

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER g: MEDICAID PROGRAM STANDARDS
PART 2090 SUBACUTE ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT SERVICES

The General Assembly's Illinois Administrative Code database includes only those rulemakings that have been permanently adopted. This menu will point out the Sections on which an emergency rule (valid for a maximum of 150 days, usually until replaced by a permanent rulemaking) exists. The emergency rulemaking is linked through the notation that follows the Section heading in the menu.

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AUTHORITY: Implementing and authorized by Section 5-10 of the Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301/5-10].

SOURCE: Adopted at 11 Ill. Reg. 2236, effective January 14, 1987; emergency amendments at 12 Ill. Reg. 11273, effective June 30, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 20061, effective November 26, 1988; emergency amendments at 15 Ill. Reg. 10222, effective June 25, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 16662, effective November 1, 1991; amended at 16 Ill. Reg. 11807, effective July 14, 1992; amended at 18 Ill. Reg. 14223, effective September 2, 1994; amended at 19 Ill. Reg. 9411, effective July 1, 1995; amended at 19 Ill. Reg. 10454, effective July 1, 1995; emergency amendment at 20 Ill. Reg. 12489, effective August 30, 1996, for a maximum of 150 days; amended at 21 Ill. Reg. 1600, effective January 27, 1997; recodified from the Department of Alcoholism and Substance Abuse to the Department of Human Services at 21 Ill. Reg. 9319; emergency amendment at 21 Ill. Reg. 14087, effective October 9, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 5895, effective March 13, 1998; emergency amendment at 22 Ill. Reg.

12189, effective June 24, 1998, for a maximum of 150 days; emergency expired November 21, 1998; amended at 22 Ill. Reg. 22403, effective December 8, 1998; emergency amendment at 23 Ill. Reg. 8832, effective July 23, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13879, effective November 4, 1999; emergency amendment at 26 Ill. Reg. 4426, effective March 8, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 12631, effective August 1 2002; amended at 27 Ill. Reg. 14022, effective August 8, 2003; emergency amendment at 35 Ill. Reg. 1465, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7754, effective April 28, 2011, for the remainder of the 150 days.

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SERVICES
SECTION 2090.10 PURPOSE

Section 2090.10 Purpose

- a) The requirements set forth in this Part establish criteria for participation by subacute alcoholism and other drug abuse treatment programs in the Illinois Medical Assistance Program operated by the Illinois Department of Public Aid (IDPA).
- b) The Department of Human Services (the Department), acting on behalf of IDPA shall certify the eligibility of applicants for participation who meet these requirements.
- c) These requirements are in addition to licensure standards established in 77 Ill. Adm. Code 250 (Hospital Licensing Requirements) and 77 Ill. Adm. Code 2060 (Alcoholism and Substance Abuse Treatment and Intervention Licenses), and are for the purpose of assuring that Medicaid recipients shall receive quality services in accordance with 42 CFR 440 and 456.
- d) These requirements shall be used by the Department for certification, recertification, and periodic inspection of providers participating in the Medical Assistance Program.
- e) In addition to the duties of the Department above, the Department shall also allocate monies within its budget, which shall be for the purpose of reimbursement to certified providers for Medicaid eligible services, as described in this Part, on behalf of IDPA. The Department shall, together with and by agreement with IDPA, provide for such reimbursement out of such funds.

(Source: Amended at 23 Ill. Reg. 13879, effective November 4, 1999)

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SECTION 2090.20 DEFINITIONS

Section 2090.20 Definitions

The following definitions shall apply to this Part:

"Adolescent": A person who is at least twelve years of age and under eighteen years of age.

"Benefit Year": The State fiscal year.

"Client": Any person who is eligible to receive services under one of the following categories: Aged, Blind, and Disabled (AABD); Temporary Assistance for Needy Families (TANF); Medical Assistance, No Grant (MANG); Refugee Repatriate Program (RRP); Title XIX eligible Department of Children and Family Services (DCFS) wards; and persons under the age of eighteen who would qualify for TANF but do not qualify as dependent children pursuant to 89 Ill. Adm. Code 140.7.

"Department": The Illinois Department of Human Services.

"Physician": A person who is licensed to practice medicine in all its branches under the Medical Practice Act of 1987 [225 ILCS 60].

