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

PART 132
MEDICAID COMMUNITY MENTAL HEALTH SERVICES PROGRAM

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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].


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), 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) Applicability of Program

1) 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, 10th Revision, Clinical Modification (ICD-10-CM) (Centers for Medicare and Medicaid Services (CMMS) (2010)) or the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (2013) (American Psychiatric Association).

2) This shall include services designed to benefit Clients:
A) Who require an evaluation to determine the need for mental health treatment; or

B) Who are assessed to require medically necessary mental health treatment to reduce the mental disability and to restore an individual to the maximum possible functioning level; or

C) 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

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

(Source: Amended at 39 Ill. Reg. 13684, effective October 1, 2015)

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:

Accessibility – Compliance with all appropriate provisions of the Americans With Disabilities Act (ADA) (42 USC 12101), as amended, and section 504 of the Rehabilitation Act of 1973 (29 USC 794). No otherwise qualified disabled individual solely by reason of a disability, shall be excluded from participation in, be denied the benefits of or be subjected to discrimination in programs, services or activities sponsored by the Provider. The Provider shall make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless it can demonstrate that making the modifications would fundamentally alter the nature of the services, program or activity. The Provider shall communicate this policy
to all visitors, recipients of services, potential recipients of services, and employees. This includes the extent to which a Provider has adapted sites where services are provided to render its physical building elements, parking lot, entry, egress, restrooms, circulation paths, telecommunications and technology accessible to persons with disabilities in accordance with the ADA, section 504, and the most recent standards identified in the Illinois Accessibility Code (71 Ill. Adm. Code 400) and/or ADA Accessibility Guidelines, whichever standard is more stringent, as well as the Provider’s reasonable modification for the delivery of services to otherwise eligible Clients for whom a site is inaccessible.

Activity – Action taken on behalf of Clients to facilitate receipt of services.

Admission Note – A written report of an initial assessment and treatment plan that initiates Part 132 services for Clients who are admitted to a specialized substitute care living arrangement or for the Client who does not have a completed mental health assessment and is admitted to Assertive Community Treatment (ACT) services or a residential facility designated by the Public Payer for the purpose of stabilizing a crisis.

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.

Assertive Community Treatment or ACT – 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 medication, as well as restore personal care, community living and social skills. ACT is further defined in Section 132.150(h).

Certification Certificate – A document by the Certifying State Agency that indicates that a stated Provider is certified to provide specific Part 132 services at specified sites.

Certified Family Partnership Professional or CFPP – An individual who is certified and in good standing as a Family Partnership Professional by the Illinois Certification Board, doing business as (dba) the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc. (IAODAPCA).

Certified Recovery Support Specialist or CRSS – An individual who is certified
and in good standing as a Recovery Support Specialist by the Illinois Certification Board, dba IAODAPCA.

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


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

Clinical Experience – Work or volunteer or internship experience providing mental health services or supports supervised by a Mental Health Professional level professional.

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.

Community Support Service or CS Service – Mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist Clients in achieving 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. CS services help Clients develop and practice skills in their home and community. CS service is further defined in Section 132.150(e).

Community Support – Residential Service or CSR Service – Mental health rehabilitation services and supports for children, adolescents and adults necessary to assist individuals in achieving rehabilitative, resiliency and identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources for individuals who reside in sites designated by the Public Payer. CSR service is further defined in Section 132.150(f).
Community Support – Team Service or CST Service – 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 rehabilitative, resiliency and recovery goals. The service consists of interventions delivered by a team that facilitates illness self-management, skill building, identification and use of adaptive and compensatory skills, identification and use of natural supports, and use of community resources. CST service is further defined in Section 132.150(g).

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.

Credential – Designation of LPHA, QMHP, MHP, RSA or professional designation as included in this Part.

Crisis Intervention Services – Interventions 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. Crisis intervention services are further defined in Section 132.150(b).

Day – A calendar day unless otherwise indicated.


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.

Focus Review – A follow-up review done to assure implementation of an accepted Plan of Correction. A focus review looks at the violations found during a full review and addressed in a required Plan of Correction to assure implementation of the Plan of Correction.

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. (See the Juvenile Court Act of 1987 [705 ILCS 405] and the Interstate Compact on the Placement of Children [45 ILCS 15].)

Healthy Kids Screen – A mental health screening done as part of an HFS Healthy Kids periodic screening (89 Ill. Adm. Code 140.485).


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


ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244-1850 (2010)).

Intervention – A deliberate interaction between staff and one or more Clients or a Client's Collateral for the purpose of alleviating the Client's symptoms of mental illness and improving the Client's level of functioning.

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 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 (LPC) 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 Nurse Practice 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 or 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 Nurse Practice 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).

Medical Necessity or Medically Necessary – An LPHA has determined through assessment that a Client has a diagnosis of mental illness or serious emotional disorder as defined in the ICD-10-CM or DSM-5 that has resulted in a significant impairment in the Client's level of functioning in at least one major life functional
area and needs one or more mental health services that are identified in the Mental Health Assessment and ITP to stabilize the Client's functioning, or to restore or rehabilitate the Client to a maximum level of life functioning. For Clients under the age of 21, medical necessity or medically necessary may additionally mean that the Client has more than one documented criteria of a mental illness or serious emotional disorder as listed in the DSM-5 that is likely to impact the Client's level of role functioning across critical life areas and needs a Medicaid reimbursable Part 132 mental health service recommended by the completion of an approved Healthy Kids screen by a physician or the completion of a Mental Health Assessment and included in an ITP that could not have been omitted without adversely affecting the Client's level of functioning.

Mental Health Assessment or MHA – A Mental Health Assessment required by Section 132.148(a) to assess the need for Part 132 services.

Mental Health Intensive Outpatient Services – Scheduled group therapeutic sessions made available for at least 4 hours per day, 5 days per week. Mental health intensive outpatient services are further defined in Section 132.150(j).

Mental Health Professional or MHP – An individual who provides services under the supervision of a Qualified Mental Health Professional and who possesses: a bachelor's degree in counseling and guidance, rehabilitation counseling, social work, education, vocational counseling, psychology, pastoral counseling, family therapy, or related human service field; a bachelor's degree in any other field with two years of supervised clinical experience in a mental health setting; a practical nurse license under the Nurse Practice Act [225 ILCS 65]; a certificate of psychiatric rehabilitation from a DHS-approved program plus a high school diploma or GED plus 2 years experience in providing mental health services; a recovery support specialist certified from, and in good standing with, the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc.; 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 a high school diploma or GED and 5 years supervised clinical experience in mental health or human services. A supervised internship in a mental health setting counts toward the experience in providing mental health 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. Any individual employed as an MHP prior to July 1, 2013 may continue to be so designated unless employment changes.

