ILLINOIS DEPARTMENT OF
HUMAN SERVICES

Division of Alcoholism
and Substance Abuse

DASA
CONTRACTUAL POLICY MANUAL

FISCAL YEAR
2011

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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 2011. Where applicable, the specific source of the mandate is referenced.

Full compliance with and a thorough understanding of, DHS/DASA rules and procedures is 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 2011 Annual Certification Plan. This plan certifies that all information contained in the plan is consistent with the terms and conditions in the FY 2011 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 2060) 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 is 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 2011 FAMILY INCOME ELIGIBILITY

Number of Dependents	Annual Income
1	$21,660
2	$29,140
3	$36,620
4	$44,100
5	$51,580
6	$59,060
7	$66,540
8	$74,020

For each additional person, add $7,480.

- **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 2011 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. 74, No. 14, January 23, 2009, pp. 4199–4201. The Income Eligibility Criteria contained in this manual is in effect for all of FY 2011. **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 therefrom.

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 Medical Benefits, All Kids and Family Care eligible 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 Medical Benefits, All Kids and Family Care eligible 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 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., pay check stubs, W-2 forms, unemployment cards, 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 patient whose treatment is reimbursed through 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.

REIMBURSABLE SERVICES

A reimbursable service is that for which payment has been or can be made by the Department. Covered services are specified in this section and are those that are generally recognized as reasonable and necessary for the diagnosis, care, treatment or rehabilitation of addiction related disorders as defined in 77 Ill. Adm. Codes 2060. Contract dollars can be used for covered services for all eligible patients, including those who have exhausted other third-party coverage (Medicare, Medicaid, insurance, etc.), provided that such services are authorized in the provider's contract, there is money available in the contract to be earned, and there is documented clinical justification to deliver services in accordance with the specifications contained in Part 2060.

COVERED SERVICES AND ESTABLISHED GUIDELINES

Covered Service	Established Guideline (per state fiscal year)
Admission and Discharge Assessment	One per episode of care
Level I	Clinically justified need
Level II	Clinically justified need
Level III.1 (Extended Residential Care)	Clinically justified need
Level III.7D (Medically Monitored Detoxification)	Clinically justified need
Level III.2D (Clinically Managed Detoxification)	Clinically justified need
Level III.5 (Day Treatment)	Clinically justified need
Level III.5 (Room and Board Only)	Clinically justified need
Level III.5 (Residential Rehabilitation)	Clinically justified need
Psychiatric/Diagnostic	Payable per encounter (one per day)
Case Management	Up to 10% of the dedicated award and/or up to 10% of the total contract award unless otherwise specified
Recovery Home - Adult	Clinically justified need
Recovery Home - Adolescent	Clinically justified need
Opioid Maintenance Therapy	Clinically justified need
Early Intervention	Up to 25% of the dedicated award and/or up to 25% of the total contract award unless otherwise specified
Community Intervention	Up to 5% of the dedicated award and/or up to 5% of the total contract award unless otherwise specified
Toxicology	Clinically justified need
Child Domiciliary Support	Clinically justified need
HIV Counseling and Testing	Clinically justified need

FY 2011 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 2011 are as follows:

Service	Minimum Unit of Service	Code	Rate
Admission and Discharge Assessment	Quarter Hour	AAS	$63.36 - per hour $15.84 - per quarter hour
Level I (Individual)	Quarter Hour	OP	$60.32 - per hour $15.08 - per quarter hour
Level I (Group)	Quarter Hour	OP	$22.80 - per hour $5.70 - per quarter hour
Level II (Individual)	Quarter Hour	OR	$60.32 - per hour $15.08 - per quarter hour
Level II (Group)	Quarter Hour	OR	$22.80 - per hour $5.70 - per quarter hour
Level III.1	Daily	HH	$64.86
Level III (Detoxification)	Daily	DX	Provider Specific
Level III.5	Daily	RR	Provider Specific
Recovery Home - Adult	Daily	RH	$46.65
Recovery Home - Adolescent	Daily	RH	$118.45
Case Management	Quarter Hour	CM	$46.68 - per hour $11.67 - per quarter hour
Psychiatric/Diagnostic	Per Encounter/Per Day	-	$78.94
Opioid Maintenance Therapy (less than 105 patients)	Weekly	OP	$85.35
Opioid Maintenance Therapy (more than 104 patients)	Weekly	OP	$68.28
Early Intervention (Individual)	Quarter Hour	EI	$60.32 - per hour $15.08 - per quarter hour
Early Intervention (Group)	Quarter Hour	EI	$22.80 - per hour $5.70 - per quarter hour
Community Intervention	Quarter Hour	CIH	$45.56 - per staff hour $11.39 - per quarter staff hour
Child Domiciliary support	Daily	CRD	$48.71
Toxicology	Per Test	TOX	As specified in exhibit
HIV Counseling and Testing	Quarter Hour	HIV	$56.24 - per hour $14.06 - 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 **Medical Benefits, All Kids and Family Care** for service delivered on that day, if applicable. However, if Medical Benefits, All Kids and Family Care 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) to the psychiatrist.

MEDICATION MONITORING

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 IV - V61.9).

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 are 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 child care
- 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 for individuals who sub-clinical or pre-treatment services 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 diagnosis of abuse or dependence. 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 stake holders 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.

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.

