**Section 2060.423 Continued Stay Review**

a) Ongoing assessment of the patient's progress in treatment shall occur in order to determine continued stay in the level of care in which the patient was placed or the need to move to another level of care or to discharge. The assessment shall be accomplished using the ASAM "continued stay" or "discharge" criteria." As the patient moves through treatment, progress shall be continually assessed and recorded in progress notes. At a minimum, a continued stay review shall include a review of the ASAM continued stay or discharge criteria, the current treatment plan, and all subsequent progress notes. Continued stay reviews shall be measured through hours or days. The type of measurement (hours or days) must be specified in the initial and each subsequent treatment plan and this measurement must remain unchanged until the next continued stay review. Continued stay review shall occur as follows:

1) upon movement to any other level of care based on any change in the level of patient functioning; or

2) every 60 calendar days or after every 10 hours of treatment for patients receiving Level I or residential extended care, every 30 calendar days or after every 27 hours of treatment for patients receiving Level II care, every 14 calendar days for patients receiving Level III care, and every 24 hours for patients receiving Level IV care;

3) prior to planned discharge;

4) every 30 days for patients in opioid maintenance therapy during the first 90 days of treatment and every 90 days thereafter for patients who demonstrate 90 days of stable participation and for whom no change has occurred in the ASAM Biomedical Conditions and Complications dimension.

b) Documentation of the continued stay review shall:

1) be by progress note in the patient record;

2) include the participation of the patient;

3) be initialed and dated by the patient;

4) be initialed and dated by the professional staff member conducting the review; and

5) be authorized as evidenced by a progress note in the patient record written and dated and initialed by the medical director or a physician working under his or her supervision if there is a change in the ASAM Biomedical Conditions and Complications dimension.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)