**ILLINOIS DEPARTMENT OF HUMAN SERVICES**

***Division of Alcoholism and Substance Abuse***

# DASA CONTRACTUAL POLICY MANUAL

REVISED 07/31/2015

FISCAL YEAR 2016

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# INTRODUCTION

The information contained within this manual is applicable to any organization with a contract to provide addiction intervention and treatment services as authorized by the Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA). Each contract specifies funding deliverables and the policy and procedures contained within this manual are based upon rules and/or contract conditions in effect for Fiscal Year 2016. Where applicable, the specific source of the mandate is referenced.

Full compliance with and a thorough understanding of, DHS/DASA rules and procedures are expected of all funded organizations. The majority of reporting and billing errors that cause delay of payment and incorrect analysis of data can be prevented by correct utilization of reporting software and adherence to procedures established in this manual.

### Annual Certification Plan

Organizations are required to submit a FY 2016 Annual Certification Plan. This plan certifies that all information contained in the plan is consistent with the terms and conditions in the FY 2016 contract, the DASA Attachment C and Exhibits.

### Relocation or Closure of Any Funded Service

Organizations must receive approval in writing from DASA at least 90 calendar days prior to the relocation or closure of any funded service. DASA may exercise its right to disapprove any movement of funded services or locations and may request the return of funding related to such service closures or relocations.

# ELIGIBILITY - PROVIDER AND PATIENT

### Provider Eligibility

To use contract dollars as a payer source for addiction intervention and treatment services, provider eligibility begins with funding via a fully executed contractual agreement with DHS/DASA that specifies the types of services that are reimbursable and the rates for these respective services.

In order to maintain eligibility, providers must deliver addiction intervention and treatment services in accordance with DHS rules that specify:

- The minimum standards necessary to deliver quality care (Part 2060);
- The minimum standards designed for administration of funding (Parts 509, 511 and 2030) as well as any other specific contractual obligations, if applicable.

Violations may result in a financial penalty or a disbursement adjustment and are considered in determining the continuation of contractual agreements with providers.

### Family Income Eligibility Criteria

To be eligible for reimbursement utilizing contract dollars as specified in a valid contract with DHS/DASA, a total family income eligibility criteria are utilized to determine the appropriateness of Department contract dollars to pay for addiction, early intervention, or treatment. If the patient meets the income criteria and can supply documented proof of such, 100% of the uniform or negotiated rate will be reimbursed.

**FAMILY INCOME ELIGIBILITY CRITERIA**
**CONTRACT REIMBURSED (NON-MEDICAID)**

**FY 2016 FAMILY INCOME ELIGIBILITY**

| Number of Dependents | Annual Income |
|---|---|
| 1 | $23,540 |
| 2 | $31,860 |
| 3 | $40,180 |
| 4 | $48,500 |
| 5 | $56,820 |
| 6 | $65,140 |
| 7 | $73,460 |
| 8 | $81,780 |

For each additional person, add $8,320.

- **Dependents are defined as the number of dependents living in the patient's immediate household as well as any for whom financial responsibility exists.**
- **Annual income is defined as all projected annual gross income per calendar year.**

The FY 2016 Family Income Eligibility Criteria is double the minimum amounts contained in the most recent poverty guidelines published by the Department of Health and Human Services (HHS) in the Federal Register, Vol. 80, No. 14, Wednesday, January 22, 2015, Notices. The Income Eligibility Criteria contained in this manual is in effect for all of FY 2016. **Organizations must establish policies and procedures to ensure income eligibility is updated when new information concerning the patient's income status becomes available. At a minimum, patient income must be re-verified on an annual basis.**

The Provider shall also establish systems regarding eligibility, billing and collection to ensure that persons entitled to other third party payment benefits (other than state or federal funds) are reimbursed from those resources.

**Income Eligibility Wavier Criteria**

Providers shall have the ability to utilize income eligibility waiver criteria on a case-by-case basis based upon hardship guidelines approved by the organization's governing board that shall, at a minimum, allow for service to be provided to:

1. a dependent adult whose spouse or other responsible party is unwilling to assume financial responsibility for the cost of treatment, and the dependent adult would, as a result, be denied access to treatment services; or
2. a dependent minor who is not covered by the Department of Healthcare and Family Services Medical Programs and/or whose parent(s) or legal guardian is unwilling to assume financial responsibility for the cost of treatment or intervention, and the dependent minor would, as a result, be denied access to treatment or intervention services; or
3. a pregnant woman who is not covered by the Department of Healthcare and Family Services Medical Programs and has no insurance benefit that covers the cost of treatment; or
4. a member of a family unit whose combined debt for prior medical expenses (not covered by insurance) exceeds 7.5% of the total gross family income, and the individual would be denied access to treatment due to the unwillingness or inability of the family to assume further debt; or
5. a patient with an extenuating circumstance that meets any additional hardship guidelines adopted by the provider's governing body; or
6. an individual for whom the fee is the sole inhibitor to accept treatment; or
7. other approved governing body criteria.

Treatment or intervention services provided to those individuals for whom exceptions to the income eligibility criteria have been granted must be done so within the current terms and conditions of the contract. Documentation corroborating the use of the waiver criteria shall be kept in the patient record or a separate financial record.

**Documentation of Income**

The patient must supply documentation of income, which is required to be kept in the patient record or a separate financial record. Acceptable examples of proof of income are a copy of the most recently filed Federal Income Tax Return or any other document indicating current status of family income (i.e., paycheck stubs, W-2 forms, unemployment cards, and Medicare or Medicaid cards). When a provider is unable to secure income verification from the patient, the provider must document in the patient record or a separate financial record what attempts were made to secure such information and the reason for the absence of such information.

Documentation from the patient supporting his or her claim shall be kept in the patient record or a separate financial record. Providers are not required to submit such documentation to DASA but this information is subject to review. Failure to maintain this documentation will result in disallowance of payments and recoupment.

**Co-Payment**

Each early intervention or treatment patient whose services are reimbursed through non-Medicaid contract dollars, should also be assessed a co-payment. **The purpose of this co-payment is to endorse the therapeutic value of a patient's direct contribution toward the cost of their care. Collection of this co-payment is the responsibility of the provider and inability to collect cannot be used as justification for discharge or denial of treatment services.** A sliding fee scale must be developed by each provider in order to determine the amount of the co-payment. The co-payment may be waived on a case-by-case basis if need exists. Any waiver of co-pay must be documented.

# REIMBURSEMENT POLICY

A covered service is that for which payment can be made by DASA. Covered services, as specified in this section, must be clinically justified or medically necessary, as applicable, and delivered in accordance with all provisions specified in 77 Ill. Adm. Code, Part 2060.

As part of the admission process, providers are required to ensure that the patient has at least applied for any applicable entitlement benefit or, if eligible, health insurance under the Affordable Care Act, if such patient is not already enrolled or insured. Providers are also expected to refer patients to other appropriately licensed providers for services the provider does not deliver or when the provider's services are not covered by the patient's Medicaid Managed Care (MCO) or insurance coverage. As such, funds contained in DASA contracts are expected to be used for covered services for income eligible patients when all other applicable entitlement or third party payment has been depleted. When this occurs, funds can be used as follows:

1. For services for any patient who has exhausted or not yet purchased third party insurance coverage OR for any annual insurance deductible.
2. For the amount of any applicable Medicaid spend-down and/or for DASA covered services that are not Medicaid reimbursable.
3. For any patient covered by Medicare who receives services from a DASA licensed organization that is not enrolled as a Medicare provider.

### Covered Services

| |
|---|
| Admission and Discharge Assessment (One Each Per Episode of Care) |
| Level I |
| Level II |
| Level III.1 (Extended Residential Care) |
| Level III.7D (Medically Monitored Detoxification) |
| Level III.2D (Clinically Managed Detoxification) |
| Level III.5 (Day Treatment) |
| Level III.5 (Room and Board Only) |
| Level III.5 (Residential Rehabilitation) |
| Psychiatric/Diagnostic (Payable Per Encounter – One Per Day) |
| Case Management, Early Intervention, Community Intervention (Maximum Allowable Referenced in DASA Exhibit I) |
| Recovery Home - Adult |
| Recovery Home - Adolescent |
| Opioid Maintenance Therapy |
| Toxicology |
| Child Domiciliary Support |
| HIV Counseling and Testing |
| Donated Funds Initiative (DFI) |

# FY 2016 REIMBURSEMENT RATES

The rates established to reimburse or calculate earnings represent what DHS/DASA has determined it will pay for each service. However, the applicable rate may not always cover the actual cost of the service. When this occurs, it is expected that providers can demonstrate how the remainder of the cost will be collected to ensure fiscal solvency. Additionally, providers who serve patients who are not contract eligible, cannot charge such patients **LESS than the DHS/DASA uniform or negotiated rate for that service.**

**Reimbursement rates for FY 2016 are as follows:**

| Service | Minimum Unit of Service | Code | Rate |
|---|---|---|---|
| Admission and Discharge Assessment | Quarter Hour | AAS | $65.28 – Per Hour<br>$16.32 – Per Quarter Hour |
| Level I (Individual) | Quarter Hour | OP | $62.12 – Per Hour<br>$15.53 – Per Quarter Hour |
| Level I (Group) | Quarter Hour | OP | $23.48 – Per Hour<br>$ 5.87 – Per Quarter Hour |
| Level II (Individual) | Quarter Hour | OR | $62.12 – Per Hour<br>$15.53 – Per Quarter Hour |
| Level II (Group) | Quarter Hour | OR | $23.48 – Per Hour<br>$ 5.87 – Per Quarter Hour |
| Level III.1 | Daily | HH | $66.81 – Daily |
| Level III (Detoxification) | Daily | DX | Daily |
| Level III.5 | Daily | RR | Daily |
| Recovery Home - Adult | Daily | RH | $48.05 |
| Recovery Home - Adolescent | Daily | RH | $122.00 – Daily |
| Case Management | Quarter Hour | CM | $48.08 – Per Hour<br>$12.02 – Per Quarter Hour |
| Psychiatric/Diagnostic | Per Encounter/Per Day | - | $81.31 – Per Encounter/Per Day |
| Opioid Maintenance Therapy *(125 or less DASA funded patients per site)* | Weekly | OP | $87.91 – Weekly |
| Opioid Maintenance Therapy *(more than 125 DASA funded patients per site)* | Weekly | OP | $70.33 – Weekly |
| Early Intervention (Individual) | Quarter Hour | EI | $62.12 – Per Hour<br>$15.53 – Per Quarter Hour |
| Early Intervention (Group) | Quarter Hour | EI | $23.48 – Per Hour<br>$ 5.87 – Per Quarter Hour |
| Community Intervention | Quarter Hour | CIH | $46.92 – Per Hour<br>$11.73 – Per Quarter Hour |
| Child Domiciliary Support | Daily | CRD | $50.17 – Daily |
| Toxicology | Per Test | TOX | See Exhibit 1 – Per Test |
| HIV Counseling and Testing | Quarter Hour | HIV | $62.12 – Per Hour<br>$15.53 – Per Quarter Hour |
| Donated Funds Initiative (DFI) | Round Trip Token<br>One-way Token<br>Quarter Hour<br><br>Quarter Hour | DFF<br>DFH<br>DFC<br><br>DFS | $ 6.18 – Round Trip<br>$ 3.09 – One-way<br>$36.04 – Per Hour<br>$ 9.01 – Per Quarter Hour<br>$35.20 – Per Hour<br>$ 8.80 – Per Quarter Hour |

