during a review within 30 days after receipt of the Notice of Deficiencies.

h) Compliance reviews for recertification shall be conducted on or about the expiration date of the current certification period. If the Certifying State Agency fails to conduct a compliance review for certification before the expiration of the current certification period, the certification shall remain valid until completion of the compliance review. Subsequent compliance reviews shall follow the process outlined in subsection (g).

i) The Certifying State Agency, HFS, or their respective agents, shall be granted access to all provider sites. All records shall be made available to the Certifying State Agency, HFS, or their respective agents, on request during the initial certification review, recertification reviews and any other compliance reviews for services delivered under this Part. Access to records shall occur in accordance

with the Confidentiality Act.

j) An applicant/provider who has been decertified by Medicare shall not be eligible for certification under this Part.

k) When a decision is made to deny certification of an applicant or recertification of a provider, the applicant/provider may appeal the decision and request a hearing in accordance with Section 132.55 of this Part and Section 10-25 of the Illinois Administrative Procedure Act [5 ILCS 100/10-25].

l) If an applicant/provider has been denied certification or recertification, or if the provider's certification has been revoked, the applicant/provider may not reapply for certification under this Part for at least one year after the date of the final decision, including any appeals regarding certification, recertification or revocation.

m) Following a review, a provider shall be notified of its level of compliance with this Part as specified in Section 132.45.

n) The findings from a review shall be placed in one of the levels of compliance as described in Section 132.45.

o) Providers that seek certification for new sites shall submit the following documentation to the Certifying State Agency:

1) A clearance letter from the Office of the State Fire Marshal or approved local fire authority, dated within the preceding 12 months, stating that each additional site complies with local and State fire safety ordinances and codes pursuant to Section 132.90. For providers certified by DHS, the clearance letter must come from the Office of the State Fire Marshal only.

2) A signed statement from a licensed plumber or licensed architect, dated within the preceding 12 months, stating that each additional site complies with applicable plumbing codes pursuant to Section 132.90.

3) A signed statement from an electrician or licensed architect, dated within the preceding 12 months, stating that each additional site complies with applicable electrical codes pursuant to Section 132.90.

4) A signed statement from the provider, dated within the preceding 12 months, attesting to compliance with requirements of physical accessibility standards pursuant to Section 132.90.

p) Providers that seek certification for additional Part 132 services shall submit a description of the additional services, including evidence of compliance with specific service definitions in this Part. Providers requesting to add Part 132 services whose standards are changed as a result of revisions to Sections 132.150 and 132.165 are expected to show compliance with standards as adopted. The description shall state how the additional services will be provided within the provider's program and shall include a listing of the LPHAs and QMHPs who will be responsible for directing the services. The provider shall submit the documentation for certification of additional services to the Certifying State Agency.

q) Additional sites or services must be approved by the Certifying State Agency before the additional sites or services may be considered for certification.

r) The provider's application for certification of additional sites or services shall be processed by the Certifying State Agency according to the provisions outlined in subsection (e). Approved additional sites or services shall be indicated on a revised certificate. If additional sites are certified, the provider shall enroll those sites in the Illinois medical assistance program. The addition of sites or services will not alter the expiration date of the certificate.

s) The Certifying State Agency shall survey any additional sites or services for compliance with this Part during the next review.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.35 Recertification and Reviews (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.40 Certification for Additional Medicaid Community Mental Health Services and/or New Site(s) (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.42 Post-Payment Review

The State agency may conduct on-site post-payment reviews to determine compliance with documentation requirements of this Part and to determine amounts subject to recoupment.

a) The State agency shall compare billed services to those listed on the ITP or Admission Note in effect at the time service was provided. The State agency will determine that the following are unsubstantiated:

1) Billings for services without a completed ITP or Admission Note being in effect, except for mental health assessment; ITP development, review and modification; crisis intervention; 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 ITP or Admission Note, except for mental health assessment; ITP development, review and modification; crisis intervention; 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 documentation required in this Part.

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

c) The State agency will report its findings to the provider through an Initial Notice of Unsubstantiated Billings.

1) The initial notice will be sent to the provider within 30 days after the completion of the on-site review.

2) The provider will have 30 days after the receipt of the initial notice to submit documentation that was not available during the on-site review. Documentation submitted may not include anything produced following the on-site review.

A) The State agency will review the additional documentation within 14 days after receipt to determine if it meets the requirements of this Part.

B) Adjustments will be made to the State agency's findings if the additional documentation meets the requirements of this Part.

d) The State agency will report the final outcome to the provider through a Final Notice of Unsubstantiated Billings or a Notice of Suspension from Billing.

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.

2) The provider will have 90 days to make corrections to its documentation processes to bring them into compliance with this Part.

3) When the provider notifies the State agency in writing that they have made the necessary corrections, the State agency will review them for compliance with this Part within 14 days.

4) If compliant, the provider will be notified by mail and may resume billing.

5) The provider may submit bills that have the required documentation for services provided during the suspension.

6) If corrections are not made within 90 days, the State agency shall revoke the provider's certification.

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

f) HFS, in its capacity as the Medicaid single state agency for Illinois, may conduct on- or off-site reviews of payments made by any and all public payers to a provider.

g) The provider may appeal the State agency's intent to recover funds as specified in Section 132.44.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.44 Appeal of Post-Payment Review Findings

a) If the State agency determines that the provider is not in compliance with the billing documentation requirements of this Part pursuant to a post-payment review conducted in accordance with Section 132.42, the State agency shall notify the provider in writing of its findings. The notice shall include:

1) The reason for the State agency's findings;

2) A statement of the provider's right to request a hearing within 20 days after the provider's receipt of the written 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.

b) If a provider chooses to appeal the State agency's findings, the provider shall submit a written request for a hearing to the State agency within 20 days after the date of receipt of the written notice.

c) The sole issue at the hearing shall be whether the provider is in compliance with billing documentation requirements set forth in this Part.

d) The request for hearing shall be filed with, and received by, the State agency within 20 days after the date of the receipt of the written notice to the provider.

e) Hearing process

1) HFS's hearing rules for medical vendor hearings at 89 Ill. Adm. Code 104.200 shall apply, except that the following Sections do not apply to these hearings: 104.204, 104.206, 104.208, 104.210, 104.216, 104.217, 104.221, 104.260, 104.272, 104.273 and 104.274.

2) The State agency shall, within 5 days after receiving the appeal, send a copy of the appeal to the Illinois Department of Healthcare and Family Services Vendor Hearings Section, 401 South Clinton, 6th Floor, Chicago, Illinois 60607.

3) The appellant shall direct all subsequent communications relevant to the hearing to the HFS Vendor Hearings Section.

4) An administrative law judge appointed by HFS shall conduct the hearing.

5) A recommended decision shall be submitted to the Director of Healthcare and Family Services and copies mailed to the parties, in accordance with the provisions of 89 Ill. Adm. Code 104.290. A copy shall also be mailed to the State agency that referred the matter to HFS.

f) Final administrative decision
The Director of Healthcare and Family Services shall issue a final administrative decision in accordance with the provisions of 89 Ill. Adm. Code 104.295.

g) Judicial review
The final administrative decision shall be subject to judicial review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art. III].

h) A provider shall be liable for reimbursement of claims submitted from the date of the final administrative decision pursuant to this Section if such decision results in an adverse finding for the provider.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.45 Compliance with Certification Requirements

a) Medicaid community mental health service providers shall be recognized according to levels of compliance with standards as set forth in this Part. Providers with findings of Level 1 and 2 will be considered to be in good standing with the State agency. The levels of compliance are:

1) Level 1 – Compliant: No written Plan of Correction will be required of the provider (90-100% compliance).

2) Level 2 – Substantial compliance: A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the identified deficiencies. Within 12 months after the date that a Plan of Correction is approved, the Certifying State Agency shall conduct a review to evaluate the provider's implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frame, the Certifying State Agency may revoke the provider's certification to provide services pursuant to this Part (75-89% compliance).

3) Level 3 – Minimal compliance: A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the identified deficiencies. After 90 days from the date that a Plan of Correction is approved, the Certifying State Agency shall conduct a review to evaluate the provider's implementation of the Plan of Correction. The provider's level of compliance must reach at least Level 2 to demonstrate implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frame, the Certifying State Agency may revoke the provider's certification to provide services pursuant to this Part (50-74% compliance).

