**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)