Mental Health Setting – A location, public or private, in a group or individual
practice, in a mental health center, hospital or clinic where services intended to reduce symptoms of mental illness are provided to persons with mental illness.

Mental Illness – A mental or emotional disorder diagnosis contained in the DSM-5 or ICD-10-CM or, for Clients under age 21, symptoms of mental illness that are likely to impact the Client's level of role function across critical life areas, 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.

Natural Setting – A setting where an individual who has not been diagnosed with a mental illness typically spends time, including home, school, work, churches, community centers, libraries, parks, recreation centers, etc. These sites are not licensed, certified or accredited as a treatment setting nor typically identified as treatment sites.

Natural Support – Persons identified by the Client who are not paid to provide support, e.g., family, friends, pastor.

Notice of Deficiencies – A written document that specifies the standards within this Part with which the Provider is not compliant.

Notice of Non-certification – A written document that notifies the applicant or Provider that the Certifying State Agency is not issuing a Certificate of Certification.

Notice of Suspension from Billing – The report generated under Section 132.42(f) following a post-payment review that details the findings for the review when less than 50% of the billings have been found to be substantiated.

Notice of Unsubstantiated Billings – The report generated under Section 132.42(c) following a post-payment review that details the findings of the review.

Off-site – Locations other than those considered on-site.

On-site – Location that is a certified Provider site as described in Section 132.90 and the surrounding Provider owned, leased or controlled property and buildings and adjacent parking areas. Additionally, any service that is provided via telephone or video or that is provided to a Client in a staff person's office in a certified site is considered on-site.
One Year Experience – A period of time consisting of at least 1,500 work hours.

Original Signature – A signature affixed to any document that is made by the person to whom the signature belongs, either in ink or via electronic means compliant with Section 132.85(f).

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.

Plan of Correction – Plan submitted in response to findings from the Certifying State Agency of non-compliance resulting from a certification or post-payment review that specifies actions the Provider or applicant will take to come into compliance with this Part by correcting the cited violations. The Plan of Correction will include the time frame for compliance and how ongoing compliance will be monitored and assured.

Provider – An organization certified to provide Medicaid community mental health services in accordance with this Part that is a sole proprietorship, partnership, limited liability corporation, unit of local government, or corporation, public or private, either for profit or not for profit.

Psychosocial Rehabilitation Service or PSR Service – Facility-based rehabilitative skill-building services for adults age 18 and older with serious mental illness or co-occurring psychiatric disabilities and addictions. The PSR interventions focus on identification and use of recovery tools and skill building to facilitate independent living and adaptation, problem solving and coping skills development. PSR service is further defined in Section 132.150(i).

Psychotropic Medication – Medication whose use for antipsychotic, antidepressant, antimanic, antianxiety, behavioral modification or behavioral management purposes is listed in the AMA Drug Evaluations or Physician's Desk Reference, or that is administered for any of these purposes.

Psychotropic Medication Administration Service – 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. Psychotropic medication administration service is further defined in Section 132.150(c)(3).

Psychotropic Medication Monitoring Service – 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. Psychotropic medication monitoring
service is further defined in Section 132.150(c)(4).

Psychotropic Medication Training Service – 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. Psychotropic medication
training service is further defined in Section 132.150(c)(5).

Public Payer – 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 Nurse Practice 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 in a mental health
setting, or who has one year of clinical experience under the supervision
of a QMHP.
Any individual meeting the minimum credentials for a LPHA under this part is deemed to also meet the credentialing requirements of a QMHP.

Rehabilitative Services Associate or RSA – An RSA must be at least 21 years of age, be a high school graduate or have a GED certificate, 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 MHP, QMHP or LPHA under this Part is deemed to also meet the credentialing requirements of an RSA. Any individual employed as an RSA prior to July 1, 2013 may continue to be so designated unless employment changes.

Screening, Assessment and Support Services or 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.

Section 504 – Section 504 of the Rehabilitation Act of 1973 (29 USC 794).

Specialized Substitute 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 Human Services, or Department of Children and Family Services.


Suspended Certificate – A certificate that is temporarily inactive due to Certifying State Agency action.

Therapy/Counseling Service – A treatment modality that uses interventions based on psychotherapy theory and techniques to promote emotional, cognitive, behavioral or psychological changes as identified in the ITP. Therapy/counseling service is further defined in Section 132.150(d).

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 39 Ill. Reg. 13684, effective October 1, 2015)

Section 132.27 Provider Qualifying Conditions

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 a waiver increases the availability of mental health services to Medicaid-eligible Clients.

b) A Provider may not subcontract for services authorized by this Part. If a Provider is unable to provide a service needed by a Client, the Provider may refer the Client to another certified Provider if another certified Provider is available and if the Client agrees to the referral. For purposes of this subsection, a contractual employee or an individual on contract is not considered to be a subcontractor.

c) Billings for services rendered under this Part shall be submitted only by the Provider that directly provided the service and only to the Public Payer that is funding the service.

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

Section 132.30 Application, Certification and Recertification Processes

a) 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 to provide Medicaid community mental health services 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.

b) 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

c) The applicant shall submit to DHS or DCFS 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 include information including, but not limited to:

A) Applicant name and business status, including evidence of being in good standing to do business in the State of Illinois;

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

C) Description of population to be served, including age groups;

D) Description of how the Clients will actively participate in the development of their ITP and ongoing services;
E) Description of each service to be certified, how it will be provided by the applicant, and evidence of applicant's ability to provide each service in compliance with this Part:

i) For Psychosocial Rehabilitation, the applicant must submit a work week schedule for each site, including the name of the staff at each location who has co-occurring training or experience;

ii) For Assertive Community Treatment, the applicant must submit the names of staff on each team, indicating their credentials and their role on the team, e.g., CRSS, experience in co-occurring disorders, and the time worked each week; and

iii) For Community Support Team, the applicant must submit the names of staff on each team, indicating their credentials and their role on the team, and the amount of time that each staff works on the team weekly;

F) List of sites to be certified and the services to be provided at each site;

G) The address of all accessible sites and the plan for modifications needed for persons with disabilities;

H) Fire clearance for each site, pursuant to Section 132.90;

I) A staffing roster including staff qualifications and supervisory responsibilities for each of the sites; and

J) Policies required in Subpart B of this Part.

d) If the application form and all of the required components are in compliance with this Part, the Certifying State Agency shall issue to the Provider a Certification Certificate for the Medicaid Community Mental Health Services Program.

