**Section 2030.1310 Special Provisions for Purchase of Medical Services**

a) The purpose and intent of the Purchase of Medical Services program is to make the following medical services available to indigent Illinois residents: emergency medical assessment and treatment, backup medical support to social setting detoxification and other alcoholism treatment services, and medical detoxification when necessary.

b) Facilities providing services to alcoholics shall comply with the provisions of the Act and any applicable Department rules.

c) The programmatic and administrative requirements and procedures set forth in this Section are applicable to all services for which reimbursement is expected.

d) Basis of Payment

 The basis of payment for eligible costs is the rate established by the Department of Public Aid under the Medicaid program, if a Department of Public Aid Provider Agreement exists, or as negotiated by the Department.

e) Eligible Providers of Services

 General and osteopathic hospitals, non-hospital emergency centers, and free-standing alcohol and substance abuse centers licensed by the State of Illinois.

f) Reimbursable Services

1) Alcoholism Purchase of Medical Services funds may not be used for any other primary diagnosis of non-alcoholic psychiatric conditions or any other concomitant medical conditions.

2) Purchase of Medical Services funds may be expended within the program component set forth in subsection (g) provided the program components conform to any applicable licensing requirements, are operated within the context of an appropriately licensed provider, and are provided for in an executed award document.

g) Program Components

1) The following program components provide medical services provided in a non-hospital emergency center or free standing alcoholism and substance abuse screening facility or outpatient clinic of a hospital licensed by the Illinois Department of Public Health. These medical services are specifically for the treatment of acute medical symptomology and complications directly attributable to or associated with the effects of intoxication and the disease of alcoholism.

A) Medical Assessment/Emergency Treatment includes the prompt assessment of all persons to determine the nature of the alcohol related problems, the level of urgency, identification of the kind of medical treatment required and assignment for admission or firm referral to the appropriate treatment/service facility.

B) Medical Detoxification Service (hospital) which provides immediate medical detoxification services. The purpose of a medical detoxification is medical intervention and management of the person incapacitated by withdrawal from alcohol. Medical detoxification services provided to persons who fit admission criteria for a social setting detoxification treatment service facility are reimbursable services pursuant to the award document, when a social setting detoxification treatment/service facility is not available in the area.

2) For medical assessment, emergency treatment and medical detoxification services (hospital), the following apply:

A) These services are reimbursable from Purchase of Medical Services funds only by special arrangement between the hospital provider and the Department under the authority of a properly executed award document.

B) Provider fees are allowable expenses as established by the Department of Public Aid under the Medicaid program or as negotiated by the Department.

C) Physician's fees for services provided in conjunction with the above services, in order to be reimbursable through the Department's Purchase of Medical Services funds, shall be incorporated as part of the total hospital charges for each client billed to the Department unless the Department specifically contracts for physician services on a separate basis.

D) Purchase of Medical Services funds will pay for a maximum of four days' treatment in a hospital or in another medical facility which conforms to Joint Commission of Accreditation of Hospitals as set forth in The Consolidated Standards Manual – 85 For Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded-Developmentally Disabled (1984) and Department of Public Health standards.

E) The necessity for admission and any stay over four days shall be subject to the Provider's utilization review which shall include daily certification by a physician of the medical necessity for continued stay. Only charges for those days determined as medically necessary by the Provider's Utilization Review Committee will be honored for payment by the Department. Under no circumstances will the Department pay for more than ten consecutive days in any one treatment episode. Certification and Utilization Committee documentation is subject to review by the Department prior to payment.

F) Notification of inpatient services rendered must be provided to the Department or its designee within 48 hours of admission in accordance with the award document. No billings will be paid for any client for whom the Department or its designee has not received 48 hours notification. "Release of information" signed by the client which conforms with the provisions of 42 CFR Part 2 shall be provided in addition to copies of emergency room reports, admission and discharge summaries.

G) The Department may designate in the award document a local alcoholism treatment provider to act in its behalf. The award document shall specify functions and responsibilities of the local alcoholism treatment provider.

h) Client Eligibility

 This program is intended to provide financial support to individuals who cannot afford treatment and who would otherwise be denied treatment due to the lack of reimbursement by any other source. Therefore, only persons who, on the basis of inability to pay for their own treatment or lack of third party payments either through private carrier or other funding mechanism such as Medicaid or Medicare, shall be eligible for Department purchase of medical services funding. In order to be reimbursed by the Department through Purchase of Medical Services funding, providers must verify that the client's annual income is within the limitations set forth in the award document.

i) Treatment and Discharge

 The following major points should be considered in the treatment and discharge of persons under this program and documented in the individual client records:

1) Conditions which justify the necessity of treatment provided (e.g., necessity of emergency treatment, hospitalization, etc.).