# REIMBURSEMENT/DISBURSEMENT SPECIFICATIONS

### Reimbursement/Disbursement

It is not the Department's practice, or within its ability, to authorize or encourage the delivery of services beyond what the amount of funding contained in the contract can support. Therefore, if services are reported as contract services (using DARTS code DC) at anytime during the fiscal year, they are considered paid for by the amount of funding contained in the contract. Services that you do not want considered in this manner SHOULD NOT BE REPORTED TO DARTS. Providers are cautioned against the delivery of unfunded services as this practice may severely affect the delivery of quality clinical care and the organization's fiscal solvency.

### Group Counseling

Level I and II services delivered as group counseling shall be reimbursed only for 16 patients per **counseling** group supported by Department funding (Medicaid or Contract).

### Billings Linked to Level of Care

Billings should match the Level of Care for the patient. Outpatient care (Level I or II) cannot be billed on the same day as Residential care (Level III). Case management, psychiatric evaluation, and medication monitoring may be billed on the same day for any patient in any Level of Care in accordance with stated contract conditions, eligibility, limits, or exceptions.

**Level III Care - Patient Day** - No more than one patient day shall be reimbursed for any recipient in a 24-hour period.

**Day of Discharge or Transfer - Level III** - Billing for the day of discharge or transfer is allowable if services are delivered on that day. However, in accordance with the billing provisions specified above, only services in one Level of Care may be billed per patient per day. For any patient **transferred** to another level of care **within the same organization**, only one type of billing for services rendered that day will be allowed. Additionally, when this occurs within the same organization, the Level of Care in which the patient spent the majority of time on the day of discharge should be billed. (A patient's day begins at 6:00 a.m. and continues for 24 hours.) Similarly, when a patient is **discharged** by one organization and transferred to another organization for the same or a different level of care, only one organization may bill the **Department of Healthcare and Family Services Medical Programs** for service delivered on that day, if applicable. However, if the Department of Healthcare and Family Services Medical Programs were not billed, the referring and receiving organizations may both bill contract for any services rendered on the day of discharge.

### Psychiatric Evaluation

Such services are limited to the provision of a psychiatric evaluation to determine whether the patient's primary condition is attributable to the effects of alcohol or drugs or to a diagnosed psychiatric or psychological disorder. Reimbursable psychiatric evaluations may be delivered to treatment patients where need for such service is documented in the patient's individualized treatment plan. Psychiatric evaluation shall be reimbursed at the established rate on a per encounter basis (one per day). This service must be delivered by the agency's psychiatrist.

### Medication Monitoring

Psychotropic medication monitoring, using the agency's physician, must be billed at the individual counseling rate for treatment patients. Psychotropic medication monitoring includes a review of the efficacy, dosage and side effects of any psychotropic medication used by the patient. This type of medication monitoring shall also be conducted by the agency's physician or psychiatrist and billed at the individual counseling rate.

### Co-Dependence/Collaterals

A **co-dependent** is a family member or significant other of an individual with an addiction related problem. DASA funding can be used for assessment of these individuals and also for Level I services if the assessment resulted in a diagnosis of **co-dependent** (DSM-5 - Z65.8).

A **collateral** is an individual who receives minimal service as a result of participation in someone else's addiction related treatment. These services are reported and billed as a treatment service for the patient. If a collateral is seen alone, it should be billed as an individual session. If any combination of patients and/or collaterals is seen together, each participant should be billed separately under the patient's unique identification number at the group rate. As a guideline, such service should average one contact per week. If need is demonstrated to exceed this average, these types of individuals should be treated as co-dependents.

### Case Management

Case Management is the delivery of services to patients in treatment that are designed to help them handle aspects of their lives that are not necessarily related to an addiction disorder but that might impact whether the patient remains in treatment or has successful treatment outcomes. Some examples of case management services are:

- Assistance with health needs.
- Assistance with transportation but not actual transportation of clients.
- Assistance with childcare.
- Assistance with family situations, living conditions, school or work situations.

Case management services are individualized for patients in treatment. They reflect particular needs identified in the assessment process and those developed within the treatment plan.

Case management that meets the following criteria and is specified below as an eligible service can be reimbursed for a patient in any level of care:

- The service is based upon an identified need, has an identified expected outcome documented in the assessment or the treatment plan.
- The services are documented and integrated in the progress notes. Documentation must show date, time and duration and include a brief description of the service provided. The note must be signed by the person providing the service.
- Another funding mechanism or funder is not paying for the case management service.

**Examples of Case Management Activities**

- Inter/intra provider record review.
- Internal and/or external multi-disciplinary clinical staffing.
- Telephone calls, letters and other attempts to engage family members or significant others in the patient's treatment.
- Telephone calls, letters, home visits to patients to keep them engaged in treatment.
- Assistance with budgeting, meal planning and housekeeping.
- Letters, telephone calls, meetings with employers on behalf of a patient.
- Assist patients and their families in obtaining Medicaid, Social Security, cash grants, WIC, Link Cards and other entitlements that they may need.
- Assist patients and their families in obtaining medical, dental, mental health, educational, recreational, vocational and social services as specified in the treatment plan.

**Early Intervention**

Early Intervention is the ASAM Level of Care 0.5 and is an organized service delivered in a wide variety of settings that are sub-clinical or pre-treatment in nature for individuals who have at least one risk area related to primary use and/or possession of alcohol or drugs but do not have a diagnosed substance use disorder. Examples of risk areas are as follows:

- Repeated absences, suspensions or terminations from work or school environments.
- Gang Involvement.
- Criminal Justice Involvement.
- Absence from family or home, homelessness, or for youth, running away or placement in alternative living environments or schools.
- Abuse of or addiction to alcohol or drugs by a family member or significant other.
- Extreme or prolonged exposure to severe stressor, e.g., loss of home through flood or fire, death of significant other.

Early Intervention services can be provided in an individual or group setting but must be documented in a client record by time, date and duration.

### Community Intervention

Community Intervention is service that occurs within the community rather than in a treatment setting. These services focus on the community and its residents and include crisis intervention, case finding to identify individuals in need of service including in-reach and outreach to targeted populations or individuals not admitted to treatment. Outreach is the encouragement, engagement or re-engagement of at risk individual(s) into treatment through community institutions such as churches, schools and medical facilities (as defined by the community) or through Illinois Department of Human Services consultation. In-reach is the education of community institutions or state agencies and social services staff regarding the screening and referral of at risk individuals to treatment programs for the purpose of a clinical assessment.

Anticipated outcomes of community intervention include an increased awareness, "community ownership" and connectedness between the service system and community institutions. Service visibility will increase. Access to services will increase for all populations but particularly for those earlier in their "problem use" as the general public becomes more aware of alcohol and drug use symptoms and treatment resources. Examples of community intervention activities are as follows:

- Crisis Intervention consisting of brief contacts to determine appropriate interventions and/or services.
- In-reach activities such as meetings with local DHS or DCFS office staff to discuss screenings and referrals.
- Outreach activities designed to educate community stakeholders and increase referrals for treatment.
- Consultations with referral sources.
- Training, if specific funding for participation in or the delivery of this type of activity is contained within the contract.
- Client/Patient Transportation for case management or treatment activity identified through assessment or in the treatment plan.
- Language interpreter services authorized by a linkage agreement and approved in the Annual Certification Plan.

### Video Counseling

The use of video counseling has become an increasingly valuable tool in the delivery of health care services. This technology can reduce barriers to needed care by providing a cost effective alternative to traditional face-to-face services. DASA supports the use of video counseling when needed services would otherwise not be available as a result of:

- Physical disabilities.
- Mental disabilities.

- Transportation problems.
- Social barriers.
- Unavailability of specialized care.
- Unavailability of an appropriate level of care.

DASA will reimburse funded organizations for video counseling. Prior to delivery, the organization's medical director must approve policies and procedures that assure video counseling services are provided in a safe, confidential, and effective manner. These policies and procedures must describe the types of services provided and how the organization will address issues related to patient safety and security, confidentiality, use of video conferencing technology, staff training/supervision, and legal issues. Organizations are encouraged to review the "Practice Guidelines for Videoconferencing-Based Telemental Health" published by the American Telemedicine Association (ATA) and "Consideration for the Provision of E-Therapy" published by the Substance Abuse and Mental Health Services Administration (SAMHSA).

DASA will reimburse for assessments, early intervention, outpatient, and intensive outpatient services when the following criteria are met:

- Video counseling is an assessed need and included in treatment planning.
- Progress notes document when video counseling occurs.
- Individuals mandated for assessment, intervention, or treatment services require written approval from the referring source.
- Video counseling is provided between prearranged secured locations. The use of home computers or mobile devises is not allowed.

Billing requirements for video counseling are as follows:

- Video counseling is contract reimbursable through DARTS. This service is not Medicaid reimbursable (excluding psychiatric evaluations).
- Psychiatric evaluations (PEV) are reimbursable through both contract and Medicaid.
- Problem gambling, DCFS, collateral, and medication monitoring services are reimbursable.
- Allowable program codes are 44 (level II), 43 (Level I), and 42 (Level 0.5).
- Individual and group services may be provided using procedure codes IOI, IOG, OPI, OPG, EIG, and EII. Dedicated funds tagging is allowable.
- Clients, patients, and collaterals must attend regular face-to-face sessions when the need for video counseling no longer exists.