4) Level 4 – Unsatisfactory compliance: A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the cited deficiencies. After 60 days from the date that a Plan of Correction is approved, the Certifying State Agency shall conduct a review to evaluate the provider's implementation of the Plan of Correction. The provider's level of compliance must reach at least Level 3 to demonstrate

implementation of the Plan of Correction. After 90 days from the date that the Plan of Correction was approved, the provider's level of compliance must reach at least Level 2 to demonstrate implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frames, the Certifying State Agency may revoke the provider's certification to provide services pursuant to this Part (under 50% compliance).

b) When a written Plan of Correction is required, the provider shall submit the Plan of Correction within 30 days after receipt of the Notice of Deficiencies.

c) In the event that all contracts between the provider and a State agency for the provision of services under this Part are terminated, certification of the provider shall likewise be revoked and HFS will be advised of this by the State agency. The provider is solely liable for the cost of services provided after a contract has been terminated or certification has been revoked.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.50 Revocation of Certification

a) The Certifying State Agency shall issue a written notice revoking certification during a certification period for any of the following:

1) Provider meeting any of the grounds for termination set forth in 89 Ill. Adm. Code 140.16; or

2) Provider discontinuing delivery of all Medicaid community mental health services for which the provider has been certified; or

3) Provider being convicted of defrauding the medical assistance program under Article VIIIA of the Illinois Public Aid Code [305 ILCS 5/Art. VIIIA].

b) In the event that all contracts between the provider and a State agency for the provision of services under this Part are terminated, certification of the provider shall likewise be revoked and HFS will be advised of this by the State agency. The provider is solely liable for the cost of services provided after a contract has been terminated or certification has been revoked.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.55 Appeal of Certification Decisions

a) An applicant or provider may appeal the following to the Certifying State Agency:

1) Refusal to issue certification;

2) Refusal to issue recertification; or

3) Revocation of certification.

b) Certification appeal criteria and process

1) If the Certifying State Agency determines that certification or recertification should not be issued or that certification should be revoked, the Certifying State Agency shall send, by certified mail, return receipt requested, written notice to the applicant or the provider within 30 days after the determination. The notice shall contain the specific requirements with which the applicant or provider has not complied, the Certifying State Agency's proposed action, and the applicant or provider rights as follows:

A) If the applicant or provider chooses to appeal the Certifying State Agency's decision, the applicant or provider shall submit a written request for a hearing to the Certifying State Agency within 20 days after the dated receipt of the notice.

B) If an appeal is initiated by a provider, services shall be continued pending a final administrative decision unless the Certifying State Agency also determines, and notifies the provider, that conditions specified in Section 132.45(c) apply.

C) The request for a hearing shall be addressed to the appropriate Certifying State Agency as follows:

Illinois Department of Human Services
Bureau of Administrative Hearings
100 South Grand Avenue East, 3rd Floor
Springfield IL 62762-0001

or

Illinois Department of Children and Family Services
Office of Medicaid Certification
406 East Monroe

Springfield IL 62701-1498

or

Illinois Department of Corrections
Office of Medicaid Certification
1301 Concordia Court
Springfield IL 62794-9277

2) If the applicant or provider does not submit a request for a hearing, as provided in this Part, or if, after conducting the hearing, the Certifying State Agency determines that the certification or recertification should not be issued or that the certification should be revoked, the Certifying State Agency shall issue an order to that effect. If the order is to revoke the certification, it shall specify that the order takes effect upon receipt by the provider and that the provider shall not provide Medicaid community mental health services during the pendency of any proceeding for judicial review of the Certifying State Agency's decision, except by court order.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.60 Rate Setting

a) The State agency shall compute rates of reimbursement for services under this Part. The rates will be effective only after approval by HFS in its capacity as the Medicaid single state agency. Providers and the public shall be informed of any changes in the methods and standards of determining payment rates for services funded under this Part pursuant to 42 CFR 447.205 (2003).

b) Rate calculation

1) For services authorized by this Part to be reimbursed at fractions of or multiples of service hours, the State agency shall calculate rates on an hourly basis. Rates shall be calculated for each of the direct care staff classifications (RSAs, MHPs, QMHPs, and RNs) as the sum of average annual direct care wages and salaries (including paid benefits) and annual per person overhead and administrative costs necessary for direct care staff divided by billable annual direct care staff hours.

2) Average annual direct care wages and salaries shall be obtained for each of the 4 direct care staff classifications from the most recent State of Illinois Consolidated Financial Reports, as submitted to meet the requirements in Section 132.80(b). Annual per person overhead and

administrative costs necessary for direct care staff shall be calculated from a model of reasonable and efficient operation and include consideration of the cost of administrative staff, support staff, clinical supervisory staff, and site operation. Billable annual direct care staff hours shall be calculated from a model of reasonable and efficient operation and include the consideration of direct care staffing activities necessary to produce billable services that are not themselves billable, such as training, travel, documentation, and missed appointments.

A) Hourly crisis service rates shall be calculated in the manner described in subsection (b)(1) and multiplied by a factor of 1.6 to compensate for availability of 24 hours per day, 7 days per week.

B) Hourly rates for services that may be provided for groups of clients shall be calculated in the manner described in subsection (b)(2) and divided by the maximum allowable group size as specified in Section 132.150, with an allowance for incomplete attendance or participation.

c) Mental health services described in Subpart C of this Part may be integrated into a comprehensive array and billed on a per diem basis and defined on an individual specialized substitute care provider basis by the State agency using the factors enumerated in subsection (b) of this Section.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

SUBPART B: PROVIDER ADMINISTRATIVE REQUIREMENTS

Section 132.65 Organizational Requirements

a) The provider shall operate in a manner consistent with all applicable State laws and federal regulations, and adopted procedures.

b) A provider shall have written operating policies and procedures that detail and explain the operation of programs and the delivery of services, including a description of staff decision-making authority.

c) A provider shall have proof of insurance against professional and physical liabilities.

d) A provider shall ensure the availability of staff or consultants capable of using languages or methods of communication used by Medicaid-eligible clients served by the provider.

e) The provider shall have an active system of program evaluation.

1) This system shall monitor quantitative characteristics such as caseload information and qualitative characteristics such as client satisfaction.

2) The evaluation system shall include mechanisms for producing evaluation reports that describe the outcome of monitoring activities and provide for the use of the results to improve the program.

(Source: Amended at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.70 Personnel and Administrative Recordkeeping

a) The provider shall have a comprehensive set of personnel policies and procedures that include, but are not limited to:

1) Job descriptions and qualifications and documentation of current licensure and certification for all staff, including those on contract with the provider or with an entity subcontracting with the provider. The provider shall also maintain job descriptions for volunteers and unpaid personnel;

2) Documentation that staff providing or supervising services pursuant to this Part meet the staff qualifications defined in this Part, and that their individual performance is evaluated no less frequently than once every 12 months; and

3) Documentation that the provider has written personnel policies concerning hiring, evaluating, disciplining and terminating staff.

b) The provider must show documentation indicating that staff have engaged in professional development and continuing education activities. Acceptable documentation may include, but is not limited to, training approval forms, reimbursement/payments for training, training calendars, outlines of training activities, or a list of notifications or training events.

c) A provider certified or funded by DHS shall not employ a person in any capacity until the provider has inquired of the Department of Public Health as to information in the Nurse Aide Registry concerning the person. If the Registry has information substantiating a finding of abuse or neglect against the person, the provider shall not employ him or her in any capacity.

d) Each provider shall develop, implement and maintain a plan for clinical

supervision of all non-licensed staff who perform Part 132 services. A LPHA or QMHP must provide the supervision for a minimum of one hour per month through face-to-face, teleconference or videoconference. Supervision must be documented in a written record.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.75 Program Evaluation (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.80 Fiscal Requirements

a) Providers shall have a formal accrual accounting system in accordance with any generally accepted accounting principles (GAAP).

b) The provider shall submit to the Certifying State Agency within 180 days after the end of the State fiscal year the State of Illinois Consolidated Financial Report, unless the State agency extends the time-frame for a provider.

c) The provider shall comply with the requirements governing audits, false reporting and other fraudulent activities pursuant to 89 Ill. Adm. Code 140.30 and 140.35 for services provided to Medicaid-eligible clients.