2) Description of medical services critical to and consistent with diagnosis shall include but not be limited to:

A) Examinations

B) Laboratory studies

C) Special diagnostic studies

D) Present illness – treatment plan

E) Discharge plan

3) Firm referral to other alcoholism treatment programs in the client's community to ensure a continuum of care.

j) Financial Determination

1) Total documentation demonstrating that all third party funding sources have been exhausted need not be supplied by the hospital provider at the time of billing. However, such documentation shall be on file for inspection by Department staff or its designee. The hospital provider shall provide Department staff or its designee with access to all records pertaining to the client for whom billing is made under the award document.

A) The absence of a notice of denial of payment from all other sources for which the client is eligible shall be grounds for the Department to require reimbursement of charges and/or to deny payment.

B) In the event that an additional source pays provider charges subsequent to payment by the Department, the Department shall be immediately notified and provision made for repayment either directly or through a billing adjustment.

2) Consent and firm referral forms must be in the client's file. Absence of such forms during monitoring review shall be grounds for the Department to require reimbursement of charges and/or deny payment.

k) Program Review

 The Department or its designee may inspect and review the hospital provider's Utilization Review Committee minutes and cumulative monthly summaries to evaluate the quality of services provided by the hospital provider. In conducting such inspection the Department shall adhere to the confidentiality requirements of Part 21 of Article VIII of the Illinois Code of Civil Procedure [735 ILCS 5/Art. III, Part 21].

l) Fiscal Auditing

1) The Department will conduct random sample audits of client records to determine if the services billed for were provided. The Department will contact the local alcoholism treatment provider to determine any contacts, notifications and linkage performed.

2) The Department or other State or private agency, on behalf of the Department, will conduct random sample post billing audits of client's eligibility and financial status and, if such audit reveals that the hospital provider has billed for an ineligible client or has failed to pursue all sources of payment before billing Department, the hospital Provider shall return to the Department all monies paid on behalf of such ineligible or financially able client.

m) Basis for Program Rates

 Department rate methodology will be used for purchase of medical services when possible. Department funding alternatives include but are not limited to the following:

1) The Department shall reimburse the provider for eligible treatment services to alcoholics at the Department of Public Aid per diem rate established for each provider.

2) In those instances in which an exception to this rate is requested, the Department will review the proposed alternative rate structure and its supporting documentation. If the Department approves the alternative rate structure, a copy of such approved rates, with the effective dates, shall be attached to each copy of the agreement between the provider and the Department and shall be the basis for computing charges to the Department. Situations in which the Department will approve an alternative rate structure include but are not limited to the following:

A) The provider is the sole source provider in the area;

B) The provider, through internal fiscal restructuring, can deliver this service at a more economical rate;

C) Volume/market conditions make it advantageous to the provider to develop special package service rates.

3) For purposes of revising the rate during the award document period of performance, the provider must present the Department with fiscal and programmatic documents supporting a proposed revised rate at least thirty days prior to an implementation date which, if approved by the Department, will be attached to the agreement. The approved revised rate change shall not affect the maximum compensation payable under the award document.

n) Billing Procedures

 The Department shall supply each hospital provider with billing forms. The provider shall submit its billings to the Department in accordance with the following instructions:

1) The "Summary of Services Provided" form should be prepared in triplicate. Providers are to attach itemized billings, including documentation of need for services rendered, to one copy and send additional copies (total of two) to the Department or its designee and retain one copy for the provider records.

2) The "Summary of Services Provided" form must be prepared in the same manner by physicians when fees for services are not included in the per diem rate. In those instances, providers will make simultaneous submission of physician's and provider's "Summary of Services Provided."

3) The "Summary of Services Provided" form must be received by the Department no later than the 10th day of the month if payment is to be processed in that month.

4) Billings must be submitted to the Department on a monthly basis within thirty (30) days after the end of each month for services provided in such month.