**Telephone Counseling**

DASA believes face-to-face counseling is the preferred method of clinical interaction. However, telephone counseling used in combination with face-to-face services can be an effective tool in reducing barriers to treatment engagement and increasing retention in non-residential services.

Prior to the delivery of telephone counseling, the organization's medical director must develop protocols and authorizes procedures that include the requirements listed below.

The use of telephone counseling presents special challenges and organization providing this option must ensure that staff are trained on its use. DASA allows the use of telephone counseling when services cannot be accessed as a result of:

- Physical disability.
- Mental disability.
- Transportation problems.
- Problems with childcare (or dependent care).
- Social barriers.
- Unforeseen crisis that may prohibit the scheduled face-to-face session.

Once the need for telephone counseling is established, DASA will reimburse for levels 0.5 and I care when the following criteria are met:

- The initial assessment and continued stay reviews are conducted face to face.
- Telephone counseling is an assessed need and included in the treatment plan.
- Progress notes reflect when telephone counseling occurs.
- Individuals in mandated treatment require written approval from the mandated referral source.
- The patient attends regular face-to-face sessions when the assessed need for telephone counseling no longer exists.
- Unforeseen barriers occur that keep the patient/client from participating in the scheduled face-to-face session and delay of the session would be problematic. Use of telephone counseling in this case is episode specific and justification is documented in a progress note. (If this type of behavior becomes a pattern, the problem needs to be assessed as a real barrier or assessed as a change in treatment strategy.)

Telephone counseling billing requirements are as follows:

- Telephone counseling is contract reimbursable through DARTS. This service is not Medicaid reimbursable.
- Gambling services are reimbursable.
- Activity Code for reporting Telephone counseling services to DARTS is 08.
- Allowable program codes are 43 (Level I) and 42 (Level 0.5).
- Individual services only - OPI and EII procedure codes.
- Dedicated funds tagging allowable.

## Billing Methadone Patients

All Methadone patients must have an open demographic record in DARTS. Billable services are then calculated in DARTS based upon submissions to the Pharmacy Log. If the patient does not have an open demographic record in DARTS, services will not calculate.

Methadone services are covered by the case rate, which pays weekly as specified in the contract. The case rate pays for dispensing, at least one individual counseling session per month, toxicology and medical services as well as any other service required by State and Federal regulations. Assessment, case management and medication monitoring can be billed in addition to the case rate.

Providers cannot bill additional Level I services to a Methadone patient using DASA contract funds, regardless of where the patient is receiving Methadone.

If a patient on Methadone requires Level II or III care, the provider of that service can bill and receive reimbursement even if they or another provider is receiving the case rate for outpatient Methadone services. In these instances, the Methadone specific services that are considered part of the case rate must be delivered in addition to the Level II and III care. Any provider who has Medicaid certification for Level I care may also provide additional clinically appropriate individual and group counseling for a Methadone patient who is Medicaid eligible.

# FUNDING SPECIFICATIONS

### Exhibit 1

Each Fiscal Year contract has an Exhibit 1 that describes the applicable billing unit/program numbers, addresses, and rates. Providers are asked to review these at the start of each fiscal year and report any discrepancies to the agency's contract manager.

# SUBAWARDS

### Medical/Laboratory Services Purchases

Support service purchases, such as medical/laboratory services, do not require a subaward. The purchase agreement should address any protocol and/or Administrative Rule requirements/criterion stated within the DHS/DASA contract and/or this manual related to the service(s) purchased.

### Clinical Services Purchases

The requirements for any request to subaward treatment activities funded by DHS/DASA are referenced in 77 Illinois Administrative Code Chapter X: Part 2030\Subpart B\Section 150: Subawards. Should the request for a subaward be approved and the provider subcontracts with another entity to perform treatment or ancillary support, or recovery services identified as deliverables within the Community Services Agreement, the principal vendor must have a signed state fiscal year specific subcontract agreement with the entity providing such services. The subaward agreement must be signed and approved by DHS/DASA prior to the initiation of any services. Failure to obtain such approval may result in a disallowance of payment as result of DHS/DASA voucher reviews, reconciliations, and or post-payment audit reviews.

### Subaward/Subcontract Elements

The proposed subcontract will be reviewed using at a minimum the items outlined below. Additional information beyond that listed can/may be requested by DHS/DASA staff in order to make a thorough review of the potential subcontract. The review of the proposed subcontract and any approvals shall address and provide assurance of the following items within the subcontract:

1. Subcontractors name, address, phone number, fax number, and email; copies of the applicable DASA license for all service sites to be utilized;
2. Copy of all licenses and certifications held by staff, who are performing the treatment, recovery support, or intervention services;
3. Language and copies (attached by Addenda) of the applicable DHS/DASA Community Services Boiler Plate, the applicable DHS/DASA Community Services Agreement, and DHS/DASA Attachment C, which specify requirements under which the subcontracted vendor must adhere to as well;
4. Listing of services to be provided by the subcontractor;
5. Applicable rates for services to be provided;
6. Location/site where services are to be provided;
7. Applicable Administrative Rules;
8. Applicable federal requirements;
9. Services documentation requirement;

10. Billing requirements/ processes for the subcontractor;
11. Payment processes and agreements with the subcontractor
12. Post-payment audits/monitoring requirements and liability of the subcontractor;
13. Renewals, revocations of the contract;
14. Authorized representatives for billing and contract approval for the subcontract; and
15. Annual vendor/subcontractor reconciliation process to be employed.

# BILLING REQUIREMENTS

### Unique Identification

The Recipient Identification Number (RIN) is required for all client/patients supported by Department funds. Providers must request a RIN from DHS, if the client/patient does not have one, prior to billing for any service.

### Service Data Reporting (Billing)

Most billing is accomplished electronically utilizing DARTS (Department's Automated Reporting and Tracking System). Appropriate software containing this system is provided free of charge. A flow chart outlining the steps in the billing process is included with this manual.

Providers can report DARTS and third party service data on a weekly basis using file transfer protocol (FTP) but must report data at least monthly. Providers shall also report any other data so requested by DASA by the prescribed time lines. The preferred method of reporting service data is through software supplied by the Department for any such service that can be reported through this mechanism. The Department assumes no responsibility for late, incomplete or inaccurate data produced by any software.

An adjustment to future disbursement or a suspension or termination of contract may occur unilaterally and without prior notice if a provider is late reporting any required financial or service data. Disbursement may be reinstated when all data is submitted and approved by DASA. Providers shall be given immediate notice when such suspension or termination has occurred by DHS/DASA.

DASA may conduct random reviews to determine accuracy of provider's service data. The provider shall be able to verify data entries upon request. DASA may delay or suspend disbursement or terminate funding immediately without prior notice if the provider produces late reporting. Late reporting is defined as late for two consecutive months or for any three months during the fiscal year. DASA shall immediately notify the provider that such delay, suspension or termination has occurred.

The provider agrees to notify DASA immediately through a written request to the Help Desk upon discovery of any problem relative to the delivery of or submission of any required service or financial data.

### Data Reporting Errors

Services will be rejected for errors in data entry or for errors related to the recipient's eligibility status. If services are rejected in the Edit and Balance process that occurs at DASA, the provider will receive this information in an Accepted/Rejected report in Mobius. Providers should review these errors to see if correction is necessary and resubmit, if appropriate.

In all instances, if an error occurs and the service can be rebilled, the service should be resubmitted utilizing DARTS. **Please remember that services should be resubmitted as close to the date of the error report as possible.**

### Monitoring/Audits

DASA monitors the patterns, accuracy, and timeliness of provider reporting to determine compliance with programmatic contractual conditions and conducts post-payment audits to determine compliance with required clinical, administrative, and financial standards. Patient and financial records are meant to substantiate compliance. Providers must establish and maintain audit trails to document services delivered and billed to eligible patients. Financial and patient record completeness, and accuracy are essential for demonstrating compliance and to avoid financial penalty.

### Late Payment/Services Submission

DASA has two established billing periods:

- Medicaid Funds: Medicaid funds can be paid if accepted for payment and processed within 180 days of the date of service.
- All Other DASA Funds: Any other DASA funds can be paid if they are delivered within the applicable state fiscal year, accepted for payment before annually established dates relative to the end of the lapse period and do not exceed the established fiscal year amount of funding contained in the contract.

Payment or Acceptance of Services Beyond Established Billing Periods:

- Requests for payment or service acceptance beyond established billing periods are allowable if the delay in submission was due to DASA or Healthcare and Family Services (HFS) processing.
- Requests for service acceptance or reimbursement from DASA funds other than Medicaid may only be submitted for the prior state fiscal year. Requests for reimbursement from Medicaid may only be submitted up to two years from the date of service. All requests shall be in writing and include the reason the established billing period was exceeded. Supporting documentation must be attached. All requests must also adhere to the conditions specified in the DASA contract, applicable manuals and/or letter of agreement or memorandum of understanding. If the request is for reimbursement from a federal project fund, it must reference the federal grant fiscal year funding as specified in the DASA contract. All other requests for reimbursement shall be for the same type of program funds identified in the DASA contract.

If the request is denied, it will be for one of the following reasons:

- It is determined that the delay in submission is not the fault of DASA or HFS.
- Insufficient funds to satisfy the request in the specific project or program area.
- No availability of funds within DASA's appropriation authority.
- Federal discretionary projects for the applicable federal project year have been fully expended. Thereby, no funds are available to satisfy the claim.

If the request for non-Medicaid funds is approved, DASA will apply the appropriate service credit or approve the services for reimbursement from the Illinois Court of Claims. All such approvals are subject to on-site and/or electronic audit. All requests will be responded to in writing and will specify the reason for the denial or acceptance.

If the request is for DASA Medicaid funds, the provider will be required to complete an approved HFS form for each Medicaid claim and send to HFS for processing. All such approvals are subject to on-site and/or electronic audit. All requests will be responded to in writing and will specify the reason for the denial or acceptance.

# PAYMENT INQUIRY INFORMATION

Please follow the process below to review payments made to your agency.

### STEP 1

Go to www.ioc.state.il.us.