d) Billings for services rendered under the Medicaid community mental health services program shall be submitted only by the provider of the service and only to the public payer with which the provider has contracted for the service.

e) The provider shall determine if there are any third party payers liable for treatment costs incurred by a client and shall follow procedures for seeking payment from these parties and for calculating subsequent Medicaid charges as outlined in 89 Ill. Adm. Code 140. A third-party payer is any entity, other than the client or public payer, with an obligation to the client to pay for services defined in this Part.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.85 Recordkeeping

a) The provider shall maintain records, including but not limited to the following:

1) All payments received, including cash;

2) All payments made, including cash;

3) Corporate papers, including stock record books and minute books;

4) All arrangements and payments related in any way to the leasing of real estate or personal property, including any equipment;

5) All accounts receivable and payable;

6) Service billing files;

7) Clinical records as defined in Section 132.100; and

8) Individual client information, including: guardianship, representative payee, trust beneficiary and resource availability.

b) Required records shall be retained for a period of not less than 6 years from the date of service, except that if an audit is initiated within the required retention period the records shall be retained until the audit is completed and every exception resolved. This provision is not to be construed as a statute of limitations.

c) Required records shall be readily available for inspection, audit and copying during normal business hours by personnel representing the Certifying State Agency, the public payer, HFS, or the Centers for Medicare and Medicaid Services (CMMS), U.S. Department of Health and Human Services. Reviewing personnel shall make all attempts to examine such records without interfering with the professional activities of the provider.

d) The compilation and storage of and accessibility to client information and clinical records shall be governed by written policies and procedures, in accordance with the Confidentiality Act and HIPAA.

e) Clinical records and other client information shall be secured from theft, loss, or fire.

f) Electronic signature or computer-generated signature codes are acceptable as authentication of record content.

1) In order for a provider to employ electronic signatures or computer-generated signature codes for authentication purposes, the provider shall adopt a policy that permits authentication by electronic or computer-generated signature.

2) At a minimum, the policy shall include adequate safeguards to ensure confidentiality of the codes, including, but not limited to, the following:

A) Each user shall be assigned a unique identifier that is generated through a confidential access code.

B) The provider shall certify in writing that each identifier is kept strictly confidential. This certification shall include a commitment to terminate a user's use of a particular identifier if it is found that the identifier has been misused. "Misused" shall mean that the user has allowed another person or persons to use his or her personally assigned identifier or that the identifier has otherwise been inappropriately used.

C) The user shall certify in writing that he or she is the only person with user access to the identifier and the only person authorized to use the signature code.

D) The provider shall monitor the use of identifiers periodically and take corrective action as needed. The process by which the provider will conduct monitoring shall be described in the policy.

3) A system employing the use of electronic signatures or computer-generated signature codes for authentication shall include a verification process to ensure that the content of authenticated entries is accurate. The verification process shall include, at a minimum, the following provisions:

A) The system shall require completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps or obvious contradictory statements appearing within those designated fields. The system shall also require that correction or supplementation of previously authenticated entries shall be made by additional entries, separately authenticated and made subsequent in time to the original entry.

B) The system shall make an opportunity available to the user to verify that the document is accurate and the signature has been properly recorded.

C) The provider shall periodically sample records generated by the system to verify the accuracy and integrity of the system.

4) Each report generated by a user shall be separately authenticated.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.90 Provider Sites

For the purpose of this Part, provider sites are discrete locations, other than a licensed foster family home, that are owned or leased by a provider for the purpose of providing Medicaid community mental health services.

a) The provider shall use sites deemed accessible in accordance with the Americans With Disabilities Act of 1990 (42 USC 12101 et seq.). "Accessibility" is determined by the extent to which the provider has adapted sites where services are provided to render its parking lot, entrances, hallway and physical facilities (lavatories, drinking fountains, ramps, etc.) available to persons with disabilities as well as the provider's arrangement to provide services to otherwise eligible clients for whom their site is inaccessible. The Certifying State Agency may waive or require specific accommodations to meet the needs of clients served at a particular site.

b) Provider sites shall be in compliance with approved State and local ordinances and codes relating to fire, building and sanitation, and health and safety requirements as follows:

1) Fire safety in accordance with rules of the Office of the State Fire Marshal at 41 Ill. Adm. Code 100.

2) Building requirements shall be in compliance with the uniform or national building code adopted by the local or county ordinance. Documentation may include a written statement from an electrician or licensed architect stating that the site is in compliance with applicable electrical codes and a written statement from a licensed plumber or licensed architect stating that the site is in compliance with applicable plumbing codes.

c) To ensure the sanitation, health and safety of the sites, the provider shall:

1) Have written policies and procedures for the provision of housekeeping services at the sites.

2) Develop and maintain a written external and internal emergency disaster plan, including a fire evacuation plan. External disasters include such occurrences as tornados, earthquakes and floods. Internal disasters include such occurrences as fire and heating and cooling systems failures.

3) Designate space, equipment, and furnishings for the provision of services which shall be conducive to privacy, comfort and safety. This includes such aspects as child size furniture in children's programs, rooms sufficiently large to accommodate groups or families, and doors that close to afford privacy.

d) The Certifying State Agency shall not review the requirements in this Section if the provider delivers Medicaid services exclusively in locations other than provider sites.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.91 Accreditation

a) The Certifying State Agency shall grant deemed status to providers having a contract with the State agency and demonstrating current accreditation status under any of the standards of the following accrediting organizations:

1) 2006 Hospital Accreditation Standards (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);

2) 2006-2007 Standards for Behavioral Health Care (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);

3) 2005-2006 Comprehensive Accreditation Manual for Health Care Networks (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);

4) COA Standards and Self Study Manual, 7th Edition (Council on Accreditation of Services for Families and Children (COA), 120 Wall Street, 11th Floor, New York, New York 10005, 2001);

5) Quality Outcomes 2005 (The Council on Quality Leadership, 100 West Road, Suite 406, Towson, Maryland 21204, 2005);

6) Standards Manual and Interpretive Guidelines for Behavioral Health (Commission on Accreditation of Rehabilitation Facilities (CARF), 4891 East Grant Road, Tucson, Arizona 85711, 2006); or

7) Standards Manual and Interpretive Guidelines for Employment and Community Support Services (Commission on Accreditation of Rehabilitation Facilities (CARF), 4891 East Grant Road, Tucson, Arizona 85711, 2006).

b) "Deemed status" means that if a provider has been accredited by any of the accrediting organizations identified in subsections (a)(1) through (a)(7) of this Section, the Certifying State Agency shall deem the provider to be in compliance with the following Sections of this Part:

1) Section 132.65;

2) Section 132.70(a) and (b);

3) Section 132.85(a)(1) through (a)(6) and (a)(8), (b)and (e);

4) Section 132.95 (a) and (d) through (f) and (h);

5) Section 132.100(a) through (h) and (k) through (m); and

6) Section 132.145(f).

c) Demonstration of current accreditation status shall be achieved by submission of a certificate of accreditation and the most recent accreditation report by the provider to the Certifying State Agency.

d) If the provider's accreditation status changes for any reason, the provider shall notify the Certifying State Agency of that change within 30 days after the effective date of the change. A provider who fails to notify the Certifying State Agency of a change in accreditation may have its certification revoked pursuant to Section 132.50.

e) Deemed status may be nullified by a finding by the Certifying State Agency that the provider is non-compliant with one or more of the Sections identified in subsections (b)(1) through (b)(6) of this Section.

f) If a provider offering only non-residential services is accredited and is in compliance with Section 132.90 at the time of recertification, on-site inspections will not be required for recertification purposes. Sites offering residential services are subject to an on-site inspection for recertification. All new sites shall be required to undergo on-site inspections.

g) If a certified site is licensed by DCFS as a child care institution or group home, an

on-site inspection of that site may not be required for recertification purposes. The site must be in good standing with DCFS and must be in compliance with Section 132.90 at the time of recertification. All new sites shall be required to undergo on-site inspection.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.95 Utilization Review

The provider shall have a written utilization review (UR) plan and ongoing activities to assess the appropriateness of Medicaid community mental health services, intensity/level of services, and continued services for the client. Such services may be subject to utilization management parameters established by the public payer. These parameters may include, but not be limited to, the volume of service delivered to a single client over a fixed period of time or significant changes in volume of service billed by a specific provider. The written UR plan shall address:

a) The methods and procedures for performing and recording individual case reviews by persons not involved in providing services to the clients whose records are reviewed;

b) The authority and functions of the individual case review designated unit, which may be:

1) A representative committee, chaired by a QMHP, and including QMHPs, MHPs, and RSAs; or

2) A QMHP;

c) Procedures describing the method for selecting cases for quarterly case review and the procedures for reviewing 10 percent of the clients served under this Part annually;

d) Procedures to ensure that the review includes and summarizes the client's progress over the previous 90 days;

e) Policies and procedures for documenting and reporting individual case reviews findings, determinations and recommendations to the supervising QMHP and, if applicable, the billing department;

f) Procedures for appeal by clients and staff affected by the UR decisions with which they disagree;

g) Provisions for ensuring confidentiality of individual case reviews, determinations,

results and/or recommendations in accordance with the Confidentiality Act and HIPAA; and

h) Procedures for following up on case review recommendations.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.100 Clinical Records

The client's clinical record shall contain, but is not limited to the following:

a) Identifying information, including client's name, Medicaid recipient identification number, address and telephone number, gender, date of birth, primary language or method of communication (e.g., Spanish, American Sign Language, communication board), name and phone number of emergency contact, date of initial contact and initiation of mental health services, third party insurance coverage, marital status, and source of referral;

b) Documentation of consent for or refusal of mental health services;

c) Assessment and reassessment reports;

d) A single consolidated ITP within a provider organization. The ITP must be current;

e) Admission Note, if applicable;

f) Documentation concerning the prescription and administration of psychotropic medication as specified in Section 132.150(d)(1);

g) Documentation of missed appointments;

h) Documentation of client referral or transfer during any active service period to or from the provider's programs or to or from other providers;

i) Documentation to support services provided for which reimbursement is claimed shall be in the format specified by the public payer, shall be legible and shall include, but not be limited to, the following elements:

1) The specific service, including whether the service was rendered in a group, individual or family setting and a note in the periodic report indicating the specific Part 132 mental health services billed by name or code;

2) The date the service was provided;

3) The start time and duration for each service;

4) The setting where services were rendered; and

5) Written documentation describing the interaction that occurred during service delivery, including the client's response in relation to the goals in the ITP.

j) Comprehensive mental health services and short-term diagnostic mental health services shall be documented:

1) According to subsection (i) of this Section; and

2) On a daily basis by completion of shift treatment summaries and other service documentation.

A) Shift treatment summaries may only be used to document community support residential services;

B) Shift treatment summaries shall be completed according to subsection (i); and

C) Shift treatment summaries shall include the client's general level of role functioning over the period being documented;

k) ITP reviews describing the client's overall progress;

l) A written record of the client's major accidents or incidents that occur at the site with regard to a specific client, whether self-reported or observed, and resulting in an adverse change in the client's physical or mental functioning; and

m) Discharge summary documenting the outcome of treatment and, as necessary, the linkages for continued services.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.105 Continuity and Coordination of Services (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.110 Availability of services F7(Repealed)F2

(Source: Repealed at 19 Ill. Reg. 16178, effective November 28, 1995)

Section 132.115 Provisions (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.120 Service Needs Evaluation (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.125 Treatment Plan Development and Modification (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.130 Psychiatric Treatment (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.135 Crisis Intervention (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.140 Day Treatment (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

SUBPART C: MENTAL HEALTH SERVICES

Section 132.142 Clients' Rights

To assure that a client's rights are protected and that all services provided to clients comply with the law, providers shall ensure that:

a) A client's rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5].

b) The right of a client to confidentiality shall be governed by the Confidentiality Act and the Health Insurance Portability and Accountability Act of 1996.

c) Justification for restriction of a client's rights under the statutes cited in subsections (a) and (b) shall be documented in the client's clinical record. In

addition, the client affected by such restriction, his or her parent or guardian and any agency designated by the client pursuant to subsection (d)(2) shall be notified of the restriction.

d) Staff shall inform the client prior to evaluation services of the following:

1) The rights in accordance with subsections (a), (b) and (c);

2) The right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. Staff shall offer assistance to a client in contacting these groups, giving each client the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality, Inc.;

3) The right to be free from abuse, neglect, and exploitation;

4) The right to be provided mental health services in the least restrictive setting;

5) The right or the guardian's right to present grievances up to and including the provider's executive director or comparable position. A record of such grievances and the response to those grievances shall be maintained by the provider. The executive director's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is final);

6) The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights; and

7) The right to contact the public payer.

e) The information in subsection (d) shall be explained using language or a method of communication that the client understands and documentation of such explanation shall be placed in the clinical record.

(Source: Added at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.145 General Provisions

A provider shall comply with the following:

a) A provider shall, at a minimum, directly provide mental health assessment, ITP

development, review, modification (see Section 132.148(c)) and at least one additional Part 132 mental health service. Directly provided means that the QMHP and LPHA who signed the mental health assessment and ITP are employed by or contractual employees of the provider. The public payer may waive the requirement of at least one additional Part 132 mental health service if it deems that such waiver increases the availability of mental health services to Medicaid-eligible clients.

b) A provider may subcontract for services authorized by this Part. There shall be a written agreement between the provider and the subcontractor that defines their contractual agreement and assures the subcontractor's compliance with applicable service provisions of Subpart C. All subcontractors must be certified to participate in the Illinois Medicaid program and enrolled as a provider with HFS. All subcontracts must be approved by and on file with the State agency and, when applicable, the public payer. For purposes of this subsection, an employee or contractual employee is not considered to be a subcontractor.

c) Unless specified otherwise, services under this Part shall be provided to clients with a diagnosis of mental illness as defined in Section 132.25 and whose level of role functioning, in the absence of treatment or medication, is impaired. The provision of mental health services is expected to result in an improvement or prevention of regression in the client's existing condition.

d) Consent

1) Prior to the initiation of mental health services, the provider shall obtain written or oral consent from the client and the client's parent or guardian, as applicable.

2) Consent must be given by the parent or guardian for a child under 12 years of age, except a child 12 through 17 years of age can consent to treatment for 5 sessions.

3) If the client is determined to be in need of crisis intervention services, or if the assessment is court ordered for the client, consent is not required.

4) Legally competent adults who participate in treatment services are deemed to have consented.

5) Oral consent shall also be documented in the record.

e) An LPHA shall provide the clinical direction and determination of medical necessity of mental health services as documented by his/her dated signature on the mental health assessment and ITP.

f) When discharging a client from services, the provider shall ensure the continuity and coordination of services as provided in the client's ITP. The provider shall:

1) Communicate, consistent with the requirements of Section 132.142, relevant treatment and service information prior to or at the time that the client is transferred to a receiving program of the provider or is terminated from service and referred to a program operated by another service provider, if the client, or parent or guardian, as appropriate, provides written authorization; and

2) Document in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services.

g) Services provided under this Part are subject to the provisions of an executed contract between the provider and the public payer. The public payer is not required to reimburse services under this Part not enumerated in the contract.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.148 Evaluation and Planning

a) Mental health assessment is a formal process of gathering information regarding a client's mental and physical status and presenting problems through face-to-face, video conference or telephone contact with the client and collaterals, resulting in the identification of the client's mental health service needs and recommendations for service delivery. A diagnosis of mental illness is not required prior to beginning a mental health assessment.

1) A mental health assessment is required prior to the development and implementation of an ITP. A mental health assessment is not required prior to the initiation of crisis services described in Section 132.150(b) and case management services described in Section 132.165(a)(1).

2) A written mental health assessment report shall be a compilation of the following:

A) Identifying information: name, gender, date of birth, primary method of communication;

B) Extent, nature, and severity of presenting problems;

C) DSM-IV or ICD-9-CM diagnosis;

D) Family history, including the history of mental illness in the family;

E) Mental status evaluation, including, at a minimum, attention, memory, information, attitudes, perceptual disturbances, thought content, speech, affect, suicidal or homicidal ideation, and an estimation of the ability and willingness to participate in treatment;

F) Client preferences relating to services and desired treatment outcomes;

G) Personal history, including mental illness and mental health treatment;

H) History of abuse/trauma (childhood sexual or physical abuse, intimate partner violence, sexual assault or other forms of interpersonal violence);

I) Present level of functioning, including social adjustment and daily living skills;

J) Legal history and status, including guardianship and current court involvement;

K) Assessment of risk, including the identification of factors that may endanger either the client or the client's family and other immediate threats to the client's personal safety (e.g., gang involvement, domestic violence, elder abuse);

L) Education, specialized training, and vocational skills;

M) Employment history;

N) Interests, activities and hobbies;

O) History of current alcohol or other substance use, abuse or dependence;

P) Name and contact information of the client's primary care physician;

Q) Previous and current psychotropic medications, including date of most recent psychiatric evaluation;

R) General physical health, including date of last physical examination, any known symptoms or complaints, and current medications not noted in subsection (a)(2)(Q), including over-the-counter medications;

S) Resources such as family, community, living arrangements, religion, and personal client strengths; and

T) Summary analysis, conclusions and recommendations for specific Part 132 services.

