DEPARTMENT OF HEALTH

ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

Adolescent Substance Abuse Treatment Expansion Project

(ASTEP)

Government of the District of Columbia

Revised 7/22/09

July 22, 2009

Dear Certified Substance Abuse Treatment Provider,

It is with pleasure that I welcome your participation in the Government of the District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, Adolescent Substance Abuse Treatment Expansion Program (ASTEP).

I applaud your commitment to provide treatment for District adolescents living with substance use disorders. The purpose of ASTEP is to expand access to treatment and recovery support services by allowing adolescents to access services directly from community-based substance abuse treatment providers. Through ASTEP, District adolescents will benefit from a continuum of treatment services delivered by a community of providers dedicated to delivering the best quality substance abuse treatment services. I am committed to working with APRA's provider partners to make certain that treatment is available, accessible, efficient, and effective for those seeking help.

This manual has been developed to assist you with the structured components of ASTEP. In the following pages you will find detailed information regarding process and procedures, policies, definitions, reference materials, and applicable forms. This manual will serve as a quick reference and can easily be used to educate the rest of your staff.

This manual will be periodically updated in the coming months. Our project team, in concert with you—our provider partners—will continuously look for ways to improve our processes. All updates will be mailed to you for inclusion in the manual.

Working together we will achieve the goals of making the District of Columbia a place where adolescents can obtain quality services, compassionate intervention, and realize sustainable outcomes.

Sincerely,

Tori L. Fernandez Whitney
Senior Deputy Director
Addiction Prevention and Recovery Administration

Acknowledgements

APRA acknowledges the contributions of Susan Bergmann, Alan Budney, Jutta Butler, Doreen Cavanaugh, Ann Doucette, Lonnie Hutchinson, Toby Martin, Michael McAdoo, Alina McClerklin, Neill Miner, Randy Muck, Valentine Onwuche, Keela Seales, Joan Smith, Shaun Snyder, Cathy Stanger, and Win Turner. APRA would also like to acknowledge the contributions of Chestnut Health System's Lighthouse Institute, the PDNLP Bulletin, the Sacramento, California Department of Alcohol and Drug Program and the staff at the District of Columbia Department of Health Care Finance and Department of Mental Health.

Table of Contents

1.0 Introduction and Overview

The **Addiction Prevention and Recovery Administration (APRA),** in partnership with the **Department of Health Care Finance (DHCF)** reimburses clinically necessary substance abuse treatment services for eligible clients.

This manual details the policies and procedures for delivering Medicaid and/or APRA reimbursable adolescent substance abuse treatment services in the District of Columbia.

Providers are responsible for adhering to the requirements set forth in this manual.

2.0 Participating Provider

A participating provider is an entity with an executed Human Care Provider Agreement (HCPA) with APRA and current Chapter 23 certification status.

In order to provide reimbursable substance abuse treatment services in the District of Columbia, providers must adhere to the guidelines established by APRA and outlined in their individual provider agreements. At a minimum, providers must adhere to the following requirements:

- All conditions specified in the Human Care Provider Agreement, signed by the provider and representative of APRA
- All policies and procedures established by APRA, including this manual
- The Code of D.C. Municipal Regulations, Title 29, Chapter 23
- The Choice in Drug Treatment Act of 2000, DC Official Code 7-3000 et seq.
- Notification to APRA of any change in the information supplied to enroll in the program, i.e. address, group affiliations, additional licenses acquired, etc.
- Assurance of freedom of choice to all recipients of health care services.
- For providers who will serve DC Medicaid beneficiaries, Chapter 23 certification is a requirement before a DC Medicaid application can occur. DC Medicaid applications can be found at www.dc-medicaid.com.
- In order to receive Medicaid reimbursement, the provider must have an active Chapter 23 certification.

3.0 APRA Regulations for Participating Providers

3.1 Utilization Review

In accordance with D.C. Municipal Regulation 29-2306, APRA has established procedures for reviewing the utilization of, and payment for, all substance abuse treatment services delivered by participating providers. Accordingly, providers are required, upon request, to provide APRA, designated APRA agents, or the District of Columbia Department of Health with medical and billing records.

In addition, providers must fully cooperate with audits and reviews made by APRA or its designee to determine validity of claims or the medical necessity of services rendered by the provider.