Click on “vendor payments” in left column.

### STEP 2

Enter the “Vendor TIN Num” in the field provided.

Click “OK.”

### STEP 3

Click on “Payments.”

### STEP 4

“Select a fiscal year.”

“Select an agency.”

Agency “444” is the IL Department of Human Services.

Click on the “Find Warrants” button.

### STEP 5

The left column lists the warrant/EFT#. If the number begins with zeroes, it is an Electronic Funds Transfer (EFT). The funds are deposited directly into the vendor’s bank account. Note the “issue date” in the center column. This is the date of the deposit.

### STEP 6

The “Warrant/EFT#” begins with an alpha character. An alpha character indicates that a warrant (check) was issued to the vendor. The “issue date” is the date that the warrant was released. The “paid date” is the date that the warrant cleared. If the “paid date” is blank, the warrant has not been cashed and/or has not cleared.

Double click on the warrant/EFT# for more details regarding the payment.

### STEP 7

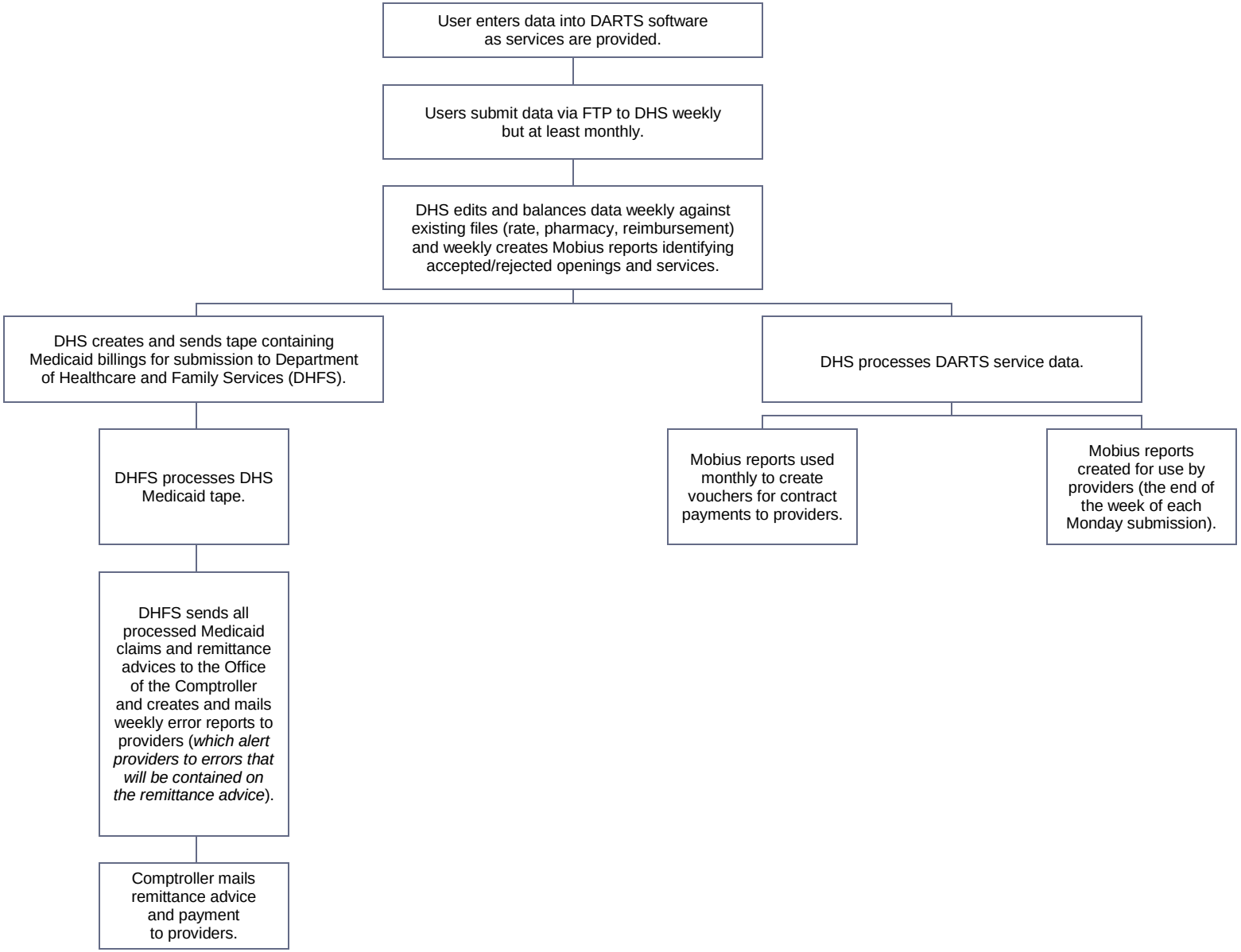
In the “IOC Accounting Line Details” box, Organization 26 indicates the Division of Alcoholism and Substance Abuse (DASA).

Notice the “Invoice” number in the top section. The first digit indicates the State Fiscal Year for which services are being paid. The letters following the first character indicate that this is a payment from DASA. For provider contract payments the alpha characters, following the fiscal year number, that are commonly used by DASA are SA and SB. The last two characters of the invoice number indicate to which month the payment is related.

Medicaid payments will have a different invoice numbering scheme. All Medicaid payments will have an “Object” number of 4560.

To request payments by EFT go to http://www.ioc.state.il.us/office/ec.cfm for information.

# *PAYMENT AND DATA PROCESSING CYCLE FLOW CHART*



# SERVICE PROTOCOLS

### Introduction

The following are DASA service protocols and deliverable requirements related to primary addiction treatment and/or adjunct services provided to eligible individuals using DHS/DASA funding. These expectations are to be considered an extension of the applicable DHS/DASA State Fiscal Year contract and will be monitored and reviewed as such. Should you have any questions regarding these protocols, please contact the DHS/DASA Help Desk at DHS.DASAHELP@illinois.gov.

### DHS/DASA Service Protocols

SECTION 1: Addiction Treatment/Ancillary Services/Recovery Services

SECTION 2: Recovery Home Services

SECTION 3: Addiction Treatment/Ancillary Services/Recovery Services for DCFS Recipient Services Protocols

SECTION 4: Toxicology Testing for assessment, placement decisions, or treatment planning for addiction Treatment

SECTION 5: Addiction Treatment/Ancillary Services for Opioid Maintenance Therapy

SECTION 6: Toxicology Testing for recipients of Opioid Maintenance Treatment

SECTION 7: Service Protocols for Addiction Treatment/Ancillary Services/Recovery Services for Problem Gambling Services

SECTION 8: Service Protocols for Addiction Treatment/Ancillary Services/Recovery Services for Daytime Childcare and Child Domiciliary Services

## SECTION 1: Service Protocols for Addiction Treatment/Ancillary Services/Recovery Services

*Target Population:* Individuals in Need of Addiction Treatment, adjunct Treatment, or Recovery Support

*Introduction:* These protocols set forth the terms and conditions applicable to addiction treatment and related services funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA).

### Specific Administrative Rules

Treatment services are to be provided according to Administrative Rule: Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.401 Levels of Care.

### Levels of Care to be Provided or Made Accessible

*Introduction:* The Section 2060.401 Levels of Care shall be made accessible to individuals screened and assessed for need based upon the most current ASAM patient placement criteria. This accessibility shall be directly provided by the provider or by direct referral and linkage to an alternate service provider who is able to provide such service.

*ASAM Patient Assessment:* Substance abuse treatment shall be offered in varying degrees of intensity based on the level of care the patient is assessed in need/placed and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the ASAM Patient Placement Criteria and with the following services definitions and protocols:

### Levels of Care

A. Level 0.5: Early Intervention

   Early Intervention: Activities that are sub-clinical or pre-treatment (ASAM .05) and designed to explore and address problems or risk factors that appear to be related to substance use, and/or to assist individuals in recognizing the harmful consequences or inappropriate substance use. Early Intervention services are for individual(s) whose problems and risk factors appear to be related to substance abuse but do not meet any diagnostic criteria for substance abuse related disorders. Such individuals are defined "at risk" and early intervention may be delivered in a wide variety of settings to at-risk adolescents or adults with the length of such service varying according to the type of activity. The ultimate goal is the reduction of the effects of substance abuse within the targeted community by identifying and engaging those in need of services. Early Intervention shall be provided to an identified individual (in an individual or group setting) and documented in a client record and shall be earned utilizing non-Medicaid funds at the established Early Intervention individual and group

rates. An organized service delivered in a wide variety of settings for individuals (adult or adolescent) who for a known reason are at risk of developing substance-related problems.

Early intervention services are considered sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use. The length of such service varies according to the individual's ability to comprehend the information provided and to use that information to make behavior changes to avoid problems related to substance use or the appearance of new problems that require treatment at another level of care. Early intervention services are for individuals whose problems and risk factors appear to be related to substance use but do not appear to meet any diagnostic criteria for substance related disorders. Examples of individuals who might receive early intervention are at-risk individuals (i.e., family members of an individual who is in treatment or in need of treatment) or DUI offenders classified at a moderate risk level.

B. Level I: Outpatient

Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that average less than nine hours per week.

C. Level II: Intensive Outpatient/Partial Hospitalization

Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of scheduled sessions for a minimum of nine hours per week.

D. Level III: Inpatient Subacute/Residential

Residential substance abuse treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall, except in residential extended care as defined in this Part, include a planned regimen of clinical services for a minimum of 25 hours per week. Inpatient care, with the exception of residential extended care as defined in this Part, shall require staff that are on duty and awake, 24 hours a day, seven days per week. During any work period, if professional staff as defined in Section 2060.309(a) of this Part are not on duty, such staff shall be available on call for consultation relative to any aspect of patient care. Residential extended care shall require staff on duty 24 hours a day, seven days per week and that low intensity treatment services be offered at least five hours per week. Any staff providing clinical services shall meet the requirements for professional staff as defined in Section 2060.309(a) of this Part. Individuals who have been in residence for at least three months without relapse may be used to fulfill any remaining staff requirements.

E. Level IV: Medically Managed Intensive Inpatient

Inpatient subacute residential substance abuse treatment for patients whose acute bio/medical/emotional/behavioral problems are severe enough to require primary medical and nursing care services. Such services are for adults or adolescents and require 24 hours medically directed evaluation, care and treatment and that a physician see the patient daily.