1) The Certifying State Agency shall issue the Certification Certificate within 30 days after the Certifying State Agency receives the completed application and all required components. The effective date of certification shall be the date that the application 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 and submit them to HFS to enroll the sites in the Illinois medical assistance program (89 Ill. Adm. Code 140).

2) The Certification Certificate shall be in effect for three years.

3) The Provider shall deliver only mental health services under this Part for which it is certified.

4) 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 within 30 days after occurrence.

5) A Provider is expected to provide Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Community Support Residential (CSR) and Community Support Team (CST) services as described in Section 132.150 within 90 days after being notified of certification for the services. If the service is not implemented within 90 days, the Provider must show compliance with the requirements in Section 132.30(c)(3)(E) before the Part 132 services can be provided.

6) If a Provider has been certified for PSR, ACT, CSR or CST services and decides to no longer provide those services, the Provider shall notify the Certifying State Agency at least 60 days prior to discontinuing the services. The service may be subject to removal from the certificate. Prior to discontinuing the service, the Provider shall submit a plan to the Certifying State Agency for transitioning Clients to other services or to other Providers.

7) The Provider shall submit team rosters for ACT and CST services upon Public Payer request.

e) If the application form and all of the required components are not in compliance with this Part, the Certifying State Agency shall issue a Notice of Deficiencies within 30 days after receiving the application.

1) If the applicant intends to proceed with applying for Medicaid certification, the applicant shall submit corrected documents to address all of the deficiencies by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies. The applicant shall submit the corrected documents to the Certifying State Agency that received the application and issued the Notice of Deficiencies.
2) If the corrected documentation is found to address all of the deficiencies included in the Notice of Deficiencies, then the Certifying State Agency shall proceed with all requirements identified in Section 132.30(d).

f) If the applicant fails to submit corrected documentation that demonstrates compliance with this Part by the due date indicated on the Notice of Deficiencies, the Certifying State Agency shall issue a Notice of Non-certification. The applicant may reapply by submitting a complete application packet to the Certifying State Agency.

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

Section 132.31 Certification Review Cycle

a) Initial Certification Review
Within 14 months after the date of the approval of the application for certification, the Certifying State Agency shall conduct an initial on-site certification review.

1) At the review, the Certifying State Agency shall evaluate the Provider's compliance with this Part and note the Provider's level of compliance as follows:

A) Level 1 – Compliant: 90-100% Compliance
   i) Providers who achieve Level 1 will be considered to be in good standing with the Certifying State Agency.
   ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.
   iii) The Provider will not be required to submit a Plan of Correction in response to the Notice of Deficiencies.

B) Level 2 – Substantially Compliant: 75-89% Compliance
   i) Providers who achieve Level 2 will be considered to be in good standing with the Certifying State Agency.
   ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying
State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.

iii) The Provider shall submit a written Plan of Correction to address each of the deficiencies included in 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.

iv) The Provider must submit the Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.

v) The Certifying State Agency shall review the Plan of Correction and notify the Provider of the results of the review within 30 days after submission of the Plan of Correction. If a Provider submits a Plan of Correction that does not address the deficiencies noted during a review, 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 the date it was notified of the unacceptable Plan of Correction. Pursuant to Section 132.47, the Certifying State Agency may suspend the Provider's certification if the Provider fails to submit an acceptable revised Plan of Correction within 10 days after the date of notification.

C) Level 3 – Minimally Compliant: 50-74% Compliance

i) Providers who score a Level 3 will not be considered to be in good standing with the Certifying State Agency.

ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.

iii) The Provider shall submit a written Plan of Correction to address each of the deficiencies included in 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.

iv) The Provider must submit the Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.

v) The Certifying State Agency shall review the Plan of Correction and notify the Provider of the results of the review within 30 days after submission of the Plan of Correction. If a Provider submits a Plan of Correction that does not address the deficiencies noted during a review, 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 the date it was notified of the unacceptable Plan of Correction. Pursuant to Section 132.47, the Certifying State Agency may suspend the Provider's certification if the Provider fails to submit an acceptable revised Plan of Correction within 10 days after the date of notification.

vi) Within 90 days after the date that the Plan of Correction is approved, the Certifying State Agency shall conduct a Level 3 focused review to evaluate the Provider's implementation of the Plan of Correction. The Provider's level of compliance must reach the equivalent of at least Level 2 to demonstrate implementation of the Plan of Correction.

vii) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference.

viii) If the Provider fails to implement the Plan of Correction within 90 days from the date of the Plan of Correction acceptance, as evidenced by less than the equivalent of a Level 2, the Certifying State Agency may suspend the Provider's certification to provide services pursuant to this Part.

D) Level 4 – Unsatisfactorily Compliant: Under 50% Compliance
i) Providers who score a Level 4 will not be considered to be in good standing with the Certifying State Agency.

ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.

iii) The Provider shall submit a written Plan of Correction to address each of the deficiencies included in 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.

iv) The Provider must submit the Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.

v) The Certifying State Agency shall review the Plan of Correction and notify the Provider of the results of the review within 30 days after the submission of the Plan of Correction. If a Provider submits a Plan of Correction that does not address the deficiencies noted during a review, 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 address the deficiencies within 10 days after the date it was notified of the unacceptable Plan of Correction. Pursuant to Section 132.47, the Certifying State Agency may suspend Provider's certification if the Provider fails to submit an acceptable revised Plan of Correction within 10 days after the date of notification.

vi) Within 60 days after the date that the Plan of Correction is approved, the Certifying State Agency shall conduct a Level 4 focused review to evaluate the Provider's implementation of the Plan of Correction. The Provider's level of compliance must reach the equivalent of at least Level 3 to demonstrate implementation of the Plan of Correction.
vii) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference.

viii) If the Provider fails to implement the Plan of Correction within the designated timeframe, as evidenced by achieving less than the equivalent of Level 3, the Certifying State Agency may suspend the Provider's certification to provide services pursuant to this Part.

ix) Within 90 days after the date that the Plan of Correction is approved, the Certifying State Agency may conduct a Second Level 4 focused review to evaluate the Provider's implementation of the Plan of Correction. The Provider's level of compliance must reach the equivalent of at least Level 2 to demonstrate implementation of the Plan of Correction. If the Provider's level of compliance in the first Level 4 focused review reached the equivalent of at least at Level 2, the Second Level 4 focused review is not required.

x) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference.

xi) If the Provider fails to implement the Plan of Correction within 60 days from the date of the Plan of Correction acceptance, as evidenced by achieving less than the equivalent of Level 2, the Certifying State Agency may suspend the Provider's certification to provide Part 132 services.