3) Only for comprehensive mental health services (see Section 132.150(n)) or short-term diagnostic and mental health services (see Section 132.150(o)), an admission note may be used to initiate services prior to the completion of a mental health assessment. An Admission Note must be completed within 24 hours after a client's admission and is effective for a maximum of 30 days.

A) The Admission Note is a written report of an initial assessment and treatment plan and shall include the following:

i) Identifying information: name, gender, date of birth, primary language or method of communication, date of initiating assessment;

ii) Client’s current mental health functioning level;

iii) Provisional diagnosis;

iv) Pertinent history;

v) Precautions (e.g., suicidal risk, homicidal risk, flight risk) and special programming to meet the client's needs;

vi) Initial treatment plan, including a list of Part 132 services that will be provided and the staff responsible for those services; and

vii) Other relevant information.

B) An Admission Note shall be completed by at least an MHP following a face-to-face or video conference meeting with the client.

C) A QMHP shall be responsible for approving the completed Admission Note as documented by the QMHP's dated signature on the Admission Note.

4) For comprehensive mental health services or short-term diagnostic and mental health services, a mental health assessment report shall be completed within 30 days after a client's admission. The provider shall complete a mental health assessment report within 30 days after a client's admission to comprehensive mental health services or short-term diagnostic and mental health services when an admission note was completed to initiate services. For all other Part 132 services, the provider shall complete a mental health assessment report within 30 days after the first face-to-face contact.

5) A QMHP who has had, at a minimum, one face-to-face or video conference contact with the client shall be responsible for the completed mental health assessment report as documented by his/her dated signature on the mental health assessment. MHPs may participate in the mental health assessment.

6) The client's family or guardian may participate in the mental health assessment during which the family will be given the opportunity to provide pertinent information or support. Participation by the family and other interested persons must be in accordance with the Confidentiality Act and HIPAA.

7) The mental health assessment report shall be reviewed and approved by the LPHA as documented by the LPHA's dated signature on the mental health assessment. The LPHA shall determine in writing if any additional evaluations are required to assess the client's functioning or service needs.

8) The mental health assessment shall be updated annually by the QMHP and the LPHA shall review and approve the assessment as documented by the LPHA's dated signature on the updated mental health assessment. MHPs may participate in the mental health assessment update.

9) The annual update of the mental health assessment shall minimally include all requirements specified under subsection (a)(2) with the exception of requirements listed under subsections (a)(2)(A), (D), (G) and (H). Providers may include requirements under subsections (a)(2)(A), (D), (G) and (H) as medically necessary and clinically indicated as part of the mental health assessment update. Providers may also indicate "no change" where applicable on the mental health assessment update if there has been no change in status.

b) A psychological evaluation, if recommended, shall:

1) Be conducted within 90 days after completion of the ITP and documented by the provider consistent with the Clinical Psychologist Licensing Act [225 ILCS 15] using nationally standardized psychological assessment instruments; a master's level professional may assist;

2) Be conducted face-to-face or video conference with the client; and

3) Result in a written report that includes a formulation of problems, tentative diagnosis and recommendations for treatment or services.

c) Treatment plan development, review and modification is a process that results in a written ITP, developed with the participation of the client and the client's parent/guardian, as applicable, and is based on the mental health assessment report and any additional evaluations. Participation by the client or parent/guardian shall be documented by the client's or parent's/guardian's signature on the ITP. Participation by the client or parent/guardian shall be documented by the client's or parent's/guardian's signature on the ITP. In the event that a client or a client's parent/guardian refuses to sign the ITP, the LPHA, QMHP or MHP shall document the reason for refusal and indicate by his or her dated signature on a progress note that the ITP was reviewed with the client and that the client or his or her parent/guardian refused to sign the ITP.

1) The ITP shall be completed within 45 days after the completion of the mental health assessment as documented by the LPHA's dated signature on the ITP. Providers of comprehensive mental health services or short-term diagnostic and mental health services must complete an ITP within 30 days after a client's admission to the program when an Admission Note was completed to initiate services.

2) A written ITP is a compilation of the following:

A) The goals of services;

B) Intermediate objectives to achieve the goals;

C) The specific Part 132 mental health services to be provided;

D) The frequency of Part 132 services to be provided; and

E) Staff responsible for delivering services.

3) The ITP shall include a definitive diagnosis that has been determined for all five axes in the DSM-IV or the ICD-9-CM. If the diagnosis cannot be determined by the time the ITP is completed or a rule out diagnosis is given, the client's clinical record must contain documentation as to what evaluations will occur in order to provide a definitive diagnosis in the ITP. A diagnosis shall be determined within 90 days and the ITP shall be modified to reflect the diagnosis, as necessary.

4) Responsibility for development of the ITP shall be assumed by a QMHP as documented by his/her dated signature on the ITP. MHPs may participate in the development of the ITP. An LPHA shall provide the clinical direction of mental health services identified in the ITP as documented by his/her dated signature on the ITP.

5) The LPHA and the QMHP shall review the ITP no less than once every 6 months and modify the ITP as necessary, as documented by their dated signatures.

6) The ITP review shall include continuity of care planning with the client or the client's parent/guardian. The ITP review shall also include an estimated transition or discharge date and identify goals for continuing care.

7) The results of crisis assessments, reassessments or additional evaluations after the client's ITP is completed shall be incorporated into a modified ITP, if appropriate, within 30 days.

8) The provider shall explain to the client and the client's parent/guardian, as applicable and as evidenced by a signed and dated statement by the provider and the client or parent/guardian, the process for the development, review and modification of the contents of the ITP. The ITP shall be developed, reviewed and modified with the participation of the client and the client's parent/guardian, as applicable.

9) The ITP and all its revisions shall be signed by the parent or guardian if the client is under 12 years of age. If the client is 12 through 17 years of age, the ITP shall be signed by the client and by the parent/guardian, as applicable, unless the client is an emancipated minor. A client 18 years of age or older or an emancipated minor shall sign the ITP. If the client is 18 years of age or older and has been adjudicated as legally incapable, the ITP shall be signed by the legally appointed guardian.

10) A copy of the signed ITP shall be given to the client, if not clinically contraindicated, and the client's parent/guardian, as applicable. The ITP and documentation that the signed ITP has been provided to the client or parent/guardian, or proof of clinical contraindication, shall be incorporated into the client's clinical record.

11) Commencement of Services

A) Mental health services may be provided concurrently with ITP development if:

i) The mental health assessment report is completed, signed and dated by the LPHA or the Admission Note is signed and dated by the QMHP;

ii) The service is recommended as medically necessary on the completed mental health assessment; and

iii) The services provided are included in the completed ITP, signed by an LPHA within the designated time frame.

B) If services are provided prior to completion of the ITP, and the client terminates services before the ITP is completed and signed, the provider must complete the ITP and document that the client terminated services and was unavailable to sign the ITP.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.150 Mental Health Services

a) All services defined in this Section shall be provided and terminated in accordance with the following criteria unless exceptions are noted:

1) The services shall be provided:

A) Following a mental health assessment or Admission Note, as applicable, and consistent with the client's ITP or Admission Note, as applicable;

B) Through face-to-face, video conference or telephone contact;

C) To clients and their families, at the client's request or agreement; with groups of clients; or with the client's family as it relates to the primary benefit and well being of the client and when related to an assessed need and goal on the client's ITP; and

D) Services may be provided on- or off-site, as indicated under the specific service.