"Professional Staff": Any person who provides clinical services as defined in 77 Ill. Adm. Code 2060 and who meets the requirements for professional staff as specified in 77 Ill. Adm. Code 2060.309. Professional staff may also be a person determined to be appropriate to deliver the clinical services provided, in accordance with 77 Ill. Adm. Code 250, Subpart W.

"Provider": Any public or private agency, organization, or institution, or unit of State or local government or other legal entity licensed to deliver alcoholism or other drug abuse services according to the requirements specified in 77 Ill. Adm. Code 2060 and enrolled to provide treatment services under the Illinois Medical Assistance Program.

"Psychiatrist": A person licensed to practice medicine in all its branches under the Medical Practice Act of 1987 [225 ILCS 60] and who meets the requirements of Section 1-121 of the Mental Health and Developmental Disabilities Code [405 ILCS 5/1-121].

"Subacute": The level of care necessary to effectively treat an alcohol and/or other drug abuser's dependency on a chemical without the more intensive measures designed to treat primary medical conditions in an acute care setting (e.g., inpatient hospitalization). Subacute care may be delivered in a facility licensed under the rules for Alcoholism and Substance Abuse Treatment and Intervention Licenses (77 Ill. Adm. Code 2060) or in a hospital, either of which is certified according to Section 2090.30 for purposes of Medicaid reimbursed alcoholism and/or other drug abuse services.

"Treatment Plan": An individually written plan for a client which identifies the treatment goals and objectives based upon a clinical assessment of the client's individual problems, needs, strengths and weaknesses.

"Under the direction of a physician": Treatment services provided under the direct supervision of a physician who is on staff and continuously directs the provision of care.

(Source: Amended at 23 Ill. Reg. 13879, effective November 4, 1999)

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SECTION 2090.30 MEDICAID CERTIFICATION/ENROLLMENT/RECERTIFICATION

Section 2090.30 Medicaid Certification/Enrollment/Recertification

- a) Providers may be certified and recertified by the Department as set forth herein and may enroll for participation in the Illinois Medical Assistance Program as provided in 89 Ill. Adm. Code 148.340(d). Application for Medicaid certification and enrollment for alcoholism and other drug abuse treatment service providers may be made by providers who are:
- 1) Currently licensed by the Department under the provisions of 77 Ill. Adm. Code 2060 for alcoholism and other drug abuse treatment services described in 77 Ill. Adm. Code 2060.
 - 2) Currently licensed by the Illinois Department of Public Health as a hospital pursuant to 77 Ill. Adm. Code 250 for the treatment services described in 77 Ill. Adm. Code 250.
- b) Medicaid Certification
- 1) Applications for certification may be obtained in person or by writing to:

Illinois Department of Human Services
100 W. Randolph, Suite 5-600
Chicago, Illinois 60601
Attention: Division of Licensing and Certification
 - 2) Applicants for new certification will be accepted from programs or parent organizations of such programs which have been licensed as specified in this Section for at least two years. Applicants shall demonstrate two years of experience in providing quality substance abuse services of the kind for which certification is being requested and for the type of population which will be served.
 - 3) Applicants shall submit documentation of the following:

- A) evidence of the need within the community for the type of services to be provided by the program for which certification is sought;
- B) description of the organization that will be operating the program;
- C) fiscal solvency of the organization;
- D) description of the physical facilities to be utilized by the program;
- E) description of the program and the clientele it serves;
- F) projection of the total number of Medicaid clients to be served each month, the average length of stay anticipated, and the estimated average per person cost of treatment;
- G) schedule of the specific dates, times and places services will be provided;
- H) number and type of people served during the previous two years in the program for which certification is sought and a description of the people served (demographics, gender, drug of choice, Medicaid eligibility, income level, etc.);
- I) name, address and professional qualifications of the program's Medical Director;
- J) name and qualifications of each individual who will be staffing the program and a description of that individual's responsibilities with respect to the program;
- K) copies of written referral agreements with other social service systems and primary medical care service systems within the applicant's area;
- L) copies of linkage agreements with other substance abuse treatment programs within the applicant's area implemented to assure availability of all levels of care as required in 77 Ill. Adm. Code 2060;
- M) documentation of the program's quality assurance system and utilization review policy as applied to the program's clinical standards which have been used for the previous two years, with a copy of the two most recent utilization review reports; and
- N) measurable outcome evaluation process used for the past two years and statistics on the program's client outcomes.