2) Initial Certification Focus Review
For all Providers that scored a Level 2 through 4 in their initial certification review, within 12 months after the date that the Plan of Correction was approved, the Certifying State Agency shall conduct an initial certification focus review to evaluate the Provider's implementation of the Plan of Correction.

A) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue an Initial Certification Focus Review Notice of Deficiencies to the Provider within 30 days after the completion of the review.
B) The Provider shall submit a written Amended Plan of Correction to address each of the remaining deficiencies. The Amended 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.

C) The Provider must submit the Amended Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.

D) The Certifying State Agency shall review the Amended Plan of Correction and notify the Provider of the results of the review within 30 days after submission of the Plan of Correction.

b) Three Year Recertification Review
The Certifying State Agency will conduct a full review of the Provider's compliance with all requirements of this Part on or around the expiration date of the current certification. At this review, the Certifying State Agency shall evaluate the Provider's level of compliance under subsection (a)(1).

1) For all Providers that score a Level 2 through 4 in their three year recertification review, within 14 months after the date that the Recertification Review Plan of Correction was approved, the Certifying State Agency shall conduct a recertification focus review to evaluate the Provider's implementation of the Plan of Correction. The focus review and follow-up will be conducted pursuant to subsection (a)(2).

2) For all Providers that score Level 2 through 4 in their three year recertification review, a follow-up focus review may be done within 12 months after the date that the Recertification Focus Review Plan of Correction was approved to evaluate the Provider's implementation of the Plan of Correction. The focus review and follow-up will be conducted pursuant to subsection (a)(2).

c) The Certifying State Agency, or its 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 any certification, recertification or other compliance review for Part 132 services. Access to records shall occur in accordance with the Confidentiality Act.

(Source: Added at 38 Ill. Reg. 15550, effective July 1, 2014)
Section 132.33 Certification of New Sites of Services

a) Providers that seek certification for a new site shall submit the following documents 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 the additional site complies with local and State fire safety ordinances and codes pursuant to Section 132.90(b)(1). For Providers certified by DHS, the clearance letter must come from the Office of the State Fire Marshal only.

2) 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(a) and, when applicable, the Provider’s plan for reasonable modifications of the site to meet the service needs of Clients unable to access the site due to physical inaccessibility.

3) A list of the Part 132 services that will be provided at the site.

b) Providers that seek certification for additional Part 132 services pursuant to Sections 132.148, 132.150 and 132.165 shall submit a description of the additional services, including evidence of compliance with specific service definition in this Part, and the sites where the services will be delivered. The description shall state how the additional services will be provided within the Providers’ program and shall include a listing of the LPHAs and QMHPs who will be responsible for directing the services. The Provider shall submit the documents for certification of additional services to the Certifying State Agency.

c) Additional sites or services must be approved by the Certifying State Agency before the additional sites or services may be used or provided.

d) Approved additional sites or services shall be indicated on a revised certificate. If additional sites are certified, the Provider shall enroll the sites in the Illinois medical assistance program. The addition of sites or service will not alter the expiration date of the certificate.

e) The Certifying State Agency shall include all additional sites or services on the next on-site certification review.

(Source: Added at 38 Ill. Reg. 15550, effective July 1, 2014)
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 Public Payer may conduct post-payment reviews to determine billing amounts subject to recoupment as a result of non-compliance with this Part. The Public Payer, HFS, or their respective agents shall be granted access to all Provider sites. All records shall be made available to the Public Payer, HFS, or their respective agents, on request during any post-payment review for payment of services delivered under this Part. Access to records shall occur in accordance with the Confidentiality Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5) Once suspension from billing is lifted, the Provider may submit bills that have the required documentation for services provided during the suspension.
6) If corrections are not made within 60 days, the Certifying State Agency may suspend the Provider's certification.

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

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

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

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

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

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

Section 132.44 Appeal of Post-Payment Review Findings

a) 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 of Unsubstantiated Billings. The appeal shall specify the grounds for the appeal.

b) The sole issue at the hearing shall be whether the Provider is in compliance with requirements set forth in this Part.

c) 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.

d) 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.

e) 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.

f) 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].

g) A Provider shall be liable for reimbursement of bills 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 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.45 Compliance with Certification Requirements (Repealed)

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

Section 132.47 Suspension of Certification

The Certifying State Agency may suspend certification during a certification period for any of the following reasons:

a) A Provider discontinues delivery of all Medicaid community mental health services for which the Provider has been certified;

b) A Provider has less than 50% of its reviewed bills substantiated in a post-payment
review and has not made required corrections within 60 days pursuant to Section 132.42(f)(2);

   c) A Provider fails to submit a Plan of Correction; or

   d) A Provider fails to implement a Plan of Correction.

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

Section 132.48 Reinstatement Following Suspension of Certification

Certification will be reinstated from suspension by the Certifying State Agency when:

   a) A Provider begins delivery of Medicaid community mental health services as defined under Sections 132.148, 132.150 and 132.165 prior to one calendar year from the date of suspension under Section 132.47(a).

   b) An on-site review of the Provider shows that corrections have been made to its documentation process so that it is in compliance with this Part prior to the end of one calendar year from the date of suspension under Section 132.47(b).

   c) A Provider submits a Plan of Correction and demonstrates implementation of the Plan of Correction prior to the end of one calendar year from the date of suspension under Section 132.47(c) and (d).

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

Section 132.50 Revocation of Certification

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

   a) Provider meets any of the grounds for termination set forth in 89 Ill. Adm. Code 140.16;

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

   c) Provider's certificate is suspended longer than one calendar year; or

   d) Provider shows a consistent failure to correct deficiencies and maintain those corrections by scoring 74% or less during two consecutive recertification reviews or having less than 50% of its reviewed bills substantiated in two consecutive
post-payment reviews.

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

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;
3) Suspension of certification; or
4) Revocation of certification.

b) Certification Appeal Criteria and Process

1) If the Certifying State Agency determines that certification or recertification shall not be issued, that certification shall be suspended, or that certification shall be revoked, the Certifying State Agency shall send 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.