2) Service termination criteria shall include:

A) Determination that the client's acute symptomatology has improved and improvement can be maintained;

B) Determination that the client's level of role functioning has significantly deteriorated to a degree where referral or transfer to a more intensive mental health treatment is indicated; or

C) Documentation in the client's clinical record that the client terminated participation in the program.

b) Crisis intervention services are activities to stabilize a client in a psychiatric crisis to avoid more restrictive levels of treatment and that have the goal of immediate symptom reduction, stabilization and restoration to a previous level of role functioning. A crisis is defined as a deterioration in the level of role functioning of the client within the past 7 days or an increase in acute symptomatology.

1) Crisis intervention services shall be provided to clients who are experiencing a psychiatric crisis and acute symptomatology. For a child or adolescent, a crisis may include events that threaten safety or functioning of the client or extrusion from the family or the community. Children in psychiatric crisis who are believed to be in need of admission to a psychiatric inpatient facility and for whom public payment may be sought shall be provided with crisis intervention pre-hospitalization screening. The child shall be screened for inpatient psychiatric admission and shall have his or her mental health needs assessed, according to the requirements of the SASS (Screening, Assessment and Support Services) Program (59 Ill. Adm. Code 131).

2) Crisis intervention services may be provided prior to a mental health assessment and prior to a mental health diagnosis.

3) Crisis intervention services shall include an immediate preliminary assessment that includes written documentation in the clinical record of presenting symptoms and recommendations for remediation of the crisis. Crisis intervention services may also include, if appropriate, brief and immediate mental health services or referral, linkage and consultation with other mental health services.

4) The preliminary assessment shall be incorporated into the mental health assessment and ITP, as applicable.

5) Crisis intervention services shall be delivered by at least an MHP with access to a QMHP who is available for immediate consultation and clinical supervision.

6) During regular hours of operation, the provider shall be able to provide immediate face-to-face or video conference crisis intervention services. Outside regular hours of operation, the provider shall be able to provide, at a minimum, crisis assessment and referral to mental health services, as necessary.

c) Client-centered consultation services are individual client-focused professional communications among provider staff, or staff of other agencies, or with others, including family members, who are involved with providing services to a client.

1) Services may consist of:

A) A meeting or conference for professional communication among provider staff, staff of other agencies, and child care systems, including school personnel or other professionals involved in the treatment process.

B) A meeting or conference for professional communication between provider staff and family members involved in the treatment process.

2) Services must be provided in conjunction with one or more mental health services identified in this Section and in accordance with the ITP.

3) Client-centered consultation does not include advice given in the course of clinical staff supervisory activities, in-service training, treatment planning or utilization review and may not be billed as part of the assessment process.

4) Client-centered consultation services shall be provided by at least an RSA.

d) Psychotropic medication services

1) Documentation requirements

A) If prescribed by a physician or an advanced practice nurse, employed by or on contract with the provider, there shall be evidence that psychotropic medication has been prescribed by the physician or advanced practice nurse per the collaborative agreement that includes physician-delegated prescription authority.

B) If a physician is employed by or on contract with the provider, there shall be evidence that psychotropic medication is reviewed at least every 90 days by a physician or advanced practice nurse.

C) Notations shall be made in the client's clinical record regarding psychotropic medication and other types of medication. Notations shall include:

i) All medication being taken by the client;

ii) Current psychotropic medication: name, dosage, frequency and method of administration;

iii) Any problems with psychotropic medication administration and activities implemented to address these problems;

iv) A statement indicating that the client has been informed of the purpose of the psychotropic medication ordered and the side effects of the medication; and

v) Assessment of the client's ability to self-administer medications.

2) Psychotropic and other medication shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security and in accordance with Department of Public Health's rules at 77

Ill. Adm. Code 300.1640.

3) Services shall be provided face-to-face.

4) Psychotropic medication administration

A) Psychotropic medication administration consists of preparing the client and the medication for administration, administering psychotropic medications, observing the client for possible adverse reactions, and returning the medication to proper storage.

B) Psychotropic medication shall be administered by personnel licensed to administer medication pursuant to the Nursing and Advanced Practice Nursing Act [225 ILCS 65] or the Medical Practice Act of 1987 [225 ILCS 60].

5) Psychotropic medication monitoring

A) Psychotropic medication monitoring includes observation and evaluation of target symptom response, adverse effects, including tardive dyskinesia screens, and new target symptoms or medication. This may include discussing laboratory results with the client.

B) Psychotropic medication monitoring shall be provided by staff designated in writing by a physician or advanced practice nurse per the collaborative agreement. The authorized staff shall not provide the service prior to the date of the signature.

6) Psychotropic medication training

A) Psychotropic medication training includes training the client or the client's family or guardian to administer the client's medication, to monitor proper levels and dosage, and to watch for side effects.

B) Psychotropic medication training shall be provided by staff designated in writing by a physician or an advanced practice nurse per the collaborative agreement.

C) Psychotropic medication training shall be provided to clients in the following areas:

i) Purpose of taking psychotropic medications;

ii) Psychotropic medications, effects, side effects and adverse reactions;

iii) Self-administration of medications;

iv) Storage and safeguarding of medications;

v) Communicating with professionals regarding medication issues; or

vi) Communicating with family/caregivers regarding medication issues.

D) Services may be provided individually or in a group setting.

e) Therapy/counseling is a treatment modality to promote emotional, cognitive, behavioral or psychological changes as identified in the ITP. Services shall be provided face-to-face, by telephone or videoconference. Therapy/counseling intervention utilizes psychotherapy theory and techniques.

1) Therapy/counseling services may be provided to:

A) An individual client;

B) A group of 2 or more clients; or

C) A family, including parents, spouses and siblings (client need not be present).

2) Therapy/counseling services shall be provided by at least an MHP.

3) Examples of therapy/counseling include:

A) Cognitive behavioral therapy;

B) Functional family therapy;

C) Motivational enhancement therapy;

D) Trauma counseling;

E) Anger management; and

F) Sexual offender treatment.

f) Community Support − Individual (CSI)

1) Community Support − Individual services are mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist clients in achieving and maintaining rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill building, identification and use of natural supports, and use of community resources.

2) Service Activities and Interventions shall include:

A) Coordination and assistance with the identification of individual strengths, resources, preferences and choices;

B) Assistance with the identification of existing natural supports for development of a natural support team;

C) Assistance with the development of crisis management plans;

D) Assisting with the identification of risk factors related to relapse and development of relapse prevention plans and strategies;

E) Support and promotion of client self-advocacy and participation in decision making, treatment and treatment planning;

F) Assisting the client to build a natural support team for treatment and recovery;

G) Support and consultation to the client or his/her support system that is directed primarily to the well-being and benefit of the client; and

H) Skill building in order to assist the client in the development of functional, interpersonal, family, coping and community living skills that are negatively impacted by the client's mental illness.

3) Program requirements

A) CSI services shall be provided face-to-face, by telephone or by video conference.

B) A minimum of 60% of all Community Support − Individual services must be delivered in natural settings and out of the provider's offices. This requirement will be monitored in the aggregate for a provider for an identified billing period but will not be required for each individual.

C) CSI services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings, and at hours that do not interfere with the client's work, educational and other community activities.

4) Staffing requirements
CSI services shall be delivered by at least an RSA.

5) Service exclusions
CSI is an integral part of ACT and Community Support Team and shall not be considered a separate service for clients who receive ACT or CST. CSI services may be provided for a maximum of 30 days on an individual basis as authorized by the public payer and in accordance with a treatment plan in order to facilitate transition to and from the ACT or CST.

g) Community Support − Group (CSG)

1) Community Support − Group services consist of mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist a group of clients to achieve and maintain rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions delivered by individuals or multidisciplinary teams that facilitate illness self-management, skill building, identification and use of natural supports, and use of community resources.

2) Service Activities and Interventions shall include those activities and interventions described in subsection (f)(2).

3) Program requirements

A) CSG services shall be provided face-to-face in group settings ranging in size from 2 to 15 clients;

B) A minimum of 60% of all Community Support Group services must be delivered in natural settings and out of the provider's offices. This requirement will be monitored in the aggregate for a provider for an identified billing period, but will not be required for each individual client.

C) CSG services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings and at hours that do not interfere with the client's work, educational and other community activities.

4) Staffing requirements
CSG services shall be delivered by at least an RSA.