- 4) Applicants shall submit evidence that they are in compliance with all applicable Department audit requirements as specified in 89 Ill. Adm. Code 507.
- 5) Applications which are missing significant components or which have inadequate information shall be returned to the applicant with a statement specifying the missing or inadequate information. Completed applications may be resubmitted. Applications which are missing less significant components may be held by the Department and the applicant notified in writing of the missing information. The applicant may submit only the missing components. The Department shall hold such incomplete applications no more than 30 calendar days.
- 6) Certification is site-specific and services are to be provided on-site, unless they are provided in accordance with the off-site service provisions as set forth in 77 Ill. Adm. Code 2060.203.
- 7) Sites providing 24 hours of services to clients and having more than 16 beds shall not be certified for Medicaid enrollment for other than adolescent residential rehabilitation services.
- 8) In order to receive certification for a site having 16 beds or less, a program must meet the following criteria:
 - A) be a free-standing program of 16 or fewer beds; or
 - B) be within a larger facility, as a distinct unit of 16 beds or less, which:
 - i) is licensed;
 - ii) is physically separate from other certified and licensed programs (for example, separated by floors, wings, or other building sections);
 - iii) provides a level of care significantly different in clinical content from other certified and licensed programs (for example, adult versus adolescent care, women versus men, hearing impaired versus non-impaired);
 - iv) has a separate cost center (budgeting, accounting, etc.);
 - v) has separate staffing; and
 - vi) has separate operating policies and procedures.
- 9) Prior to certification, the Department shall conduct an on-site inspection.

- 10) Based upon the on-site inspection and a review of the application for certification, the Department will certify the program if the Department determines that:
- A) the applicant has proven that an unmet need for the services exists in the community the program will serve;
 - B) the organization operating the program is fiscally sound and responsible;
 - C) the program management is experienced in business and in the delivery of substance abuse services;
 - D) the program has sufficient written agreements with social, medical and other substance abuse service providers within its area to assure proper linkage of services to an individual;
 - E) the program has experience with the Medicaid eligible population it intends to serve;
 - F) the program has adequate physical facilities and adequate numbers of professional staff to provide the services;
 - G) the program conducts utilization review and has a quality improvement plan; and
 - H) the program has a measurable outcome evaluation process in place that provides measurable indicators of improvement by program participants.
- 11) The Department shall notify the applicant in writing of its determination regarding certification.
- A) **Approval of Certification/Medicaid Enrollment**
If the Department certifies the program, it shall include the IDPA Medicaid enrollment forms with the letter of certification. The applicant shall submit the completed enrollment forms along with a copy of the letter of certification to IDPA. However, providers who have applied for hospital licensure for the first time and hold a provisional hospital license for treatment services are not eligible to apply for Medicaid enrollment for those treatment services.
 - B) **Denial of Certification**
If the Department is not able to certify the program based on the criteria outlined in this Section, the Department shall notify the applicant in writing, describing those deficiencies that will result in a denial of the certification. The applicant has 60 days after receipt of the notice to correct the deficiencies and supply the new information to the Department. If the new information indicates that the program

meets the criteria of this Part, the Department shall certify the applicant. If the program continues to fail to meet the requirements of this Part, the Department shall deny the application for certification. If certification is denied, the applicant may appeal the Department's decision and request a hearing pursuant to 89 Ill. Adm. Code 104: Subpart C (Medical Vendor Hearings).

- 12) Certification shall be effective on the date of approval by the Department and shall remain in effect until the expiration of the provider's license as required in this Section or for three years for any provider not licensed by the Department. Certification is also subject to any sanctions levied under Section 2090.100 of this Part. After the effective date of certification, the provider may deliver services to Medicaid recipients that will be reimbursable after the applicant completes the IDPA Medicaid enrollment procedure.
- 13) When and if a certified provider is no longer licensed as set forth in this Section (whether voluntarily or involuntarily) the certification shall be null and void. Upon proof by the Department's licensing division that the license is no longer in effect, the Department shall notify the provider by certified mail that certification is null and void.
- 14) Recertification
 - A) To be eligible for recertification, providers shall be in compliance with all Sections of 77 Ill. Adm. Code 2060 referenced in this Part.
 - B) To be eligible for recertification, providers who receive funding from the Department shall be in compliance with all applicable Department audit requirements specified in 89 Ill. Adm. Code 507.
 - C) Providers shall apply for recertification at least 90 days prior to the expiration of the provider license.
 - D) Providers shall submit a recertification application provided by the Department. In addition, the provider shall submit copies of all utilization review (UR) reports and results of the program's measured outcome evaluations since the date of last inspection.
 - E) The Department shall review all documents and the results of the last licensure inspection and shall recertify the program if it complies with the requirements of the Alcoholism and Other Drug Abuse and Dependency Act and this Part.
- 15) Denial of Recertification