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
2) If the applicant or Provider does not submit a request for a hearing, as provided in this Section, or if, after conducting the hearing, the Certifying State Agency determines that the certification or recertification shall not be issued or that the certification shall 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 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.58 Utilization Management by the Public Payer

a) The recommendation by the provider's LPHA using the standards in Section 132.145 for determining medical necessity may be reviewed by an LPHA employed by the public payer, or an LPHA designee to confirm ongoing medical necessity for each prescribed service in each client record selected for review after the initiation of services. The public payer shall notify the provider of the findings of the medical necessity review within 7 days after the end of the review.

b) If there is a finding in the review that ongoing medical necessity is not demonstrated, the public payer may not pay for any service it determines is not medically necessary unless a request for reconsideration or an appeal is filed.

c) If the public payer and the LPHA of the provider do not concur on medical necessity, the provider may request reconsideration of the decision of the public payer in writing within 30 days after the review to the public payer specifying the grounds for the reconsideration. The provider may submit additional supporting evidence or documentation for the reconsideration. During the reconsideration, the client may continue to receive service that will be funded by the public payer.

1) The reconsideration request shall be reviewed by an LPHA, designated by the public payer, who has not been involved in the medical necessity review finding, within 14 days after receipt of the reconsideration request.

2) If the LPHA denies the reconsideration request of the provider, the
provider may appeal in writing within 5 days after the date of the denial to the director/secretary of the public payer. No additional evidence or documentation may be provided for the appeal.

3) The appeal provisions in Section 132.44 are not applicable to appeals under this Section.

4) The director/secretary shall issue a final administrative decision regarding the appeal.

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

d) If an appeal is filed, the client may continue to receive service that will be funded by the public payer during the appeal process.

e) If the finding of the final appeal agrees that the service is not medically necessary, the provider must inform the client of the finding and work with the client to make an informed choice about continuing the service with non-public payer funding or receiving a different medically necessary Part 132 service.

(Source: Added at 35 Ill. Reg. 8860, effective May 26, 2011)

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, interpreters 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 time 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) Off-site rates shall be calculated to compensate providers for staff time necessary for travel to off-site treatment locations.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

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.

f) The provider shall have an active system for determining compliance with all client record requirements of this Part.

1) The provider shall maintain policies describing the methods for performing client record compliance audits. Audits shall be performed by persons not involved in providing services to the clients whose records are reviewed;

2) The provider shall maintain procedures describing the method for selecting cases for client record compliance audits. Procedures shall include methods for ensuring a review of 10 percent of the clients served under this Part annually; and

3) Client record compliance audits shall verify each client record's compliance with requirements included in Sections 132.100, 132.142, 132.145(b), 132.148, 132.150 and 132.165.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

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, interns and other unpaid personnel;

2) Documentation that staff, volunteers, interns and other unpaid personnel 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. 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) Providers shall not allow any person to work or volunteer in any capacity until the provider has inquired of the Department of Public Health as to information in the Health Care Worker 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) Providers shall perform background checks in compliance with requirements set forth in the Healthcare Worker Background Check Act and in the Illinois Department of Public Health’s rules at 77 Ill. Adm. Code 955.

e) Each provider shall develop, implement and maintain a plan for clinical supervision of QMHPs, MHPs and RSAs who perform Part 132 services. Group supervision is acceptable and the size of the group should be conducive to the provision of clinical supervision. Supervision must be documented in a written record. Supervision of staff as noted in this subsection must be for a minimum of one hour per month through face-to-face, teleconference or videoconference.

1) QMHPs must be supervised by an LPHA.

2) MHPs and RSAs must be supervised by, at a minimum, a QMHP.

3) LPHAs are not required to have clinical supervision under this Section.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

Section 132.75 Program Evaluation (Repealed)

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

Section 132.80 Fiscal Requirements
a) 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.

b) 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 Part 132 services.

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

Section 132.85 Recordkeeping

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

1) Documents required for cost reporting and audit purposes as per the executed contract between the provider and the public payer;

2) Service billing files;

3) Clinical records as defined in Section 132.100; and

4) Individual client information, including representative payee, trust beneficiary and resource availability; and

5) all other documents as required in this Part.

b) Required records shall be retained for a period of not less than 6 calendar 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 delivery and documentation of services.

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, HIPAA and HITECH.

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 when compliant with the following requirements:

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 36 Ill. Reg. 18582, effective December 13, 2012)

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, as amended, and the Illinois Accessibility Code and the ADA Accessibility Guidelines, whichever is more stringent. Providers must maintain a written policy for reasonable modifications for the provision of services to Clients unable to access the Provider's sites due to physical inaccessibility.

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.

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

1) 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.

2) 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) If a Provider offering only non-residential services is accredited and is in compliance with this Section at the time of recertification, on-site inspections may 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.

e) 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 this Section at the time of recertification. All new sites shall be required to undergo on-site inspection.

f) 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 38 Ill. Reg. 15550, effective July 1, 2014)

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) 2012 Hospital Accreditation Standards (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);

2) 2012 Standards for Behavioral Health Care (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);

3) 2012 Comprehensive Accreditation Manual for Health Care Networks
(Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);

4) Council on Accreditation Standards, Eighth Edition (Council on Accreditation of Services for Families and Children (COA), 120 Wall Street, 11th Floor, New York, New York 10005, 2012);

5) Quality Outcomes 2012 (The Council on Quality and Leadership, 100 West Road, Suite 406, Towson, Maryland 21204, 2012);

6) Standards Manual and Interpretive Guidelines for Behavioral Health (Commission on Accreditation of Rehabilitation Facilities (CARF), 4891 East Grant Road, Tucson, Arizona 85711, 2012); or

7) Healthcare Facilities Accreditation Program (HFAP), (2008 Accreditation Requirements for Mental Health Centers, 142 E. Ontario Street, Chicago IL 60611).

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), the Certifying State Agency shall deem the Provider to be in compliance with the following Sections of this Part:

1) Section 132.65(a), (b), (c), (d) and (e);

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

3) Section 132.80(a);

4) Section 132.85(a), (b), (c), (d) and (e);

5) Section 132.90(a), (b)(2), (c), (d), (e) and (f);

6) Section 132.95(b), (d), (e), (f), (g), (h), (i) and (j);

7) Section 132.100(b), (c), (d), (f), (g), (h), (j), (k) and (l); and

8) Section 132.145(c).