**Ancillary Services Ancillary Treatment, Intervention or Support Services**

These services are defined and have the following services protocols:

A. Toxicology

Urine, blood or saliva analysis to determine the presence of alcohol and/or other drugs in clients who receive treatment or intervention services.

B. Case Management

Activities designed to augment clinical services for a patient while in treatment. These activities include the provision, coordination, or arrangement of ancillary services designed to support a specific patient's substance abuse treatment with the goal of improving clinical outcomes. Services may occur in the home or in other community environments and are for the purpose of patient engagement and retention in treatment. Substance abuse case management must be individualized to the specific patient as reflected by an individualized assessment and contained within the treatment plan. Case management may begin with admittance to treatment and proceed through continuing care. All funded substance abuse case management must be documented in the patient record so that a post-payment audit can confirm the delivery of reported services.

C. Community Intervention

Activities that occur within the community rather than in a treatment setting. Such services include crisis intervention, language interpreter services, case finding to identify individuals in need of service including in-reach and outreach to targeted populations or individuals not admitted to treatment. Outreach is the encouragement, engagement or re-engagement of at risk individual(s) into treatment or through an Illinois Department of Human Services consultation or community service. In-reach is the education of State agency and social services staff regarding the screening and referral of at risk individuals to treatment programs for the purposes of a clinical assessment. <u>All Community Intervention services shall be earned in staff hours utilizing non-Medicaid funds at the established Community Intervention rate.</u>

D. Recovery Home

Services as specified in Part 2060.509 and/or in this Manual’s Protocols section as Section 2.

E. Medications

Limited reimbursement for the cost of medications for Providers who deliver substance abuse treatment services.

F. Interpreter Services

These are DASA funded sign and other technology services provided for individuals with a Deaf or Hearing Impairment. These services are for all levels of treatment, adjunct, and recovery support services for these individuals.

G. Psychiatric Evaluation

An evaluation and/or examination of a client and exchange of information to determine whether the client's condition is due to the effects of alcohol and/or other drugs or to a diagnosed psychiatric disorder.

H. Medication Monitoring

Counseling to review a patient's use of medications while in treatment that is conducted by the organization's psychiatrist or physician as a part of an individual counseling session.

I. Specialized Recovery Services/Adjunct Services/System Development Activity

The provision of special or unique projects. Descriptions are specified in a provider unique contract via the scope of services section of the applicable DHS Community Service Agreement.

## SECTION 2: Service Protocols for Recovery Home Services

*Target Population:* Individuals assessed as in need of Recovery Home Support Services.

*Introduction:* These protocols set forth the terms and conditions applicable to Recovery Home services funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA) for recovery home services for recovering substance abusers. Services include housing, intermittent staff support and/or access to ancillary self-help group, or skill building activities, which assist in obtaining or help maintaining a lifestyle free of substance abuse/dependence.

*Client Co-Payment:* The Provider may assess a fee or co-payment to clients in accordance with DHS/DASA Rules and Contractual Policy manuals, but must show how they will ensure that fees are not a barrier to admission, continuing stay, completion, and service reporting. If a co-payment is assessed, the Provider shall ensure that the agency has a policy regarding the assignment of client co-payment for recovery home services, which is annually reviewed and approved by the Board of Directors. This policy must provide for a waiver process for individuals who receive DASA funded services, and are unable to pay the co-payment fee. This policy must take into account the client's annual level of income, number of dependents, and their ability to pay for any potential co-payment assigned. This process must assure that no DASA eligible client is denied recovery home services on the basis of inability to pay an agency assigned co-payment. Providers shall submit any applicable fee policies and sliding fee scales to the DASA Program Manager. Sliding fee scales must be based on income and family size.

### Administrative Rules/Guidelines

Recovery Home services are to be provided according to Administrative Rule: Title 77: Public Health Chapter X: Department Of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment And Intervention Licenses Section 2060.509 Recovery Homes.

### Recovery Home Specific Programmatic/Service Requirements

A. The Provider shall ensure that all individuals receiving recovery home services funded by this award have a substance abuse or dependence diagnosis.
B. The Provider shall ensure that all individuals receiving recovery home services are sufficiently stable and are actively seeking assistance in obtaining or help maintaining a drug and alcohol free lifestyle. Assistance can include but is not limited to 12-step groups, faith based recovery activities, or other sobriety based activities/groups that meet the specific social or cultural needs of the individual.

C. The Provider shall maintain on site an individualized client record, which includes at a minimum:
    1. Documentation supporting that the individual is in recovery from a substance abuse/dependence disorder, and is in need of Recovery Home services;
    2. An individual recovery plan that contains goals and objectives, needed support services/activities, and employment/vocational development/skill building objectives. The plan shall address how the recovery plan will build supports within the resident's "home living" environment and how the resident will access additional treatment services if needed; and
    3. Documentation of any involvement in the recovery home's organized activities, and access and utilization of natural supports, community based agency support or other services needed to assist in maintaining the individual recovery plan. These notes should also include documentation of the agency's contacts regarding recovery support services collaboration and supports accessed to support the individuals recovery plan while in residence and post discharge (when possible). Such documentation includes scheduled appointments (medical and/or other), linkage agreements, and recovery support or coaching services provided to house residents.
D. If the Provider delivers recovery home services to adolescents, the Provider shall employ a minimum of seven staff to ensure at least one staff person is present when the residents are in the recovery home including weekends and holidays. The Provider shall further ensure that at least two of these seven staff are in management/supervisory roles and meet all professional requirements specified in 77 Illinois Administrative Code, Chapter X, Part 2060.509(g–h).
E. The Provider shall adhere to all requirements specified in Ill. Adm. Rule, Part 2060.325(a–m), pertaining to Patient/Client Records and Part 2060.509 relative to Recovery Home Services.
F. The Provider shall ensure that staff, providing any type of service for a child or adolescent receiving childcare at the Recovery Home, or residing at the Recovery Home with a parent who is a resident, consent to a background check to determine whether they have been indicated as a perpetrator of child abuse or neglect in the Child Abuse and Neglect Tracking System (CANTS), maintained by the Department of Children and Family Services as authorized by the Abused and Neglected Child Reporting Act [325 ILCS 5/11.1(15). This background check should also include utilizing the Law Enforcement Agency Data System (LEADS) maintained by the Illinois State Police. The organization shall have a procedure that precludes hiring of indicated perpetrators based on the reasons set forth in 89 Ill. Adm. Code 385.30(a) and procedures wherein exceptions will be made consistent with 89 Ill. Adm. Code 385.30(e) and procedures for record keeping consistent with 89 Ill. Adm. Code 385.60.

G. The Provider shall have documentation of a written emergency plan and practices which meets the requirements of 77 Illinois Administrative Code, Chapter X; Part 2060.305(c-1).
H. The Provider shall have a quality improvement plan, which has documentation of goals, quarterly measures, and reviews of objectives, anticipated outcomes, and results of annual services improvement activities/actions.
I. All required documented information shall be made available to the Department upon request.
J. The Provider must assure bunk beds are not used unless they are for children age 12 and under, and that all beds are non-folding, at least 36 inches wide, and are furnished with a flame retardant mattress.
K. The Provider must assure no bedroom is in an attic or in an area with a floor more than three feet below the adjacent ground level.
L. The Provider shall attend and participate in DASA sponsored meetings, training and technical assistance targeted to recovery home providers. The Provider shall be notified of requests to participate and shall be responsible for all related travel expenses. The Recovery Home services provider shall provide staff development training at least annually to their staff. These sessions shall include educational sessions on cultural competency, awareness, sensitivity, and limited English speaking client services.
M. Should the provider maintain board approved policies and procedures regarding the use of volunteers for any in-kind staff coverage, house monitoring, house support staff, or house maintenance staff an annually renewed volunteer agreement shall be maintained. Such agreement shall cover administrative operation policies and procedures , confidentiality requirements, and all personnel policies applicable to paid staff as well as in-kind staff volunteers.
N. The provider shall not utilize active DHS/DASA clients as in-kind volunteers for the program, and may not submit any billing to DHS/DASA for Recovery Home per diem services for volunteer house managers/monitors.

**Specific Reporting Requirements**

The Recovery Home must maintain a daily attendance and activity log for each site signed by each resident daily by staff and the resident. These signatures shall serve as confirmation of the resident's presence at the recovery home and/or be considered original source/records data to support services reporting/earnings.

## SECTION 3: Service Protocols for Addiction Treatment/Ancillary Services/Recovery Services for DCFS Recipient Services Protocols

*Target Population:* Individuals and family members who are actively being served by the Illinois Department of Children and Client Services as Active Clients

*Introduction:* These protocols set forth the terms and conditions applicable addiction treatment and related services funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA) for recovery home services for recovering substance abusers. Services include housing, intermittent staff support and/or access to ancillary self-help group, or skill building activities, which assist in obtaining or help maintaining a lifestyle free of substance abuse/dependence

### Specific Administrative Rules

Treatment services are to be provided according to Administrative Rule: Title 77: Public Health Chapter X: Department Of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.401 Levels Of Care

*Client Co-payment: Modification for DCFS Clients:* The Provider may assess a fee or co-payment to clients in accordance with DHS/DASA Rules and Contractual Policy manuals, but must show how they will ensure that fees are not a barrier to admission, continuing stay, completion, and service reporting. Providers shall submit any applicable fee policies and sliding fee scales to the DASA Program Manager. Sliding fee scales must be based on income and family size and must begin at zero.

### Administrative Requirement/Reporting

*Reporting:* The Provider shall complete, via a format approved by DASA and DCFS, a client progress report on a monthly basis for each DCFS client while the client is receiving treatment. The completed report is to be forwarded to the clients assigned DCFS caseworker every 30 days and at the time of discharge from treatment. The Provider shall maintain a copy of the report in the client's case file. A discharge summary is also to be completed and forwarded to the caseworker upon treatment case closure.

*Training and Staff Requirements:* The Provider shall participate fully in cross training events or other related meetings arranged, convened and/or endorsed by DASA. Providers shall also send program representatives to the DASA/DCFS regional partnership meetings.