5) Service exclusions
CSG services is an integral part of ACT and shall not be considered a separate service for clients who receive ACT. CSG services may be provided for a maximum of 30 days on an individual basis as authorized by the public payer in accordance with a treatment plan in order to facilitate transition to and from the ACT.

h) Community Support − Residential (CSR)

1) Community Support − Residential services consist of mental health rehabilitation services and supports for children, adolescents and adults necessary to assist individuals in achieving and maintaining rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill building, identification and use of natural supports, and use of community resources for individuals who reside in sites designated by the public payer.

2) Service Activities and Interventions shall include those activities and interventions described in subsection (f)(2).

3) CSR services shall be provided face-to-face, by telephone or by video conference in group or individual settings.

4) Eligibility criteria: Individuals eligible for CSR shall include individuals whose mental health needs require active assistance and support to function independently as developmentally appropriate within home, community, work and/or school settings and who are in public payer designated residential settings.

5) Staffing requirements
CSR services shall be delivered by at least an RSA.

6) Service exclusions
Many CSR activities are an integral part of ACT and CST and shall not be considered a separate service for clients who receive ACT or CST. CSR services may be provided for a maximum of 30 days on an individual basis as authorized by the public payer and in accordance with a treatment plan in order to facilitate transition to and from the ACT or CST or while a client is receiving residential services to stabilize a crisis.

i) Community Support − Team (CST)

1) Community Support − Team services consist of mental health rehabilitation services and supports available 24 hours per day and 7 days per week for children, adolescents, families and adults to decrease hospitalization and crisis episodes and to increase community functioning in order for the client to achieve and maintain rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions delivered by a team that facilitates illness self-management, skill building, identification and use of natural supports, and use of community resources.

2) Service Activities and Interventions shall include those activities and interventions described in subsections (e) and (f)(2).

3) Program requirements

A) CST services shall be provided face-to-face, by telephone or by video conference to an individual or family member;

B) A minimum of 60% of all Community Support Team services must be delivered in natural settings and out of the provider's offices. This requirement will be monitored in the aggregate for a provider for an identified billing period, but will not be required for each individual client;

C) CST services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings and at hours that do not interfere with the client's work, educational and other community activities;

D) CST shall maintain a client-to-staff ratio of no more than 18 clients per full time equivalent staff;

E) Documentation shall demonstrate that more than one member of the team is actively engaged in the direct service to the individual.

4) Eligibility criteria
Individuals eligible for CST services are those who require team-based outreach and support for their moderate to severe mental health symptoms and who, with such coordinated clinical and rehabilitative support, may access and benefit from a traditional array of psychiatric services. A less intensive service must have been tried and failed or must have been considered and found inappropriate at this time, and the individual must exhibit 3 or more of the following:

A) Multiple and frequent psychiatric inpatient readmissions, including long-term hospitalization;

B) Excessive use of crisis/emergency services with failed linkages;

C) Chronic homelessness;

D) Repeat arrest and re-incarceration;

E) History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow-through, taking medications, following a crisis plan, or maintaining housing;

F) High use of detoxification services (e.g., 2 or more episodes per year);

G) Medication resistance due to intolerable side effects or the individual's illness interfering with consistent self-management of medications;

H) Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated clinical and supportive interventions;

I) Because of behavioral health issues, the child or adolescent has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent;

J) Clinical evidence of suicidal ideation or gesture in the last 3 months;

K) Ongoing inappropriate public behavior within the last 3 months, including public intoxication, indecency, disturbing the peace, etc.;

L) Self-harm or threats of harm to others within the last 3 months; or

M) Evidence of significant complications such as cognitive impairment, behavioral problems or medical problems.

5) There shall be documentation in the assessment or client record that the individual meets 3 of the above eligibility criteria.

6) Staffing requirements
CST services shall be delivered by:

A) A full-time team leader who is at least a QMHP and serves as the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team;

B) An RSA or MHP who works under the supervision of the QMHP and who works on the team in sufficient full-time equivalents to meet the required client-to-staff ratio;

C) Preferably, one team member who is an individual in recovery; and

D) No fewer than 3 full-time equivalent staff meeting the required team components (shall include the team leader).

7) Service exclusions
CST is an integral part of ACT and CSI and shall not be considered a separate service for clients who receive ACT and CSI. CST services may be provided for a maximum of 30 days on an individual basis as authorized by the public payer and in accordance with a treatment plan in order to facilitate transition to and from the ACT or CSI.

j) Assertive community treatment (ACT)

1) ACT is an intensive integrated rehabilitative crisis, treatment and rehabilitative support service for adults (18 years of age and older) provided by an interdisciplinary team to individuals with serious and

persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders. The service is intended to promote symptom stability and appropriate use of psychotropic medications, as well as restore personal care, community living and social skills.

2) Service Activities and Interventions
The ACT team shall assume responsibility for assisting the client to achieve improved community functioning by providing:

A) Comprehensive assessment;

B) Individualized treatment and recovery planning;

C) Service coordination;

D) Crisis assessment and intervention;

E) Symptom assessment and management;

F) Supportive counseling and psychotherapy;

G) Medication prescription, administration, monitoring and documentation;

H) Dual diagnosis substance abuse services;

I) Work and education related services;

J) Activities of daily living, including residential supports;

K) Social/interpersonal relationship and leisure time skill building;

L) Peer support services;

M) Environmental and other support services; and

N) Family psychoeducation.

3) Program requirements

A) ACT shall be provided face-to-face, by telephone or by video conference.

B) ACT services shall be available 24 hours per day, 7 days per week, with emergency response coverage, including psychiatric coverage. Crisis services shall be available 24 hours per day, 7 days per week.

C) A minimum of 75% of all team contacts shall occur out of the office.

D) A minimum of 3 contacts per week shall be provided to most ACT clients and all clients shall receive a minimum of 4 face-to-face contacts per month.

E) The ACT team shall conduct organizational staff meetings at least 4 times per week at regularly scheduled times, according to a schedule established by the team leader.

4) Eligibility criteria

A) Adults who require assertive outreach and support in order to remain connected with necessary mental health and support services and to maintain stable community living and who have not benefited from traditional services and modes of delivery as evidenced by any of the following:

i) Multiple and frequent psychiatric inpatient readmissions;

ii) Excessive use of crisis/emergency services with failed linkages;

iii) Chronic homelessness;

iv) Repeat arrests and incarcerations;

v) Client has multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers;

vi) Client exhibits functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills; or

vii) Client has persistent or severe psychiatric symptoms, serious behavioral difficulties, a mentally ill/substance abuse diagnosis, and/or high relapse rate.

B) DHS shall authorize ACT services for eligible individuals.

5) Staff qualifications

A) Each ACT team shall consist of at least 6 full-time equivalent staff. The psychiatrist and program assistant shall not be counted toward meeting the 6 full-time equivalent requirement. All teams are required to minimally consist of:

i) A full-time team leader who is the clinical and administrative supervisor of the teams and also functions as an ACT clinician. The team leader shall be a licensed clinician;

ii) A psychiatrist who works on a full or part-time basis for a minimum of 10 hours per week for every 60 enrolled clients. With a waiver by the public payer, an Advanced Practice Nurse may substitute for up to half of the psychiatrist's time;

iii) A full-time registered nurse who provides services to all ACT team enrollees and who works with the ACT team to monitor each client's clinical status and response to treatment. The registered nurse functions as a primary practitioner on each ACT team for a caseload of clients. Existing ACT providers may use an LPN with 2 years experience in mental health services as part of an ACT team until July 1, 2009. After that date, a registered nurse is required as a member of the ACT team. New ACT providers shall be required to utilize an RN on all ACT teams.

iv) Four rehabilitative services associates who work under the supervision of a licensed clinician and function as primary practitioners for a caseload of clients and who provide rehabilitation and support functions; and

v) A program/administrative assistant who is responsible for organizing, coordinating and monitoring all non-clinical operations of ACT.

B) At least one of the members of the core team shall have special training and certification in substance abuse treatment and/or treating clients with co-occurring mental health and substance abuse disorders.

C) At least one of the members of the team shall be an individual in recovery. This staff person is a fully integrated ACT team member who provides consultation to the ACT team and highly individualized services in the community, and who promotes self-determination and decision making.

D) At least one member of the core team shall have special training in rehabilitation counseling, including vocational, work readiness and educational support.