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 A

Each Fiscal Year contract has an Exhibit A that describes the applicable funding terms and conditions for treatment, intervention and related services. Section I of this Exhibit specifies the total organizational funding and designates a portion of this funding that is dedicated. NOT ALL CONTRACTS HAVE DEDICATED FUNDING. Section II of Exhibit A specifies the expected mix of service delivery and those categories of restricted disbursement. Section III of Exhibit A specifies the reporting mechanism for dedicated funding.

NON-DEDICATED FUNDING

Non-dedicated funding may be available in a contract to serve clients/patients in accordance with authorized addiction intervention or treatment licensure and service priority requirements as follows:

- For delivery of Level I, II, III.1, III.2, III.5 and III.7 treatment services and for Recovery Homes. Any of these services may be delivered to any population as long as the Provider remains compliant with service priority requirements.
- For delivery of case management, early intervention and community intervention services.

RESTRICTED DISBURSEMENT

Restricted Disbursement means that the Provider shall deliver and bill for services whose calculated values meet, but do not exceed, the amount designated for the target population or service for the current fiscal year. Categories of restricted disbursement are specified in the Exhibit A.

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 an error report diskette that will contain the rejected services. 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 12 months of the date of service and if the bill does not exceed the established fiscal year obligation
- 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.
- If the request 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.

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.

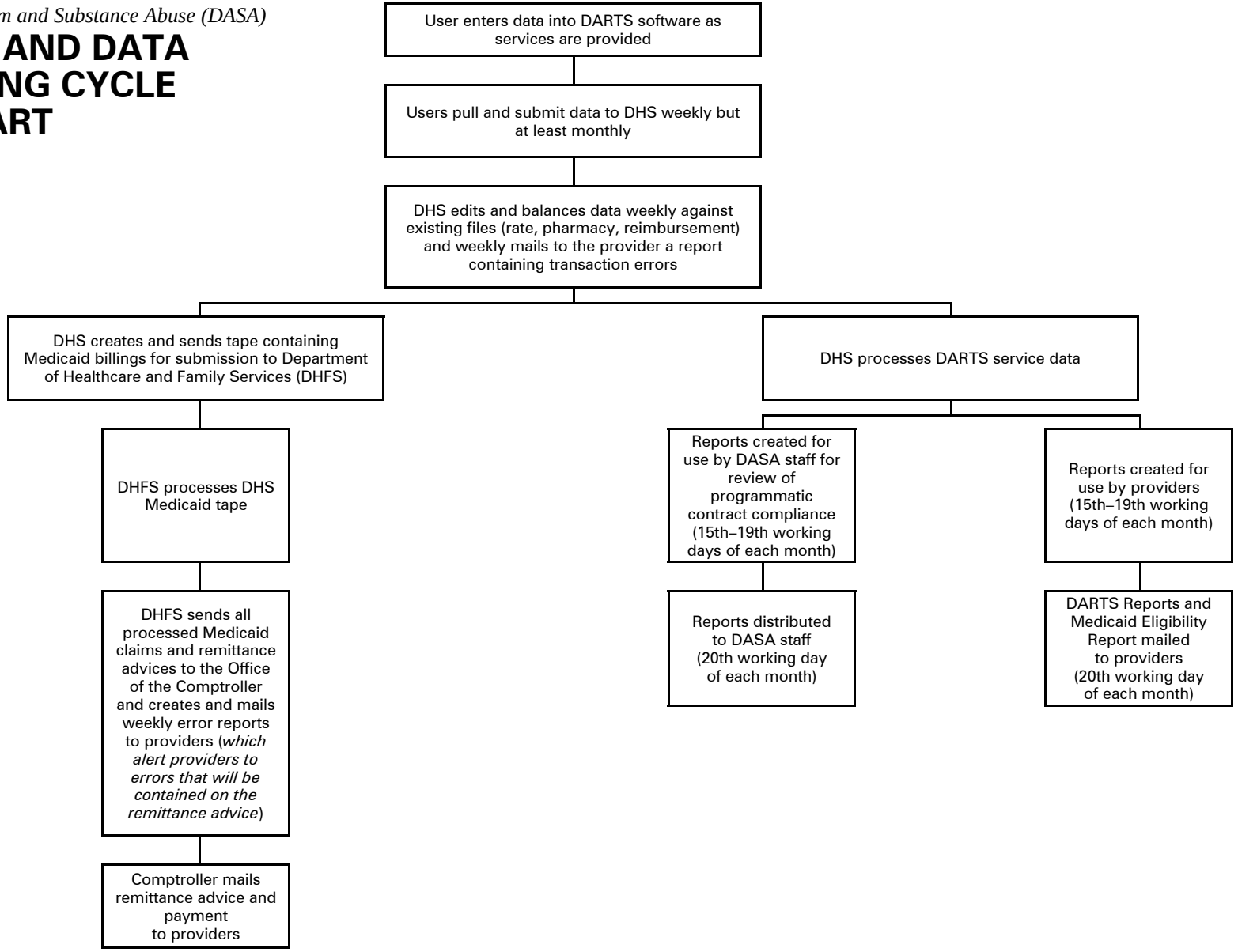
Medicaid payments will have a different invoice numbering scheme. All Medicaid payments will have an "Object" number of 4560.

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

Division of Alcoholism and Substance Abuse (DASA)

PAYMENT AND DATA PROCESSING CYCLE FLOW CHART

JULY 2010



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FISCAL YEAR 2011