### Target Population Specific Service Protocols

1. The Provider shall also ensure that case coordination occurs with DCFS and Purchase of Service offices.
2. With the exception of individual cases where circumstances may prohibit, the Provider shall conduct an assessment (Form CFS 440-5 Adult Substance Abuse Screen), within five (5)

days of receiving a referral. The referring agency shall be informed on a timely basis when the referred client does not keep an appointment for an assessment and/or outreach services, as defined herein.

3. The Provider shall deliver outreach services to all DCFS involved clients as appropriate in order to sustain gains made in treatment. Ongoing activities should be designed to support an aggressive community outreach model whenever possible. The provision of outreach services will vary based upon client need and the level of care provided.
4. The Provider shall assure that all DCFS involved clients receive parenting training approved by DCFS.
5. The Provider shall address the transportation needs of DCFS involved clients receiving outpatient treatment services.
6. The Provider shall assist in meeting the childcare needs of DCFS clients when receiving outpatient treatment services. On-site or off-site childcare arrangements are allowable.
7. The Provider shall establish and maintain linkage agreements with local agencies to help secure any necessary mental health, substance abuse, domestic violence, childcare or housing needs for DCFS clients. Client referrals to agencies providing the aforementioned services should be documented in the client files.
8. If Childcare or child domiciliary services are provided, such services must be accordance with the Service Protocols Section 8: Service Protocols for Addiction Treatment/Ancillary Services/Recovery Services for Daytime Childcare and Child Domiciliary Services

*Treatment Services to be Provided:* The Section 2060.401 Levels of Care shall be made accessible to individuals screened and assessed for need based upon the most current ASAM patient placement criteria. This accessibility shall be directly provided by the provider or by direct referral and linkage to an alternate service provider who is able to provide such service.

*ASAM Patient Assessment:* Substance abuse treatment shall be offered in varying degrees of intensity based on the level of care the patient is assessed in need/placed and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the ASAM Patient Placement Criteria and with the following services definitions and protocols.

**Levels of Care**

A. Level 0.5: Early Intervention

Early Intervention: Activities that are sub-clinical or pre-treatment (ASAM .05) and designed to explore and address problems or risk factors that appear to be related to substance use, and/or to assist individuals in recognizing the harmful consequences or inappropriate substance use. Early Intervention services are for individual(s) whose problems and risk factors appear to be related to substance abuse but do not meet any diagnostic criteria for

substance abuse related disorders. Such individuals are defined "at risk" and early intervention may be delivered in a wide variety of settings to at-risk adolescents or adults with the length of such service varying according to the type of activity. The ultimate goal is the reduction of the effects of substance abuse within the targeted community by identifying and engaging those in need of services. Early Intervention shall be provided to an identified individual (in an individual or group setting) and documented in a client record and shall be earned utilizing non-Medicaid funds at the established Early Intervention individual and group rates. An organized service delivered in a wide variety of settings for individuals (adult or adolescent) who for a known reason, are at risk of developing substance-related problems.

Early intervention services are considered sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use. The length of such service varies according to the individual's ability to comprehend the information provided and to use that information to make behavior changes to avoid problems related to substance use or the appearance of new problems that require treatment at another level of care. Early intervention services are for individuals whose problems and risk factors appear to be related to substance use but do not appear to meet any diagnostic criteria for substance related disorders. Examples of individuals who might receive early intervention are at-risk individuals (i.e., family members of an individual who is in treatment or in need of treatment) or DUI offenders classified at a moderate risk level.

B. Level I: Outpatient

Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that average less than nine hours per week.

C. Level II: Intensive Outpatient/Partial Hospitalization

Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of scheduled sessions for a minimum of nine hours per week.

D. Level III: Inpatient Subacute/Residential

Residential substance abuse treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall, except in residential extended care as defined in this Part, include a planned regimen of clinical services for a minimum of 25 hours per week. Inpatient care, with the exception of residential extended care as defined in this Part, shall require staff that are on duty and awake, 24 hours a day, seven days per week. During any work period, if professional staff as

defined in Section 2060.309(a) of this Part are not on duty, such staff shall be available on call for consultation relative to any aspect of patient care. Residential extended care shall require staff on duty 24 hours a day, seven days per week and that low intensity treatment services be offered at least five hours per week. Any staff providing clinical services shall meet the requirements for professional staff as defined in Section 2060.309(a) of this Part. Individuals who have been in residence for at least three months without relapse may be used to fulfill any remaining staff requirements.

E. Level IV: Medically Managed Intensive Inpatient
Inpatient subacute residential substance abuse treatment for patients whose acute bio/medical/emotional/behavioral problems are severe enough to require primary medical and nursing care services. Such services are for adults or adolescents and require 24 hours medically directed evaluation, care and treatment and that a physician see the patient daily.

**Ancillary Services Ancillary Treatment, Intervention or Support Services**

These services are defined and have the following services protocols:

A. *Toxicology:* Urine, blood or saliva analysis to determine the presence of alcohol and/or other drugs in clients who receive treatment or intervention services.

B. *Case Management:* Activities designed to augment clinical services for a patient while in treatment. These activities include the provision, coordination, or arrangement of ancillary services designed to support a specific patient's substance abuse treatment with the goal of improving clinical outcomes. Services may occur in the home or in other community environments and are for the purpose of patient engagement and retention in treatment. Substance abuse case management must be individualized to the specific patient as reflected by an individualized assessment and contained within the treatment plan. Case management may begin with admittance to treatment and proceed through continuing care. All funded substance abuse case management must be documented in the patient record so that a post-payment audit can confirm the delivery of reported services.

C. *Community Intervention:* Activities that occur within the community rather than in a treatment setting. Such services include crisis intervention, case finding to identify individuals in need of service including in-reach and outreach to targeted populations or individuals not admitted to treatment. Outreach is the encouragement, engagement or re-engagement of at risk individual(s) into treatment or through an Illinois Department of Human Services consultation or community service. In-reach is the education of State agency and social services staff regarding the screening and referral of at risk individuals to treatment programs for the purposes of a clinical assessment. <u>All Community Intervention services shall be earned in staff hours utilizing non-Medicaid funds at the established Community Intervention rate.</u>

D. *Recovery Home:* Services include housing, intermittent staff support and/or access to ancillary self-help group, or skill building activities, which assist in obtaining or help maintaining a lifestyle free of substance abuse/dependence. Services as specified in Part 2060.509 and/or in Service protocols/ Section 2: Recovery Home Services within this manual.
E. *Medications:* Limited reimbursement for the cost of medications for Providers who deliver substance abuse treatment services.
F. *Deaf and Hearing Impairment/Language Interpreter Services:* The provider must assure that language interpretation or sign language services are not a barrier to clients seeking addiction treatment services. DASA funded providers have access to DASA funded sign and other DHS technology services for individuals with a Deaf or Hearing Impairment seeking/receiving DASA funded treatment/recovery services. These services are for all levels of treatment, adjunct services, and/or recovery support services for these individuals. Language interpreter services must be a part of the providers Limited English Plan as required by the current DHS Community Services Agreement: Exhibit H/Linguistic and Cultural Competency Guidelines and Assurance. If DASA contract funds billed as Community Intervention are utilized for language interpretation, the provider must have a written linkage agreement that is approved by DASA as part of the Annual Certification Plan.
G. *Psychiatric Evaluation:* An evaluation and/or examination of a client and exchange of information to determine whether the client's condition is due to the effects of alcohol and/or other drugs or to a diagnosed psychiatric disorder.
H. *Medication Monitoring:* Counseling to review a patient's use of medications while in treatment that is conducted by the organization's psychiatrist or physician as a part of an individual counseling session.

## SECTION 4: Service Protocols for Toxicology Testing for Assessment, Placement Decisions, or Treatment Planning for Addiction Treatment

*Target Population:* Individuals receiving addiction treatment services ( assessment, placement decisions, or treatment planning)

*Introduction:* These service protocols and requirements for DHS DASA funded toxicology services applicable to treatment and related services for Providers funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA). Such funds are not intended to guarantee or cover 100% of the Providers toxicology requirements and the Provider may be required to expend additional funds to meet additional toxicology requirements. Toxicology services used solely for assessment, placement decisions, or treatment planning must at a minimum meet the requirements of for the specific services protocols below.

*Client Co-Payment:* If a co-payment is assessed, the Provider shall ensure that the agency has a policy regarding the assignment of client co-payment, which is annually reviewed and approved by the Board of Directors. This policy must provide for a waiver process for individuals who receive DASA funded services, and are unable to pay the co-payment fee. This policy must take into account the client's annual level of income, number of dependents, and their ability to pay for any potential co-payment assigned. This process must assure that no DASA eligible client is denied services on the basis of inability to pay an agency assigned co-payment. Providers shall submit any applicable fee policies and sliding fee scales to the DASA Program Manager. Sliding fee scales must be based on income and family size.

### Specific Toxicology Services Protocols/Requirements for Opioid Maintenance Administrative/Legal Actions/Assessment, Placement Decisions or Treatment Planning

A. Providers using toxicology testing solely for assessment, placement decisions, or treatment planning shall either 1) contract with a CLIA certified laboratory or 2) operate a laboratory approved by the U.S. Department of Health and Human Services (Clinical Laboratory Improvement Standards (CLIS)) or 3) if the Provider chooses to use "Point of Care" testing/procedures that have low risk of an erroneous result, shall apply for and maintain a Clinical Laboratory Improvement Amendments (CLIA) Certificate of waiver as outlined in federal regulation CFR Title 42 - Public Health/Part 493 (Laboratory Requirements)/Sections 493.35 (Application for a certificate of waiver) and 493.37 (Requirements for a certificate of waiver).
B. Definition: Point of Care Testing for the purpose of this exhibit is defined as testing administered at the location of the client.

C. Providers shall have policies and procedures for waived toxicology testing that contain the following:
    1. The type, purpose, and limitations of their toxicology testing;
    2. Protocols ensuring compliance with applicable federal, state, and local laws;
    3. Protocols ensuring compliance with specific testing requirements;
    4. Toxicology testing clinical documentation and billing procedures; and
    5. Personnel training and quality improvement protocols.
D. The rate of payment for all vendor purchased toxicology services is identified in the current DHS/DASA state fiscal year Contractual Policy Manual located at http://www.dhs.state.il.us.
E. Should the provider supply any client identifying information with the toxicology samples submitted to the vendor, the provider must have a an annually renewed business associate agreement on file which addresses all HIPAA and 42 CFR confidentiality requirements required of DASA funded providers.
F. Should the DASA funded provider enter into a purchase of services agreement with a toxicology laboratory services entity, the DASA funded provider must maintain a business/services agreement with the laboratory services entity that assures the adherence to any requirements within these protocols, including maintaining a copy of the entities valid CLIA certification for the laboratory utilized.