3.2 Consequences of Misuse and Abuse

If routine utilization review procedures indicate services have been billed for that are not medically necessary, inappropriate, contrary to customary standards of practice, or violate applicable regulations, the provider will be notified in writing. Claims that have not been approved may be delayed or suspended. The provider may need to explain billing practices and provide records for review. Providers will be required to refund payments made by APRA if the services are found to have been billed and been paid by APRA contrary to policy, the provider has failed to maintain adequate documentation to support their claims, or billed for medically unnecessary services.

3.3 Quality Assurance Program for Participating Providers

APRA is responsible and accountable for the implementation of a program to ensure clinical and fiscal compliance with the provisions of Chapter 23, the HCPA, and all applicable laws and regulations. Providers are subject to review by APRA's Office of Certification and Regulation, Office of Quality Assurance, and the Deputy Director of Operations to ensure compliance.

3.4 Consequences of Fraud

If an investigation by APRA shows that a provider submitted false claims for services not rendered or provided assistance to another in submitting false claims for services not rendered, APRA will initiate termination proceedings pursuant to the provider's HCPA and Chapter 23 regulations. In addition to administrative action, the case record may be referred to the appropriate authority for investigation.

The following administrative actions can be taken in response to provider misuse, fraud, and/or abuse.

3.5 Restitution

If a provider has billed and been paid for undocumented or medically unnecessary services, APRA will review the error and determine the amount of improper payment. The provider may be required to either submit payment or provide repayment through future claims. If the 100% review of disputable claims becomes impractical, random sampling techniques will be implemented to determine the amount of the improper payment. An appeal by a provider is not a sufficient reason to postpone restitution procedures. In addition, the provider is prohibited from billing the client for amounts the provider is required to repay.

3.6 Termination

A Human Care Provider Agreement can be terminated due to, but not limited to, the following:

- Failure to comply with applicable federal or District laws, rules, or regulations;
- Performing a type of treatment or rehabilitation service for which the provider has not been certified;
- Intentionally billing or accepting payment for services not provided;
- Intentionally billing or accepting payment for services that have also been billed to APRA outside the HCPA, Medicaid, or a third party payer;
- Misrepresenting the qualifications of an employee providing the service;
- Intentionally billing for a different quantity or quality of medications than actually provided;
- Providing a type of treatment for which the client has not given informed consent;
- Defaulting on its contractual obligations; or,
- APRA or the provider may terminate the HCPA for any reason by giving written notice at least ninety (90) days before such termination to the other party of its intent to terminate the Agreement.

3.7 Notification

When a Human Care Provider Agreement is terminated, APRA will provide thirty (30) days notice and will include the reason for the action, the effective date of the action, and other action taken beyond termination. Upon notification of termination, the provider may submit all outstanding claims for allowable services rendered prior to the date of termination. The District shall pay invoices submitted not later than thirty (30) days following the termination date.

In addition, upon termination of the Provider Agreement, APRA may release all pertinent information to:

- The Centers for Medicaid and Medicare Services (CMS-formerly known as HCFA)
- District, State, and local agencies
- State and county professional societies
- General public

3.8 Consequences of Termination

Upon termination, the provider will be prohibited from receiving payment, either directly or indirectly, from APRA. This includes payment for professional or administrative services through any group practice, medical, clinic, medical center, individual provider, or other facility.

3.9 Appeal Process

A provider may request a formal review if the provider disagrees with an administrative decision made by APRA. Areas that may be appealed include, but are not limited to:

- Denial of payment
- Termination of a Human Care Provider Agreement
- Administrative action.

Written requests for appeals must be sent to the Director of the District of Columbia Department of Health. A copy of all appeals must be sent to APRA. See Appendix A: Contact Information for Formal Appeal of APRA Decision

4.0 Notice Requirements for Proposed Operational Changes

4.1 Requirement to Provide APRA with 30 day Written Notice

Participating ASTEP providers must provide APRA with written notice thirty (30) days prior to implementing any of the following operational changes, including all aspects of the operations materially affected by the changes:

- A change in the program's or facility's geographic location;
- A change in the settings where services are performed (e.g. outpatient clinic to home-based);
- A planned sale, lease, or change in ownership;
- The proposed addition or deletion of major service components;
- A change in required staff qualifications;
- A proposed change in organizational structure;
- A change in the population served;
- A change in bed capacity, and;
- A change in program capacity.