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 is suspended, lost or discontinued, the Provider shall notify the Certifying State Agency of that change within 30 days after the effective date of the change.

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 subsection (b).

f) Granting of deemed status is subject to annual review of national accreditation standards and revision of this Part pursuant to the Illinois Administrative Procedure Act [5 ILCS 100].

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

Section 132.95 Utilization Review

The provider shall have a written utilization review (UR) plan and ongoing assessment of the medical necessity of Medicaid community mental health services, including the intensity/level of services and continued need for each service for the client. The written UR plan shall address:

a) A review of medical necessity or that services are medically necessary, as determined by:

1) The definition of medical necessity in this Part;

2) The type, severity and chronicity of the client’s symptoms;

3) The severity of impairment in the client’s role functioning;

4) The risks that a client’s symptoms or level of role functioning pose to the safety of the client or to others with whom the client interacts;

5) The expected short-term and long-term outcome of each service needed by the client; and

6) Progress made in response to treatment, if the client is currently receiving treatment;

b) 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;
c) 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;

d) 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;

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

f) Procedures to ensure that the review includes and summarizes the client's involvement in service planning and provision over the previous 90 days;

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

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

i) Provisions for ensuring confidentiality of individual case reviews, determinations, results and/or recommendations in accordance with the Confidentiality Act and HIPAA; and

j) Procedures for following up on case review recommendations.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

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, method of communication, and documentation of how anything other than verbal English communication needs were accommodated, 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 or Healthy Kids screen, if applicable;

f) Documentation concerning the prescription and administration of psychotropic medication as specified in Section 132.150(c)(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, shall support the amount of time claimed, 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 original signature, name and credential of the staff providing the service;

5) The site or, if off-site, the specific off-site location where services were rendered; and

6) Written documentation of each service provided as described in Section 132.148, 132.150 or 132.165;

j) ITP reviews describing the Client's overall progress;
k) A written record of the Client's major accidents or incidents that occurred at the site, whether self-reported or observed, and resulting in an adverse change in the Client's physical or mental functioning; and

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

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

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 (Repealed)

(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 record. Documentation shall include a plan with measurable objectives for restoring the client's rights that is signed by the client or the client's parent or guardian, the QMHP and LPHA. In addition, the client affected by such restrictions, his or her parent or guardian, as appropriate, and any agency designated by the client pursuant to subsection (d)(2) of this Section shall be notified of the restriction and given a copy of the plan to remove the restriction of rights.

d) Staff shall inform the client prior to evaluation services and annually 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. The client or guardian will be informed on how his or her grievances will be handled at the provider level. 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 the final authority at the provider level);

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

7) The right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances; and

8) The right to have disabilities accommodated as required by the American With Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5].

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: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

Section 132.145 General Provisions

A provider shall comply with the following:

a) Informed Consent

1) Prior to the initiation of mental health services, the provider shall obtain written or oral consent for these services demonstrating that the client or guardian, as applicable, knows all of the risks and costs involved in the treatment, including the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment.

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 outpatient sessions of no more than 45 minutes in duration.

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.
b) An LPHA shall provide the clinical direction and recommend medically necessary services as documented by his or her dated original signature with credentials on the mental health assessment and ITP. In determining whether there is medical necessity for each service under this Part, the LPHA shall consider and document that consideration, among other factors, including:

1) The definition of medical necessity in this Part;

2) The type, severity and chronicity of the client's symptoms;

3) The severity of impairment in the client's role functioning;

4) The risks that a client's symptoms or level of role functioning pose to the safety of the client or to others with whom the client interacts;

5) The expected short-term and long-term outcome of each service needed by the client;

6) Progress made in response to treatment, if the client is currently receiving treatment; and

7) Criteria or guidance published by the public payer for the purposes of defining and evaluating the medical necessity of each service.

c) 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.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

Section 132.148 Evaluation and Planning Services

a) Mental health assessment (MHA) service 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. MHA services may be
provided without appearing on an ITP.

1) An Admission Note may be used to initiate services prior to the
completion of a mental health assessment for a Client who is admitted to a
specialized substitute care living arrangement; a residential facility
designated by the Public Payer for the purpose of stabilizing a crisis; or
Assertive Community Treatment (ACT) prior to the completion of a
comprehensive assessment as required in Section 132.150(h)(2)(A). An
Admission Note must be completed within 24 hours after a Client's
admission and is effective for a maximum of 30 days.

A) An 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 and method of communication, date of
   initial 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 original
signature with credentials on the Admission Note.
2) An HFS approved Healthy Kids mental health screen may be used to initiate services prior to the completion of a mental health assessment by a Provider certified under this Part for a Client who is under age 21.

A) A Healthy Kids screen remains effective for the initiation of services for 60 days from the date the physician completed it as indicated by physician dated signature.

B) A Healthy Kids screen may be used by a certified Provider for a maximum of 30 days from the initial face-to-face contact with the Client while the mental health assessment is being completed.

3) 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 psychological evaluation services described in subsection (b), crisis services described in Section 132.150(b) and case management services described in Section 132.165(a)(1).

4) The Provider shall complete a mental health assessment report within 30 days after the first face-to-face contact for services not initiated with an Admission Note or Healthy Kids mental health screen. When a Client is hospitalized for crisis services, the first face-to-face contact shall be the initial contact following discharge from the hospital.

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

A) Identifying information: name, gender, date of birth, primary language and method of communication, name and contact information of Client's primary care physician, and guardian;

B) Reasons for seeking or being referred for current mental health treatment, including symptoms of mental illness;

C) DSM-5 or ICD-10-CM diagnosis;

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

E) Mental status evaluation;
F) Client preferences relating to services and desired treatment outcomes;

G) Personal history of symptoms of mental illness and mental health treatment, date of most recent psychiatric evaluation, and whether the Client has taken or is now taking psychotropic medication;

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

I) Social adjustment and daily living skills;

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

K) Identification of factors in the current environment that may create threats to Client's personal safety (e.g., gang involvement, domestic violence, elder abuse);

L) Strengths and resources (e.g., education and vocational skills, current employment and employment history, interests/hobbies, financial and material resources, and supportive social relationships with family and friends, as well as more intrinsic resources, including hope, motivation, self-confidence and sense of belonging within a community of one's peers);

M) History of and current alcohol or other substance use, abuse or dependence, and any previous substance use treatment/recovery efforts;

N) Client's report on general physical health, including date of last physical examination; and

O) Summary analysis and conclusions regarding the medical necessity of services.