**Specific Reporting Requirements**

To receive reimbursement for testing covered by this exhibit, the Provider shall report all toxicology services billing using the current State Fiscal Year version of the Department's Automated Reporting and Tracking System (DARTS) software.

## SECTION 5: Service Protocols for Addiction Treatment/Ancillary Services for Opioid Maintenance Therapy

*Target Population:* Individuals who have been assessed as in need of Opioid Maintenance Therapy.

*Introduction:* These protocols set forth the terms and conditions applicable to Methadone Services/addiction treatment and related services funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA) for opioid maintenance therapy for recovering substance abusers. Services include medication, physical examinations, counseling services, and all other services required by state and federal regulations, with the exception of toxicology services, which are funded separately.

*Client Co-Payments:* The Provider may attempt to collect additional fees, based on a sliding fee schedule, but because the case rate is considered "all inclusive", services may not be denied or terminated for failure to pay these fees. Providers are responsible for conducting on-going self-sufficiency surveys to determine continued patient eligibility for the provision of state-funded services. The Provider shall not charge clients any separate admission, application, evaluation, registration, or other related fees.

**Administrative Rules**

State

1. All services must be provided in accordance with : Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.401 Levels Of Care (hereafter referred to as Part 2060).

Federal

2. The Provider shall conduct, record, and maintain biennial inventories of narcotic drug stocks as specified in 21CFR1304.11(c).
3. The Provider shall execute, process, and maintain DEA Form 222 as specified in 21CFR1305.
4. The Provider shall maintain current Power of Attorney for DEA Form 222 as specified in 21 CFR1305.07 and shall revoke Power of Attorney for former employees.
5. The Provider shall maintain physical security controls as specified in 21CFR1301.72.
6. The Provider shall satisfy all applicable requirements under 42 CFR 8 SAMHSA including accreditation and 21CFR1301-1307 (DEA) specific to the treatment of narcotic addicts and the delivery, storage, security, and accountability of methadone. Documentation of SAMHSA approval, DEA registration, and accreditation must be maintained on-site and be available to DASA staff on demand.

**Administrative Requirements**

1. The Provider shall have a designated Authorized Organization Representative and Medical Director.
2. The award total for OMT services has been calculated by multiplying the weekly OMT reimbursement rate by the number of cases funded by 52 weeks ("Case Rate").
3. The case rate covers all methadone services, to include but not be limited to: dispensing, Level I counseling, medical services and all other services as required by State and Federal regulations with the exception of toxicology testing services which is funded separately.
4. The reimbursement rate for OMT is based upon the total number of cases at each site, either less than 105 cases or 105 or more cases.
5. The Provider shall forward to DASA, as the State Methadone Authority, copies of all CSAT-approved accrediting body survey reports, Provider responses to these surveys, accrediting body responses and subsequent documentation of accrediting body awards or denials. (Providers may give permission for CSAT-approved accrediting bodies to forward their surveys and documentation of awards or denials directly to the DASA State Methadone Authority. Otherwise, the responsibility to forward these required documents rests with the individual Provider.)
6. Providers with Automated Dispensing Machines are responsible for:
    a. Calibrating the machine on a weekly basis according to manufacturer procedures/specifications.
    b. Limiting access to medical order entries, i.e., changes in dosage and pickup orders, to licensed physicians only.
    c. Printing daily activity reports for client dispensing, bottle control, and no shows.
    d. Taking physical drug inventories and updating the machines on a daily basis.
    e. Printing all reports as requested by inspectors and the State Methadone Authority.

**Documentation**

1. The Provider shall maintain on-site and on an ongoing basis, the "Daily/Weekly Medication Accounting Sheet" and the "Exception Medication Record." These records may be maintained electronically.
2. The Provider shall maintain records as specified in 21CFR1304.
3. The provider shall submit opiate dispensing information to DHS, Unified Health Systems, utilizing the approved DHS interface, on a weekly basis.
4. The Provider shall submit all closings to DASA as follows: within one month after a patient has completed or been transferred, patients in outpatient treatment within 30 days of having no contact and patients in residential treatment within three (3) days of having no contact. The discharge record shall include completion of the National Outcome Measures (NOMS) fields.

The Provider shall submit opiate dispensing information to DHS, Unified Health Systems, utilizing the approved DHS interface, on a weekly basis.

5. All services documentation must be kept as required by Part 2060.325 Patient/Client Records and/or written correspondence from DHS DASA.

**Target Population Specific Service Protocols Regarding Dosing Services**

Opioid Maintenance Therapy (OMT) Specific Service/Programmatic requirements are:

1. The Provider shall ensure that the initial dose of methadone does not exceed 30 milligrams and that the total dose for the first day does not exceed 40 milligrams unless the Provider's Medical Director documents in the patient's record that a 40 milligrams dose was not sufficient to suppress opiate abstinence symptoms (42 CFR 8).
2. The Provider shall insure that all clients are actually seen by a Physician and receive a physical examination conducted by a Physician prior to the client's admission to treatment and the client's ingestion of the initial dose of Methadone. Physician Extenders, i.e., Physician's Assistants (PAs) and Advanced Practice Nurses (APNs), may conduct the actual physical examination but the Physician must review and sign off on physicals conducted by PAs or APNs, and see the client prior to the client's admission to treatment and the initial dose of medication. The Physician is the ONLY staff member who can order the client's admission to OMT treatment and assign the medication dosage.
3. The Provider shall also ensure that at least eight random tests or analyses are performed on each patient during each year in comprehensive maintenance treatment (42 CFR 8).
4. A patient may not receive more than a one-month supply of narcotic drugs at one time (42 CFR 8) unless the Provider receives prior approval from CSAT.
5. Each Provider shall be responsible for all programmatic requirements involving continuing treatment.

**Medication Exceptions**

1. The Provider shall have a policy regarding take-home medication, in accordance with SAMHSA regulations and exceptions to policies regarding take-home supply of medication prior to services implementation, the Provider shall request and have appropriate CSAT approvals for any policy exceptions to regulations as well as all policies regarding supplies of take-home medication.
2. An exception may be made to the take-home supply of medication policy, which permits a temporary or permanently reduced clinic attendance schedule, if in the reasonable clinical judgment of the Provider's physician:
    a. The patient has been found to be responsible in handling narcotic drugs and has a physical disability which interferes with his or her ability to conform to the applicable mandatory clinic attendance schedule; or

b. The patient has been found to be responsible in handling narcotic drugs and has exceptional circumstances, such as illness, family crises, travel, or other hardship.

3. The rationale for each exception and the physician's approval must be entered into the client record.

## SECTION 6: Service Protocols for Toxicology Testing for Recipients of Opioid Maintenance Treatment

*Target Population:* Individuals receiving Opioid Maintenance Therapy

*Introduction:* These service protocols and requirements for DHS DASA funded toxicology services applicable to treatment and related services for Providers funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA). Such funds are not intended to guarantee or cover 100% of the Providers toxicology requirements and the Provider may be required to expend additional funds to meet additional toxicology requirements. Toxicology services provided as part of Opioid Maintenance Treatment or that could result in adverse criminal or administrative actions must meet the specific program requirements of Section 6 of the services protocols. Toxicology services used solely for assessment, placement decisions, or treatment planning must at a minimum meet the requirements of Section 4 of the services protocols.

*Client Co-Payment:* If a co-payment is assessed, the Provider shall ensure that the agency has a policy regarding the assignment of client co-payment services, which is annually reviewed and approved by the Board of Directors. This policy must provide for a waiver process for individuals who receive DASA funded services, and are unable to pay the co-payment fee. This policy must take into account the client's annual level of income, number of dependents, and their ability to pay for any potential co-payment assigned. This process must assure that no DASA eligible client is denied services on the basis of inability to pay an agency assigned co-payment. Providers shall submit any applicable fee policies and sliding fee scales to the DASA Program Manager. Sliding fee scales must be based on income and family size.

**Specific Toxicology Services Protocols/Requirements for Opioid Maintenance**

A. The number of panels (tests) specified herein is the minimum expectation. The actual number of tests may vary based upon the negotiated costs of each test and the needs of each Provider. The Provider must test for the minimum number of panels as described.
B. The Provider shall negotiate the following with the laboratory of the Provider's choice:
    1. The choice of testing medium (urine, sputum or sweat) to be used for the toxicology test;
    2. Which five drugs will comprise the standard testing panel;
    3. The cost of each panel;
    4. Onsite versus laboratory testing;
    5. Collection techniques;
    6. The cost and frequency for confirmation testing; and
    7. Any other issues related to toxicology testing for the five drugs comprising the standard testing panel.

C. Opioid Maintenance Treatment providers shall ensure that all testing, tests for, at a minimum, five drugs: one of which must be methadone. It is suggested that tests for Amphetamines and Barbiturates not be routinely requested unless clinically indicated due to the minimal abuse historically reported by programs. Instead, tests providing more realistic value such as Benzodiazepines, Marijuana, and PCP should be more routinely requested. Additionally, the Provider shall ensure that it can test for six (6) Monoacetylmorphine - 10 ng/ml.