Participating ASTEP providers must provide APRA with written notice thirty (30) days prior to implementing any change in the ownership of a facility or program owned by an individual, partnership, or association, or in the legal or beneficial ownership of 10% or more of the stock of a corporation that owns or operates a facility or program.

4.2 APRA's Discretion to Re-inspect Program for Compliance

The Department, upon notification, may at its discretion require re-inspection to ensure that the facility or program will remain in compliance with the provisions of the Choice in Drug Treatment Act of 2000, DC Official Code 7-3000 et seq, The Code of D.C. Municipal Regulations, Title 29, Chapter 23, and all other applicable provisions of law.

Notwithstanding the provisions of Section 4: Notice Requirements for Proposed Operational Changes, ASTEP providers must comply with other notification requirements as required by applicable District and federal laws and regulations.

5.0 Unusual Incidents and Investigations

5.1 General Provisions Regarding Unusual Incidents

Suspicious or unusual incidents include, but are not limited to, the following apparent or alleged incidents involving clients, staff and/or visitors, occurring on or off site during program operating hours and/or while staff was on official duty and client(s) were participating in a supervised aspect of the program:

- Unexplained or suspicious physical injury or any death of a client, visitor or staff;
- Apparent or alleged physical abuse or neglect, which results in physical injury or would have resulted in injury or death; or
- Apparent or alleged sexual assault or abuse.

5.2 Requirement to Develop and Implement Unusual Incident Reporting Plan

Each ASTEP provider must develop and implement written policies and practices related to individual abuse, neglect, and unusual incidents to insure prompt reporting and a prompt, impartial investigation and review.

The procedures of a substance abuse treatment facility or program shall specify the methods of investigation and review of unusual incidents, including identification of staff responsible for conducting the investigation. The policies, procedures and practices shall include, but are not limited to the following:

- A written submission to APRA of all incidents under investigation involving abuse, sexual assault, neglect, injury, death, or any other incident alleged to be of a criminal nature or that threatens the health and safety of clients and/or staff;
- A provision that if the safety of an individual is threatened as, determined by the facility's or program's director, the alleged perpetrator shall not work directly with clients until the investigation is completed; and
- A requirement that an investigation conducted by a substance abuse treatment facility or program shall be initiated within twenty-four (24) hours of reporting of the incident and shall be completed within ten (10) calendar days.

ASTEP providers must maintain in a secure file, copies of all complaints, unusual incident reports, investigation findings, and actions taken, with a separate file for those that may be of a criminal nature. These records shall be readily available for review by APRA.

ASTEP providers must review unusual incident investigation findings and take appropriate action, including steps to reduce the likelihood of further recurrences of such incidents.

5.3 Requirement to Report Unusual Incidents to APRA within 24 hours

ASTEP providers must provide APRA with written notice of any unusual incident which results in physical injury or death within twenty-four (24) hours of the incident or within twenty-four (24) hours of the program director becoming aware of the incident.

ASTEP providers must provide a written submission to APRA of all incidents under investigation involving abuse, sexual assault, neglect, injury, death, or any other incident alleged to be of a criminal nature or that threatens the health and safety of clients and/or staff. Any investigation conducted by a substance abuse treatment facility must be completed within ten (10) calendar days of the incident.

- APRA may grant an additional ten (10) day extension to a facility or program upon receiving a written request for an extension of time within which to complete an investigation;
- APRA shall grant or deny a request for an extension within twenty-four (24) hours of receiving the request.

ASTEP providers must submit written findings of an unusual incident investigation to APRA within twenty-four (24) hours of completing the investigation.

ASTEP providers must cooperate with APRA in the completion of investigations conducted by APRA staff.

5.4 Provisions Relevant to Unusual Incidents Involving Minors

An apparent or alleged incident of abuse or neglect involving a minor under the age of eighteen (18), including reporting of abuse or neglect of minors by parents, guardians or others, shall be immediately reported to the District of Columbia Metropolitan Police Department and to the Child and Family Services Agency (CFSA).