6) If a definitive diagnosis has not been determined per the DSM-5 or the ICD-10-CM by the time the MHA report is completed or a rule out diagnosis is given, the MHA report must contain documentation as to what evaluations will occur in order to provide a definitive diagnosis. A definitive diagnosis shall be determined within 90 days after the completion of the MHA report.
7) 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 original signature with credentials on the mental health assessment. MHPs may participate in the mental health assessment.

8) 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.

9) The mental health assessment report shall be reviewed and approved by the LPHA as documented by the LPHA’s dated original signature with credentials 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.

10) The mental health assessment shall be updated annually by the QMHP who has, at a minimum, one face-to-face contact with the Client to complete the updated mental health assessment. The annual update must occur within 12 months after the LPHA’s original signature on the mental health assessment report or the previous update. The QMHP shall be responsible for the completed update as documented by his or her dated original signature with credentials on the updated mental health assessment. The LPHA shall review and approve the assessment as documented by the LPHA’s dated original signature with credentials on the updated mental health assessment. MHPs may participate in the mental health assessment update.

11) For services initiated by an Admission Note or Healthy Kids mental health screen, the Provider shall complete a mental health assessment report or a comprehensive assessment for an ACT Client within 30 days after the Client’s admission.

12) The annual update of the mental health assessment shall minimally include all requirements specified under subsection (a)(5) with the exception of requirements listed under subsections (a) (5) (A), (D), (G) and (H). Providers may include requirements under subsections (a) (5) (A), (D), (G) and (H) as medically necessary and clinically indicated as part of the mental health assessment update. Following review of a requirement,
Providers may also indicate "no change" where applicable on the mental health assessment update if there has been no change in status.

13) Specific documentation of the delivery of mental health assessment service must include a description of the time spent with the Client or Collateral gathering information.

b) Psychological Evaluation

1) A psychological evaluation service, if recommended, shall:

A) Be completed within 90 days after completion of the MHA report, be documented by the Provider, and be consistent with the Clinical Psychologist Licensing Act [225 ILCS 15] using nationally standardized psychological assessment instruments; a master's level professional may assist;

B) Be conducted face-to-face or video conference with the Client; and

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

2) Specific documentation of the delivery of psychological evaluation service must identify the specific nationally standardized psychological assessment instruments used.

c) Treatment plan development, review and modification service 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. The ITP may be known also as a rehabilitation treatment plan or a recovery treatment plan. Active participation by the Client and the Client's parent/guardian, as applicable, is required for all ITP development, whether it is the initial ITP or subsequent reviews and modifications. The Client may choose to actively involve Collaterals in the ITP process. Participation by the Client and the Client's parent/guardian, as applicable, shall be documented in the plan and confirmed by the Client's and the parent's/guardian's, as applicable, dated original signature on the ITP. In the event that a Client or the Client's parent/guardian, as applicable, refuses to sign the ITP, the LPHA, QMHP or MHP shall document the reason for refusal and indicate by his or her dated original signature with credentials on documentation in the record that the ITP was developed with the active participation of the Client and the Client's parent/guardian, as applicable, and that the Client or the Client's parent/guardian, as applicable, refused to sign the ITP.
1) The initial ITP shall be completed within 45 days after the completion of the mental health assessment as documented by the LPHA's dated original signature with credentials on the ITP. When an Admission Note or Healthy Kids mental health screen was completed to initiate services, the ITP shall be developed, following the completion of a mental health assessment, within 30 days after the Client's date of admission.

2) A written ITP is a compilation of the following:
   A) The goals/anticipated outcomes of services;
   B) Intermediate objectives to achieve the goals;
   C) The specific Part 132 mental health services to be provided;
   D) The amount, frequency and duration of Part 132 services to be provided; and
   E) Staff responsible for delivering services.

3) The ITP shall include a definitive diagnosis per the DSM-5 or the ICD-10-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 include the diagnosis determined as a result of additional evaluations recommended in the MHA report within 90 days after completion of the MHA report.

4) Responsibility for development, review and modification of the ITP shall be assumed by a QMHP as documented by his/her dated original signature with credentials 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 original signature with credentials on the ITP.

5) The LPHA and the QMHP shall review the ITP no less than once every 6 months from the date of the LPHA original signature on the most recent ITP to determine if the goals set forth in the ITP are being met and whether each of the services described in the plan has contributed to meeting the stated goals. The ITP shall be modified if it is determined that there has been no measurable reduction of disability or restoration of functional level.
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/or persons of the Client's choosing, which may include a 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.

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) Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110], a copy of the signed ITP shall be given to the Client 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 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 or a Healthy Kids mental health screen completed by a physician is in the Client record;

ii) The specific Part 132 service is recommended as medically necessary on the completed mental health assessment or Admission Note or Healthy Kids mental health screen; and
iii) The specific Part 132 services provided are included in the completed ITP, signed by an LPHA as required by this Part.

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.

12) Specific documentation of delivery of treatment plan development, review and modification service must include a description of the time spent with the Client or Collateral developing, reviewing or modifying the ITP.

(Source: Amended at 39 Ill. Reg. 13684, effective October 1, 2015)

Section 132.150 Treatment 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 as permitted under each specific service;

C) To clients, and their families or collaterals at the client's request or agreement; with groups of clients; or with the client's family or collaterals 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 include interventions 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.

7) Specific documentation of the delivery of crisis service must include a preliminary assessment, a description of the intervention and the client response to service.

c) 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 prescribed for the client;

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

iii) Any problems with psychotropic medication administration and changes 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) Psychotropic medication administration service

   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 administration services must be provided face-to-face.

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

   D) Specific documentation of the delivery of psychotropic medication administration service must include a description of the activity.

4) Psychotropic medication monitoring service

   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 may be provided face-to-face or using videoconferencing, with one exception. Phone consultation is allowed for psychotropic medication monitoring when a client is experiencing adverse symptoms from psychotropic medication and phone consultation with another professional is necessary.

   C) 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.
D) Specific documentation of the delivery of psychotropic medication monitoring service must include a description of the intervention.

6) Psychotropic medication training service

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 may be provided face-to-face or using video conferencing.

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

D) 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.

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

F) Specific documentation of the delivery of psychotropic medication training service must include a description of the intervention, client’s or family/s/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

d) Therapy/counseling service is a treatment modality that uses interventions based on psychotherapy theory and techniques to promote emotional, cognitive,
behavioral or psychological changes as identified in the ITP. Services shall be provided face-to-face, by telephone or videoconference.