If the Department is not able to recertify the program based on its review and inspection, the Department shall notify the applicant in writing, describing those deficiencies that will result in a denial of the recertification. The applicant has 30 days after receipt of the notice to correct the deficiencies

and supply the new information to the Department. If the new information indicates that the program meets the criteria of this Part, the Department shall recertify the program. If the program continues to fail to meet the requirements of this Part, the Department shall deny the application for recertification and shall notify the applicant in writing, giving the reasons for the denial. The provider may appeal the Department's decision and request a hearing pursuant to 89 Ill. Adm. Code 104: Subpart C (Medical Vendor Hearings). Certification shall remain in effect pending the final decision on recertification unless the provider is sanctioned pursuant to Section 2090.100 of this Part. When the denial of recertification is final, the provider shall arrange for transfer of all Medicaid clients of the program as appropriate.

(Source: Amended at 23 Ill. Reg. 13879, effective November 4, 1999)

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SECTION 2090.35 GENERAL REQUIREMENTS

Section 2090.35 General Requirements

- a) To be reimbursable, treatment services shall be provided in compliance with all provisions specified in 77 Ill. Adm. Code 2060. Specifically, physician and professional staff involvement in treatment services shall be in compliance with 77 Ill. Adm. Code 2060.417, 2060.419, 2060.421, 2060.423 and 2060.425. The provider shall only bill for services that are reimbursable.
- b) The provider shall submit Medicaid claims as soon after the service date as is reasonable unless there is good cause for later submission. In any event, all claims for services (both initial and previously rejected) must be submitted to the State on a timely enough basis to be paid within 12 months from the date of service. If such claims are not submitted within this time frame, the provider may request an exception from the Department and IDPA to allow these claims to be processed. Exceptions will only be granted if it is determined that the delay in submission was due to Department or IDPA processing errors.
- c) Information Collection
 - 1) The provider shall report, on a monthly basis, demographic and service system data using the Department's Automated Reporting and Tracking System (DARTS), in the manner and data format prescribed by the Department. The data collected shall be for the purpose of assessing individual client performance and for planning for future service development. Information to be reported by the provider, for each individual served by a program certified under Section 2090.90 of this Part, shall include but is not limited to the following:
 - A) Name, date of birth, gender, race and national origin, family size, income level, marital status, residential address, employment, education and referral source.

- B) Special population designation, such as Medicaid eligible clients, women with dependent children, intravenous drug users (IVDUs), DCFS clients, DHS clients, and criminal justice clients.
 - C) Drug/alcohol problem areas treated, characterized by drugs of use, frequency of use, and medical diagnosis.
 - D) Closing date information, such as the reason for discharging the client from the program.
- 2) The Department shall supply providers with DARTS software.
 - 3) Disclosure of information contained within DARTS is governed by the specific provisions of federal regulations under Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR 2 (1997)) and the Health Insurance Portability and Accountability Act, 42 USC 1320d et seq., and the regulations promulgated thereunder at 45 CFR 160 and 164, to the extent those regulations apply to the provider and the information that is contained within DARTS.
- d) The reimbursement limits herein shall not be applied in situations where to do so would deny an eligible individual under age 21 from receiving "early and periodic screening, diagnostic and treatment services" (ESPSDT) as defined in 42 USC 1396d(r). With the exception of adolescent residential rehabilitation as specified in Section 2090.40(c)(1) of this Part, services as set forth in this Part shall be reimbursable to an eligible individual under age 21 for as long as the services are clinically necessary pursuant to review which is consistent with subsection (a) of this Section. (The reimbursement limit for adolescent residential rehabilitation services as set forth in Section 2090.40(c)(2) of this Part is not considered to be a denial of required, early and periodic screening, diagnostic and treatment services.)
 - e) The reimbursement limits herein shall not be applied where to do so would deny services to a pregnant woman that have been determined to be clinically necessary pursuant to review which is consistent with subsection (a). This exemption from the limits exists during the pregnancy and through the end of the month in which the 60-day period following termination of the pregnancy ends (post partum period), or until the services are no longer clinically necessary, whichever comes first. This exemption shall not apply to a woman who enters treatment services after delivery.
 - f) The provider shall not be reimbursed for services delivered in more than one Medicaid covered subacute alcoholism or other drug abuse level of care per client per day except for ancillary psychiatric diagnostic services.
 - g) Group treatment in Level I and II care shall be reimbursed only for up to 12 clients per group that are supported by any type of Department contract funding.