A substance abuse treatment facility or program shall immediately notify the parent or legal guardian of any incident involving a minor under the age of eighteen (18). If the parent or legal guardian is suspected of being the alleged perpetrator, the facility shall exercise clinical judgment when informing the parent or guardian that the provider initiated the report in accordance with the Prevention of Child Abuse and Neglect Act of 1977, effective September 23, 1977 (D.C. Law 2-22; D.C. Code § 2-1351 et seq.).

6.0 Treatment Accessibility and Compliance with the Americans with Disabilities Act (ADA)

6.1 Requirement of Treatment Accessibility and Compliance with the ADA

The District of Columbia Department of Health, Addiction Prevention and Recovery Administration is committed to making District programs, services, and activities available to qualified District residents, regardless of disability. In addition, the District is committed to compliance with the Americans with Disabilities Act (ADA). Therefore, ASTEP providers must ensure that no barriers (architectural, communication, procedural, or otherwise) impede the delivery of services or arrange for access to services free from all barriers.

6.2 Development of Policies and Procedures to Support Accessibility

ASTEP providers must establish policies and procedures that support accessibility to all qualified individuals.

6.3 Policies and Procedures to Ensure Accessibility for Individuals with HIV/AIDS

ASTEP providers must establish policies and procedures which stipulate that individuals infected with the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) have equal access to services.

7.0 Eligible ASTEP Participants

7.1 General Overview of ASTEP Participant Eligibility

An eligible recipient of adolescent substance abuse services through ASTEP must meet all of the following requirements:

- District residents;
- Younger than the age of 21 or up to 22 years of age with a Social Security Administration determination of disability;
- Without private medical insurance, or whose medical insurance does not cover substance abuse treatment services;
- Who are Medicaid eligible or who have been determined ineligible to receive Medicaid benefits by the Income Maintenance Administration (IMA); and
- With an Axis I diagnosis of a substance use disorder.

7.2 District Residency

An adolescent is eligible for substance abuse treatment services through ASTEP if he or she presents evidence of District of Columbia residency. Documents that establish District of Columbia residency for the purpose of receiving APRA reimbursable substance use treatment services include:

- A valid motor vehicle operator's permit issued by the District;
- A non-driver identification card issued by the District;
- A voter registration card with an address in the District;
- A copy of a lease or a rent receipt for real property located in the District;
- A utility bill for real property located in the District; or
- A copy of the most current federal income tax return or Earned Income Credit Form.

Under certain circumstances, Medicaid beneficiaries may not be domiciled in the District of Columbia.

7.3 Maintenance of District of Columbia Residency

An adolescent receiving substance abuse treatment services through ASTEP must maintain District residency while participating in ASTEP. A provider may request any one (1) of the documents listed in Section 7.2 to confirm District residency.

It is the responsibility of the provider to confirm that clients enrolled in their program maintain District residency. Invoices submitted for services delivered to clients who are not District of Columbia residents are subject to nonpayment.

7.4 Age Limitations

An adolescent is eligible for substance abuse treatment services through ASTEP if he or she is younger than the age of 21. Eligibility ends on the date of the participant's twenty-first (21) birthday. Benefits may be available for participants with a Social Security Administration determination of disability up to the date of the twenty-second (22) birthday.

Providers must coordinate client's transition into adult treatment as the client approaches his or her 21st birthday.

7.5 Availability of Private Insurance

An adolescent is eligible for substance abuse treatment services through ASTEP if he or she is currently uninsured or his or her private insurance does not cover substance abuse treatment.

7.6 Medicaid Eligibility

An adolescent is eligible for substance abuse treatment services through ASTEP if he or she is a D.C. Medicaid recipient or if the Income Maintenance Administration (IMA) has reviewed the adolescent or his or her parent or legal guardian's Medicaid application and denied the application due to ineligibility for Medicaid benefits.

7.7 Diagnosis of a Substance Use Disorder

An adolescent is eligible for substance abuse treatment services through ASTEP if he or she is currently diagnosed with a Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. Text Revision (DSM IV TR) Axis I substance use disorder.

8.0 Accessing Services

8.1 Accessing Treatment Services

An adolescent may access substance abuse treatment services from a participating ASTEP provider in one of several ways:

- parent or guardian request,
- referral from a District of Columbia government agency (such as the Child and Family Services Agency (CFSA), Department of Mental Health (DMH), or Department of Youth Rehabilitative Services (DYRS)),
- referral from a community or faith-based organization, or
- self referral.