E) Each team shall be expected to maintain a staff to client ratio of no more than one full time equivalent staff per 10 clients, which shall not include the psychiatrist and program assistant. As the number of clients increase, ACT teams shall add staff to maintain the required ratio.

6) Services may be provided following a determination of eligibility for ACT services and may commence prior to the completion of a mental health assessment and the ITP when immediate assistance is needed to obtain food, shelter or clothing.

7) Case management is an integral part of ACT and shall not be considered a separate service.

8) ACT shall not be provided in combination with other Part 132 services, except under the following conditions:

A) In accordance with an ITP to facilitate transition to and from ACT services; and

B) While a client is receiving community support residential services to stabilize a crisis.

k) Psychosocial Rehabilitation

1) Psychosocial rehabilitation services are facility-based rehabilitative skill-building services for adults age 18 and older with serious mental illness or co-occurring psychiatric disabilities and addictions. The focus of treatment interventions includes skill building to facilitate independent living and adaptation, problem solving and coping skills development. The service is intended to assist clients' ability to:

   A) Live as independently as possible;

   B) Manage their illness and lives with as little professional intervention as possible; and

   C) Achieve functional, social, educational and vocational goals.

2) Psychosocial rehabilitation services shall include the following service interventions and activities to assist the client in achieving improved community functioning:

   A) Individual or group skill building activities that focus on the development of skills to be used by clients in their living, learning, social and working environments, which includes skill development for:

      i) Socialization, adaptation, problem solving and coping;

      ii) Self-management of symptoms or recovery;

      iii) Prevocational and work readiness; and

      iv) Pre-educational and education readiness;

   B) Cognitive behavioral intervention;

   C) Interventions to address co-occurring psychiatric disabilities and substance abuse;

   D) Promotion of self-directed engagement in leisure, recreational and community social activities; and

   E) Client participation in setting individualized goals and assisting his or her own skills and resources related to goal attainment.

3) Program requirements

A) Psychosocial rehabilitation services shall be provided in an organized program through individual and group interventions;

B) Psychosocial rehabilitation services shall be available at least 25 hours per week and on at least 4 days per week;

C) Services may be provided during day, evening and weekend hours;

D) Each psychosocial rehabilitation services provider shall designate a staff member to assist in assessing client needs and progress toward achievement of treatment goals and objectives.

4) Staff qualifications

A) Each psychosocial rehabilitation program shall have a clinical supervisor or program director who is at least a QMHP;

B) PSR services shall be provided by at least an RSA;

C) The clinical supervisor or program director shall be on-site at least 50 percent of the time;

D) When the clinical supervisor is not physically on-site, the clinical supervisor or designated QMHP shall be accessible to psychosocial rehabilitation staff;

E) Each psychosocial rehabilitation program shall include at least one staff person with documented experience or training to provide services and interventions to clients with co-occurring psychiatric and substance abuse disorders; and

F) The staffing ratio shall not exceed one full-time equivalent staff to 15 clients.

5) Psychosocial rehabilitation shall not be provided in combination with any of the following services:

A) ACT;

B) Intensive Outpatient; or

C) Hospital-Based Psychiatric Clinic Service Type A.

6) Psychosocial rehabilitation may be provided on an individual basis and in accordance with an ITP to facilitate transition to and from ACT services.

l) Mental health intensive outpatient services are scheduled group therapeutic sessions made available for at least 4 hours per day, 5 days per week.

1) Mental health intensive outpatient services are for clients at risk of, or with a history of, psychiatric hospitalization who currently have ITP objectives to reduce or eliminate symptoms that have, in the past, led to the need for hospitalization.

2) Services shall be provided by at least a QMHP.

3) Mental health intensive outpatient services shall be provided with a staff to client ratio that does not exceed 1:8 for adults and 1:4 for children and adolescents. For purposes of this subsection (l) only, a child or adolescent is defined as any individual who is 17 years of age or younger.

4) Services shall be provided on a face-to-face or video conference basis.

m) Intensive family-based services are interactions with the client, or with a member of the client's family on behalf of the client, to restore the client to prior levels of functioning, to reduce the risk of more restrictive treatment for the client such as psychiatric hospitalization, to reduce the risk of alternative placement, or to avert a family crisis.

1) Intensive family-based services shall be provided only to a child or adolescent:

A) Who is served by a provider under contractual obligation to provide Screening, Assessment and Support Services (SASS), when such services have been authorized by the State's mental health crisis telephone line in accordance with the provisions of 59 Ill. Adm. Code 131 (Children's Mental Health Screening and Support Services Program); or

B) For a child for whom DCFS is legally responsible who is served by a provider under contract with DCFS to provide, and be reimbursed for, this service.

2) Services shall be provided by at least an MHP.

3) Services shall be provided on a face-to-face or video conference basis.

n) Comprehensive mental health services

1) Comprehensive mental health services are an array of services as described in Subpart C that have been approved by the public payer. One or more of these services is provided on a daily basis in order to restore or maintain the client's emotional or behavioral functioning to a level determined to be necessary for his/her successful functioning in a family, school, or community.

2) Comprehensive mental health services require that at least one of the allowable services in Subpart C is provided each day. Each service must be provided in accordance with the requirements of this Part for the respective service.

3) Comprehensive mental health services shall be provided by individuals possessing the required qualifications for each discrete service.

o) Short-term diagnostic and mental health services

1) Short-term diagnostic and mental health services are an array of services, as described in Subpart C, that have been approved by the public payer. One or more of these services is provided on a daily basis in order to assess, restore or maintain the client's emotional or behavioral functioning necessary to be at a level determined to be appropriate for his/her successful functioning in a family, school or community.

2) Short-term diagnostic and mental health services shall last no more than 45 days. One extension of an additional 45 days may be authorized, in writing, by an LPHA.

3) Short-term diagnostic and mental health services require that at least one of the allowable services in Subpart C be provided each day. Each service shall be provided in accordance with the requirements of this Part for the respective service.

4) Short-term diagnostic and mental health services shall be provided by individuals possessing the required qualifications for each discrete service.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.155 Family Intervention, Stabilization and Reunification Services (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.160 Provisions (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.165 Case Management Services

a) Mental health case management services include assessment, planning, coordination and advocacy services for clients who need multiple services and require assistance in gaining access to and in using mental health, social, vocational, educational, housing, public income entitlements and other community services to assist the client in the community. Case management activities may also include identifying and investigating available resources, explaining options to the client and linking them with necessary resources.

1) Mental health case management services shall be provided following a mental health assessment and be authorized consistent with the client's ITP, with the following exceptions:

A) Case management provided during the 30 days immediately preceding completion of the assessment.

B) The client has refused all other appropriate services under this Part.

2) Mental health case management services shall be provided by at least an RSA.

b) Transition linkage and aftercare services shall be provided to assist in an effective transition in living arrangements consistent with the client's welfare and development. This includes discharge from inpatient psychiatric care (in Institutions for Mental Diseases (IMD), general hospitals and nursing facilities), transition to adult services, and assisting the client or the client's family or caretaker with the transition.

1) Transition linkage and aftercare services may consist of:

A) Planning with staff of a client's current or receiving living arrangements (including foster or legal parents as necessary);

B) Locating placement resources;

C) Arranging/conducting pre- or post-placement visits;

D) Developing an aftercare services plan; or

E) Planning a client's discharge and linkage from an inpatient psychiatric facility, including an IMD or nursing facility, for continuing mental health services and community/family support.

2) Transition linkage and aftercare services shall be provided by at least an MHP.

(Source: Amended at 31 Ill. Reg. 9097, effective July 1, 2007)

Section 132.170 Rehabilitative Case Management Services (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.APPENDIX A Medicaid Community Mental Health Services Application Components (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.APPENDIX B Utilization Parameters (Repealed)

Section 132.TABLE A Mental Health Clinic Program Client Services (Repealed)

(Source: Repealed at 28 Ill. Reg. 11723, effective August 1, 2004)

Section 132.APPENDIX B Utilization Parameters (Repealed)

Section 132.TABLE B Rehabilitative Mental Health Services (Repealed)

(Source: Repealed at 28 Ill. Reg. _____, effective _____)

Section 132.APPENDIX B Utilization Parameters (Repealed)

Section 132.TABLE C Family Intervention, Stabilization and Reunification Services (Repealed)

(Source: Repealed at 28 Ill. Reg. _____, effective _____)