(Source: Amended at 27 Ill. Reg. 14022, effective August 8, 2003)

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SERVICES
SECTION 2090.40 REIMBURSABLE SERVICES

Section 2090.40 Reimbursable Services

- a) Level I: (formerly Outpatient Services)
 - 1) Definition
The provision of treatment services as defined in 77 Ill. Adm. Code 2060.401(b).
 - 2) Reimbursement
Level I treatment services delivered to clients are Medicaid-reimbursable via the prospective rates in effect as of the date of service (89 Ill. Adm. Code 148.370). Medicaid claims are submitted to the Department and shall meet the requirements of IDPA rules for alcoholism and substance abuse treatment programs (89 Ill. Adm. Code 148.340 through 148.370). The billable unit of service is a client hour defined as face-to-face counseling with a diagnosed client in an individual or group setting. Reimbursement shall occur by a fee-for-service mechanism, using one client hour as the base unit of service, billable to the nearest quarter-hour. No more than 25 hours may be reimbursed for an eligible adult client per benefit year.
- b) Level II: (formerly Intensive Outpatient Services)
 - 1) Definition
The provision of treatment services as defined in 77 Ill. Adm. Code 2060.401(c).
 - 2) Reimbursement
Level II treatment services delivered to clients are Medicaid reimbursable via the prospective rates in effect as of the date of service (89 Ill. Adm. Code 148.370). Medicaid claims are submitted to the Department, and shall meet the requirements of IDPA rules for alcoholism and substance abuse programs (89 Ill. Adm. Code 148.340 through 148.370). The billable unit of service is a client hour defined as face-to-face counseling with a diagnosed client in an individual or group setting. Reimbursement shall occur by a fee-

for-service mechanism, using one client hour as the base unit of service billable to the nearest quarter-hour. No more than 75 hours shall be reimbursed for an eligible adult client per benefit year.

c) Level III: (formerly Inpatient/Residential Services)

1) Definition-Adolescent Residential Rehabilitation

The provision of treatment services as defined in 77 Ill. Adm. Code 2060.401(d). Such treatment shall be for adolescents on a scheduled-only residential basis in a Medicaid enrolled hospital subacute setting, or to adolescents in a psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181.

Adolescent residential rehabilitation must be delivered in accordance with an adolescent's individualized treatment plan recommended by a physician if in a hospital setting, and under the direction of a physician if in a psychiatric facility.

2) Reimbursement

Adolescent residential rehabilitation treatment services delivered to clients are Medicaid reimbursable via the prospective rates in effect as of the date of service (89 Ill. Adm. Code 148.370). Medicaid claims are submitted to the Department and shall meet the requirements of IDPA rules for alcoholism and substance abuse treatment programs (89 Ill. Adm. Code 148.340 through 148.370). Reimbursement shall occur on a per diem basis. Through June 30, 2003, no more than 120 days shall be reimbursed for an eligible client per benefit year.

3) Definition-Day Treatment

The provision of treatment services as defined in 77 Ill. Adm. Code 2060.401(d). The treatment shall be on a scheduled-only residential basis by a program licensed pursuant to 77 Ill. Adm. Code 2060 and certified as having 16 beds or fewer as specified in Section 2090.30 of this Part and excluding room and board, meals, night supervision of dormitory areas and other domiciliary support services. Treatment services may be provided to adults and adolescents.

4) Reimbursement

Day treatment services delivered to clients are Medicaid reimbursable via the prospective rates in effect as of the date of service (89 Ill. Adm. Code 148.370). Day treatment services shall be reimbursed at a per diem rate. No more than 30 days shall be reimbursed for an eligible adult client per benefit year.

5) Definition - Medically Monitored Detoxification

The provision of detoxification services as defined in 77 Ill. Adm. Code 2060.405(a). Such services shall occur in a Medicaid enrolled hospital

subacute setting or in a residential program licensed pursuant to 77 Ill. Adm. Code 2060 and certified as having 16 beds or fewer as specified in Section 2090.30 of this Part, excluding room and board, meals, night supervision of dormitory areas and other domiciliary services. The treatment shall be for individuals 18 years or older (individuals who are 17 years old may be included provided that their assessment includes justification based on behavior and life experience).