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) Specific documentation of the delivery of therapy/counseling services must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

e) Community Support – CS service

1) Community Support – Services are mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist clients in achieving rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources. CS services help clients develop and practice skills in their home and community.

2) Service activities and interventions shall include:

   A) Assistance with identifying, coordinating and making use of individual strengths, resources, preferences and choices in natural settings;

   B) Assistance with identifying and developing existing and potential natural support persons and teams;

   C) Assistance with the development of crisis management plans;

   D) Assistance with identifying risk factors related to relapse, developing wellness plans and strategies and incorporating the
plans and strategies into daily routines in one's natural environments;

E) Support and promotion of client self-advocacy and participation in decision making, treatment and treatment planning and facilitating learning to do this for oneself;

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

G) Skill building and identification and use of adaptive and compensatory strategies 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;

H) Assistance with applying skills and strategies learned from provider-based services and interventions to life activities in natural settings; and

I) Identification and assistance with modifying habits and routines to improve and support mental health, resiliency and recovery.

3) Program requirements

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

B) CS services may be provided to:

i) An individual client;

ii) A group of 2 to 15 clients; or

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

C) A minimum of 60% of all Community Support services must be delivered in natural settings. This requirement will be monitored in the aggregate for a provider for an identified billing period separately for community support individual and community support group, but will not be required for each individual.
D) CS 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 involvement.

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

5) Specific documentation of the delivery of community support service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

f) Community Support − Residential (CSR) service

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

2) Interventions shall include those described in subsections (e) and (f).

3) CSR services shall be provided face-to-face, by telephone or by video conference in group or individual settings. Groups shall be composed of no more than 15 clients.

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) Specific documentation of the delivery of Community Support – Residential service must include a description of the intervention, client's
or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

g) Community Support – Team (CST) service

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 rehabilitative, resiliency and recovery goals. The service consists of interventions delivered by a team that facilitates illness self-management, skill building, identification and use of adaptive and compensatory skills, identification and use of natural supports, and use of community resources.

2) Interventions shall include those described in subsections (d) and (e)(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. 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 involvement;

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;

F) The CST shall conduct organizational staff meetings at least one time per week at regularly scheduled times, according to a schedule established by the team leader.
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. The individual must exhibit 3 or more of the following, or must currently be residing in a DMH residential setting or in a DCFS residential substitute care living arrangement from which transition to a less restrictive setting is imminent and, were it not for living in one of these settings, be reasonably expected by history to 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 calendar 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 and supportive interventions;

I) Because of behavioral health issues, the child or adolescent is at risk of out-of-home placement, is currently in out-of-home placement and reunification is imminent, is currently in out-of-home placement and at risk of residential placement, or is in residential placement and transition to a less restrictive placement 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 team approved by the public payer or its designee;
B) 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;
C) 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;
D) At least one member of the team who is a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP) in a program for children and adolescents. This staff person is a fully integrated CST member who provides consultation to the team and highly individualized services in the community, and who promotes self-determination and decision making; and
E) No fewer than 3 full-time equivalent staff meeting the required team components (shall include the team leader) and no more than 6 full-time equivalent staff totaling no more than 8 different staff.

7) Service exclusions
When a client is receiving CST, CS and CSR shall not be provided except under the following conditions:
A) In accordance with an ITP to facilitate transition to and from CST services; or

B) While a client is receiving services in a residential facility designated by the public payer for the purpose of stabilizing a crisis.

8) Specific documentation of the delivery of community support – Team service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

h) Assertive Community Treatment (ACT) service

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) 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 service;
E) Symptom assessment and management;
F) Supportive counseling and psychotherapy;
G) Medication prescription, administration, monitoring and documentation;
H) Dual diagnosis substance abuse services;
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 in natural settings.

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 be approved by the public payer or its designee.

B) 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 with the ACT team for up to 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 full-time staff 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.

C) 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.

D) At least one of the members of the team shall be an individual qualified as a Certified Recovery Support Specialist (CRSS). This staff person:

i) 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; and

ii) as of January 1, 2012, shall have six months to become certified as a CRSS, if not already certified.

E) At least one member of the core team shall have special training in rehabilitation counseling, including vocational, work readiness and educational support.
F) Each team shall be expected to maintain a staff to client ratio of no more than one full time 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) Service exclusions
   When a client is receiving ACT, other Part 132 services shall not be provided 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 admitted to a residential facility designated by the public payer for the purpose of stabilizing a crisis for a maximum of 30 days.

8) Specific documentation of the delivery of ACT service must include a description of intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

i) Psychosocial Rehabilitation service

1) Psychosocial rehabilitation (PSR) 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 PSR interventions focus on identification and use of recovery tools and 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 intervention as possible; and

   C) Achieve functional, social, educational and vocational goals.
2) Psychosocial rehabilitation services shall include the following interventions to assist the client in achieving improved community functioning:

A) Identification and use of strengths and recovery tools and strategies to overcome challenges, improve mental health and develop skills;

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

   i) Socialization, communication, adaptation, problem solving and coping;

   ii) Self-management of symptoms or recovery;

   iii) Concentration, endurance, attention, direction following, planning and organization; and

   iv) Establishing or modifying habits and routines;

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

C) 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. If a provider has multiple sites, the clinical supervisor or program director must be able to document a consistent schedule that includes on-site time at each location;

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 for groups shall not exceed one full-time equivalent staff to 15 clients.

5) Service exclusions

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

A) Intensive outpatient; or

B) Hospital-Based Psychiatric Clinic Service Type B.

6) Specific documentation of the delivery of psychosocial rehabilitation service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

j) 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 (j) 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.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

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 or Admission Note, 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.
3) Specific documentation of the delivery of mental health case management service must include a description of the activity.

b) Client-centered consultation services are individual client-specific professional communications among provider staff, or between provider staff and staff of other agencies who are involved with service provision to the client. The professional communication shall include offering or obtaining a professional opinion regarding the client's current functioning level or improving the client's functioning level, discussing the client's progress in treatment, adjusting the client's current treatment, or addressing the client's need for additional or alternative mental health services.

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

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

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

4) Specific documentation of the delivery of mental health client-centered consultation service must include a description of the consultation that occurred, the professional consulted, and the resulting recommendations.

c) 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.

3) Specific documentation of the delivery of mental health transition linkage and aftercare service must include a description of the activity.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)

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 ____________)