D. The Provider shall contract with a laboratory or operate a laboratory that meets the following specified criteria upon the initiation of and through the term of the contract:

1. Maintain and provide documentation supporting approval from the U.S. Department of Health and Human Services (Clinical Laboratory Improvement Standards (CLIS)).
2. Participate in one or more of the following controlled programs:
    a. College of American Pathology Advanced Toxicology Survey.
    b. American Association of Forensic Science Toxicology Survey.
    c. Certification for laboratory testing eligibility for Medicare.
3. Ensure that the chain of custody (COD) is maintained on all specimens.
4. Test all specimens for adulteration prior to the initial screening test. The laboratory shall test each urine specimen for pH (< 3 or > 11), and/or specific gravity (< 1.001 or > 1.020). When a specimen is adulterated, the laboratory shall notify the Provider within 48 hours of receipt of the specimen. The laboratory shall not test an adulterated specimen. (If the Provider determines to use a medium other than urine (i.e., sputum or sweat), the laboratory must provide a protocol to ensure that the specimens are not adulterated prior to the initial screening tests and does not test an adulterated specimen).
5. Use an immunoassay procedure for the initial screening tests for all specimens, using immunoassay technology which meets, as minimum standards, the most current requirements as referenced in Mandatory Guidelines for Federal Workplace Drug Testing Programs (53 CFR 11,983), Federal Register, Vol. 73, Number 226, Tuesday, November 23, 2008, and the following cutoffs:
    a. Amphetamines/Methamphetamine - 500 ng/ml
    b. Barbiturates - 200 ng/ml
    c. Benzodiazepines - 200 ng/ml
    d. Benzoyl ecgonine (cocaine metabolite) - 150 ng/ml
    e. Marijuana metabolite - 50 ng/ml
    f. Opiates - 2000 ng/ml
    g. Phencyclidines - 25 ng/ml
    h. Methadone - 300 ng/ml
    i. 6 Monoacetylmorphine - 10 ng/ml

6. Use GC/MS (Gas Chromatography/Mass Spectrometry) testing for all confirmation tests using the following cutoffs:
    a. Amphetamines/Methamphetamine - 250 ng/ml
    b. Barbiturates - 200 ng/ml
    c. Benzodiazepines - 200 ng/ml
    d. Benzoyl ecgonine (cocaine metabolite) - 150 ng/ml
    e. Marijuana metabolite - 15 ng/ml
    f. Opiates - 2000 ng/ml
    g. Phencyclidines - 25 ng/ml
    h. Methadone - 300 ng/ml
    i. 6 Monoacetylmorphine - 10 ng/ml
7. Ensure that all specimens submitted for initial screening and/or confirmation testing are tested within two working days of receipt of the specimens. The Provider shall be informed by the laboratory of all positive test result(s) from any screening or confirmatory tests within 48 hours of testing via computer or fax. A hard copy of the COC must follow within 10 working days and the confirmation tests must bear the signature of the certifying scientist.
8. Maintain all records/documents for all specimen tests for a minimum of three years and maintain records/documents for any specimen under legal challenge until the challenge is resolved. It shall be the Provider's responsibility to notify the laboratory of which specimens are under legal challenge. Each Provider must contract with the laboratory for forensic testimony for any legal challenge to a test result.
9. Should the provider an client identifying names with the toxicology vendor, the provider must have a an annually renewed business associate agreement on file which addresses all HIPAA and 42 CFR confidentiality requirements required of DASA funded providers.
10. Should the DASA funded provider enter into a purchase of services agreement with a toxicology laboratory services entity, the DASA funded provider must maintain a business/services agreement with the laboratory services entity that assures the adherence to any requirements within these protocols, including maintaining a copy of the entities valid CLIA certification for the laboratory utilized.

E. DHS/DASA approved Opioid Maintenance Treatment providers may access the provision of necessary toxicology services from the DHS/DASA designated OMT toxicology vendor.

## SECTION 7: Service Protocols for Addiction Treatment/Ancillary Services/Recovery Services for Gambling Services

*Target Population:* Individuals and family members who are assessed as in need of services to address a gambling disorder.

*Introduction:* These protocols set forth the terms and conditions applicable to problem gambling treatment and related services funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA). Services include intermittent staff support and/or access to ancillary self-help group, or skill building activities, which assist in obtaining or help maintaining a lifestyle free of gambling.

*Client Co-Payment:* The Provider may assess a fee or co-payment to clients in accordance with DHS/DASA Rules and Contractual Policy manuals, but must show how they will ensure that fees are not a barrier to admission, continuing stay, completion, and service reporting. Providers shall submit any applicable fee policies and sliding fee scales to the DASA Program Manager. Sliding fee scales must be based on income and family size.

### Administrative Rule

*State Rules:* Treatment services are to be provided according to the standards in: Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.401 Levels Of Care.

### Administrative Requirements

*Training/Supervision:* The Provider shall have staff that are trained to treat problem and pathological gamblers. This can be demonstrated by having staff who participated in the IDHS/DASA 30-hour Gambling Training for Counselors and certified or preparing for certification as a Problem Gambling Counselor (PCGC) through the Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA).

*Supervision/Monitoring:* The Provider will also participate in monthly clinical supervision sessions, cross-training events and other related meetings arranged or convened by DASA in order to share strategies and tools related to delivery of gambling services.

### Target Population Specific Service Protocols

1. The Provider shall administer to all individuals entering treatment, the NODS assessment tool for gambling problems. The National Opinion Research Center DSM Screen for Gambling Problems (NODS), an instrument based on DSM-5 criteria, was created by the National Opinion Research Center (NORC) at the University of Chicago. The screen was developed for use in the 1999 Gambling Impact Study (National Opinion Research Center at the University of Chicago: http://www.norc.uchicago.edu). The NODS is composed of 17 lifetime items and 17 corresponding past-year items. The maximum score on the NODS is 10. A

person scoring three or four using the most current version of the Diagnostic Statistical manual from the American Psychiatric Association for criteria on the NODS is classified as a "problem gambler," while a person scoring five or more DSM-IV criteria on the NODS is classified as a "pathological gambler." The NODS is designed to be more demanding and restrictive in assessing problematic behaviors than other screens (i.e., South Oaks Gambling Screen-SOGS) based on the DSM-IV criteria.

2. Outpatient gambling treatment and intervention services may be provided to a person in a residential rehabilitation substance abuse treatment program, if the person has been diagnosed with a problem or pathological gambling disorder. Gambling counseling services provided to individuals in a Residential Rehabilitation location must be in addition to the existing Level III Inpatient Subacute/Residential substance abuse treatment services provided, as required by Administrative Rule, Part 2060.401 Levels of Care.
3. *Section 2060.401 Levels of Care:* Substance abuse treatment shall be offered in varying degrees of intensity based on the level of care in which the patient is placed and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the ASAM Patient Placement Criteria and with the following:
4. *Level 0.5: Early Intervention:* An organized service, delivered in a wide variety of settings, for individuals (adult or adolescent) who, for a known reason, are at risk of developing substance-related problems. Early intervention services are considered sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use. The length of such service varies according to the individual's ability to comprehend the information provided and to use that information to make behavior changes to avoid problems related to substance use or the appearance of new problems that require treatment at another level of care. Early intervention services are for individuals whose problems and risk factors appear to be related to substance use but do not appear to meet any diagnostic criteria for substance related disorders. Examples of individuals who might receive early intervention are at-risk individuals (i.e., family members of an individual who is in treatment or in need of treatment) or DUI offenders classified at a moderate risk level.
5. *Level I:* Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that average less than nine hours per week. This may be individual or Group treatment sessions.
6. *Level II: Intensive Outpatient:* Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such

treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that are more than nine hours per week.

## SECTION 8: Service Protocols for Addiction Treatment/Ancillary Services/Recovery Services for Daytime Childcare and Child Domiciliary Services

*Target Population:* Children of Individuals and family members who are actively being served by DHS/DASA funded providers as active clients in treatment and recovery services.

*Introduction:* These protocols set forth the terms and conditions applicable to Child Domiciliary services for children whose guardian/Parents are receiving addiction treatment and related services funded by the Illinois Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA) for recovery home services for recovering substance abusers. Services include housing, intermittent staff support and/or access to ancillary self-help group, or skill building activities, which assist the child and family in obtaining or help maintaining a lifestyle free of substance abuse/dependence.

### Administrative Rules/Guidelines

Ensure all staff providing services to the children satisfy requirements outlined in Administrative Rule 2060, Parts .309(d), .311(a), and .313(d, f). Results of the CANTS must be in the employee's personnel file prior to working with children.

### Client Income Eligibility

The Provider may assess a fee or co-payment to clients in accordance with DHS/DASA Rules and Contractual Policy manuals, but must show how they will ensure that fees are not a barrier to admission, continuing stay, completion, and service reporting. Providers shall submit any applicable fee policies and sliding fee scales to the DASA Program Manager. Sliding fee scales must be based on income and family size and must begin at zero.

### Target Population Specific Service Protocols

1. *Daytime Childcare Services:* Should the child of a DASA funded treatment client require childcare services the vendor must secure necessary by directly providing it, or via services linkage arrangements until such time that the custodial parent is discharged from treatment and childcare is no longer needed.
2. Children should be in school or attending childcare programs either on or off-site. If the childcare program is off site, it must be licensed by the Department of Children and Family Services (DCFS). If the Provider chooses to have on-site childcare, then that funded provider shall be responsible for planning and conducting developmental and age-appropriate activities for the children in their care, and must adhere to requirement s regarding parental presence and/or all DCFS childcare requirements.

3. *Child Domiciliary Services:* If funded by DHS/DASA for child Domiciliary services, the provider shall have the following administrative procedures and policies in place which address the following for all funded childcare services:
    a. Ensure that written policy and procedures are in place for handling medical emergencies of children residing with their parents in a residential setting.
    b. Ensure authorization is obtained in writing from the mother or guardian included in the child's record for the child to be enrolled in school either on-site or off-site (site is defined as the provider's licensed treatment location).
    c. Shall have working policies and procedures in place regarding the administration of medication to children.
    d. Ensure that when the program transports mothers and their children, age appropriate safety restraints must be provided and used, and a log of all transportation services must be maintained.
    e. Ensure that policies and procedures assure adequate oversight and assurances for valid driver's licenses and insurance coverage for all transportation vehicle operators.
    f. Ensure that appropriate and nutritional meals are provided for the child/ren.
    g. Ensure that each child(ren) has his or her own bed.
    h. Ensure that agency policies and procedures utilized indicate the age range of children that may be admitted to the childcare program as part of the program's admission criteria.
4. *Services Documentation:* The provider shall maintain written documentation on each child. This documentation may be kept in a separate chart or included in the mother's chart. Children's records kept in a separate file must contain information linking the mother and her child(ren). This record shall ensure the following documentation is included in each child record:
    a. Name, address, gender, birth date, social security number, or documentation of application for social security number of the child;
    b. Mother's name and recipient identification number (RIN);
    c. Medical records, child's primary physician contact, immunization records, developmental screenings and resulting services (if any), any known allergies, emergency contact information;
    d. The name and number of the child(ren)'s pediatrician and/or primary care physician.
    e. Copies of any court documents related to custody/visitation or any other issues specific to the disposition of the child.