- 6) Reimbursement
Medically monitored detoxification services delivered to clients are Medicaid reimbursable via the prospective rates in effect as of the date of service (89 Ill. Adm. Code 148.370). Medicaid claims are submitted to the Department and shall meet the requirements of IDPA rules for alcoholism and substance abuse treatment programs (89 Ill. Adm. Code 148.340 through 148.370). Medically monitored detoxification shall be reimbursed at a per diem rate. No more than nine days shall be reimbursed for each eligible adult patient per benefit year.

d) Ancillary Psychiatric Diagnostic Services

- 1) Ancillary psychiatric diagnostic services are limited psychiatric evaluations to determine whether the client's primary condition is attributable to the effects of alcohol or drugs or to a diagnosed psychiatric or psychological disorder. Such an evaluation shall determine the client's primary condition and recommend appropriate treatment services.
- 2) Reimbursable psychiatric evaluations are limited to a psychiatric evaluation/examination of a client and the exchange of information with the primary physician and other informants such as nurses, counseling staff, or family members and the preparation of a report including psychiatric history, mental status, and diagnosis. This service shall be performed by a psychiatrist.
- 3) Reimbursable psychiatric evaluations may be delivered to clients where the need for such services is documented in the client's individualized treatment plan. Documentation of all such services shall be maintained in the client record.
- 4) Ancillary diagnostic services delivered to clients are Medicaid-reimbursable on a per-encounter basis at the practitioner's usual and customary charge, not to exceed the prevailing rate as established by IDPA pursuant to 89 Ill. Adm. Code 140.400.

(Source: Amended at 26 Ill. Reg. 12631, effective August 1, 2002)

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SECTION 2090.50 QUALITY IMPROVEMENT

Section 2090.50 Quality Improvement

Each provider shall have and adhere to a quality improvement plan developed in compliance with the provisions in 77 Ill. Adm. Code 2060.315.

(Source: Amended at 21 Ill. Reg. 1600, effective January 27, 1997)

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SECTION 2090.60 CLIENT RECORDS

Section 2090.60 Client Records

Each provider shall maintain client records in compliance with the provisions in 77 Ill. Adm. Code 2060.325.

(Source: Amended at 21 Ill. Reg. 1600, effective January 27, 1997)

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SECTION 2090.70 RATE SETTING

Section 2090.70 Rate Setting

- a) The amount approved for payment for alcoholism and other drug abuse treatment is based on the category and amount of services required by and actually delivered to a client. The amount is determined in accordance with prospective rates developed by the Department and adopted by the Department of Public Aid. The adopted rate shall not exceed the charges to the general public.
- b) Rates are generated through the application of formal methodologies specific to each reimbursable service as specified in Section 2090.40 of this Part.

(Source: Amended at 23 Ill. Reg. 13879, effective November 4, 1999)

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SECTION 2090.80 RATE APPEALS

Section 2090.80 Rate Appeals

- a) Providers may appeal their rates in writing within 30 calendar days of the postmark date of the rate notice.
- b) Appeals shall be submitted to the Department.
- c) The Department shall determine whether a reason for the appeal exists pursuant to subsection (d) of this Section and that the written appeal contains all elements required in subsection (e) of this Section. Further clarification of the information submitted may be requested of the provider.
- d) Rate appeals may be considered for the following reasons:
 - 1) Mechanical or clerical errors committed by the provider in reporting historical expenses used in the calculation of allowable costs.
 - 2) Mechanical or clerical errors committed by the Department in auditing historical expenses as reported and/or in calculating reimbursement rates.
 - 3) The Department and the provider have entered into a written agreement to amend, alter, or modify substantive programmatic or management procedures attendant to the delivery of services, which have a substantial impact upon the costs of service delivery.
 - 4) The Department has amended the licensed capacity of a facility or treatment service.
 - 5) The Department requires substantial treatment service changes as a result of mandated licensure requirements.
 - 6) The Department requires substantial changes in physical plant as a result of mandated licensure requirements. In such instances, the provider must

submit a plan of corrections for capital improvements approved by the licensing authority, along with the required cost information.

- 7) State and/or federal regulatory requirements have generated a substantial increase in allowable costs.
- e) To be accepted for review, the written appeal shall include:
- 1) The current approved reimbursement rate, allowable costs, and the additional reimbursable costs sought through the appeal;
 - 2) A clear, concise statement of the basis for the appeal;
 - 3) A detailed statement of financial, statistical, and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement;
 - 4) A citation to any mandated or contractual requirement pertinent to the appeal; and
 - 5) A statement by the provider's chief executive officer or financial officer that the application of and information contained in the vendor's reports, schedules, budgets, books and records submitted are true and accurate.

(Source: Amended at 23 Ill. Reg. 13879, effective November 4, 1999)

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SECTION 2090.90 INSPECTIONS

Section 2090.90 Inspections

- a) The Department shall conduct inspections of applicants for program certification or recertification and of certified programs to enforce compliance with this Part. Department inspections may be conducted as part of the certification/recertification application process, on a random basis to survey compliance with this Part, or in response to complaints, if the complaint sets forth charges that constitute grounds for sanction pursuant to Section 2090.100.
- b) Upon presentation of Department credentials, inspectors of the Department shall be permitted access to inspect all physical facilities and records of the program and to make inquiries of program staff and clients.

(Source: Old Section 2090.90 repealed and Section 2090.105 renumbered to Section 2090.90 and amended at 21 Ill. Reg. 1600, effective January 27, 1997)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER g: MEDICAID PROGRAM STANDARDS
PART 2090 SUBACUTE ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT
SERVICES
SECTION 2090.100 SANCTIONS FOR NON-COMPLIANCE/AUDITS

Section 2090.100 Sanctions for Non-Compliance/Audits

- a) Failure to comply with the requirements of this Part shall result in the provider being issued a written warning or having its certification suspended or terminated for the Illinois Medical Assistance Program.
- b) The Department shall issue written notification to a certified provider who has failed to comply with any provision specified in this Part. The provider shall have a maximum of 60 calendar days from the date of the written notice to correct the cited deficiencies. However, such action shall not preclude the Department from initiating proceedings as specified in subsection (g) of this Section.
- c) The Department may also conduct post-payment audits based on volume of billings, complaints, identified deficiencies or non-compliance with this Part, or pursuant to a random selection process as necessary to monitor for compliance with this Part.
- d) The Department shall audit a statistically significant randomly selected sampling of client records at the audited program.
- e) The Department shall follow the recoupment formula approved by the Department of Public Aid, should the audit result in recoupment.
- f) Upon completion of the post-payment audit the Department shall submit written notification to the program regarding audit findings and amounts determined to be recoupable. The program shall respond to the notification within 15 days with supporting documentation regarding the recoupment amount. If such documentation proves that the recoupment amount is inaccurate, the amount shall be revised. The program may also request a 100% audit. The department may reduce future payments at a percentage per month or in a lump sum, or demand repayment in a lump sum.
- g) The Department and the Department of Public Aid shall jointly initiate administrative proceedings pursuant to 89 Ill. Adm. Code 140.16 to suspend or terminate certification and eligibility to participate in the Illinois Medical Assistance

Program for reasons set forth in 89 Ill. Adm. Code 140.16 or for failing to comply with any provision of this Part. The Department may also initiate administrative proceedings pursuant to 89 Ill. Adm. Code 140.15 to recover money. Both types of proceedings shall be conducted under 89 Ill. Adm. Code 104: Subpart C (Rules of Practice for Medical Vendor Hearings).

(Source: Amended at 23 Ill. Reg. 13879, effective November 4, 1999)

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TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER g: MEDICAID PROGRAM STANDARDS
PART 2090 SUBACUTE ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT
SERVICES
SECTION 2090.105 INSPECTIONS (RENUMBERED)

Section 2090.105 Inspections (Renumbered)

(Source: Section 2090.105 renumbered to Section 2090.90 at 21 Ill. Reg. 1600, effective January 27, 1997)

Joint Committee on Administrative Rules
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TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER g: MEDICAID PROGRAM STANDARDS
PART 2090 SUBACUTE ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT
SERVICES
SECTION 2090.110 SANCTIONS FOR NON-COMPLIANCE/AUDITS (RENUMBERED)

Section 2090.110 Sanctions for Non-Compliance/Audits (Renumbered)

(Source: Section 2090.110 renumbered to Section 2090.100 at 21 Ill. Reg. 1600, effective January 27, 1997)