A referral is defined as any contact with the treatment agency, whether by telephone, letter, fax, or in-person visit, that may be reasonably interpreted as a request for services.

8.2 Self Referral

A minor of any age may consent to health services which he or she requests for the prevention, diagnosis, or treatment of substance abuse, including drug and alcohol abuse.

8.3 Assessing ASTEP Eligibility

During client intake, treatment professionals will collect relevant client information in order to determine eligibility for ASTEP participation; including District residency, Medicaid eligibility, and the availability of private insurance.

8.4 Assessment for Axis I Substance Use Disorder

After an appropriate staff person determines the client's eligibility to participate in ASTEP, a treatment counselor will collect the client's relevant treatment history and perform an assessment to determine the presence of an Axis I substance use disorder. The client must be administered a Global Appraisal of Individual Needs (GAIN) substance abuse assessment performed by a certified GAIN administrator. After the client has undergone the GAIN assessment, an interdisciplinary team must review the assessment findings and determine whether the client meets the criteria for an Axis I substance use disorder diagnosis pursuant to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., currently the DSM-IV-TR. If the client meets all criteria for ASTEP participation, this information will be used to determine the level of care appropriate for treatment.

8.5 Referral to Treatment

After determining the client's eligibility to participate in ASTEP and assessing for the presence of an Axis I substance use disorder, an interdisciplinary team will determine the level of care appropriate for treatment. The client will be offered his or her choice of treatment provider. Once the client has selected a treatment program, the provider may either begin delivering treatment services or coordinate the client's transfer to the substance abuse treatment program of his or her choice. See Section 36: Step-Up, Step-Down, or Transfer of Clients to Other Substance Abuse Treatment Programs

9.0 Procedures for Determining ASTEP Eligibility

ASTEP providers must adhere to the following procedures to determine client eligibility to receive substance abuse services. ASTEP providers must determine client eligibility to participate in ASTEP before providing substance abuse services.

9.1 Assessing District of Columbia Residency

It is the responsibility of the provider to ensure that the prospective client is a District of Columbia resident. Documents that establish District of Columbia residency for the purpose of receiving substance abuse services through ASTEP include:

- A valid motor vehicle operator's permit issued by the District;
- A non-driver's identification card issued by the District;
- A voter registration card with an address in the District;
- A copy of a lease or a rent receipt for real property located in the District;
- A utility bill for real property located in the District; or
- A copy of the most current federal income tax return or Earned Income Credit Form.

If the client, due to his or her age, cannot present any of the aforementioned documents establishing District of Columbia residency, the provider may accept proof of such residency from the client's parent or legal guardian.

If the client has been referred to treatment by a District of Columbia government agency, such as CFSA, DYRS, or DMH, documentation establishing residency is not required.

Under certain circumstances, Medicaid beneficiaries may not be domiciled in the District of Columbia.

The provider must make a photocopy of the document(s) presented to establish residency and include such documentation with the client's file.

9.2 Assessing Private Insurance Eligibility

It is the responsibility of the provider to request proof of private medical insurance from every prospective client who presents for substance abuse services. If the client presents proof of private medical insurance, it is the responsibility of each provider to determine whether the client's private medical insurer reimburses substance abuse treatment.

If the client, or his or her guardian, presents proof of insurance benefits, the provider must contact the private insurer's customer service or benefits line and inquire as to

whether substance abuse treatment services are covered. Thereafter, the provider may complete intake and proceed to screening and assessment.

9.3 Assessing Medicaid Eligibility

It is the responsibility of the provider to ensure the client's DC Medicaid eligibility on the date of service. If a provider supplies services to an ineligible recipient, the provider cannot collect payment from DC Medicaid. The provider must verify:

- Recipient's name and Medicaid identification number
- Effective dates of eligibility
- Services restricted to specified providers
- Third-party liability

In order to determine Medicaid enrollment, the provider agency must contact the automated Interactive Voice Response System (IVR). See Appendix B: IVR Instructions.

- If the client is currently enrolled in a Medicaid Managed Care Organization (MCO), the IVR automated system will state that the client is eligible for Medicaid benefits. Thereafter, the provider may complete intake and proceed to screening and assessment.

    - When calling the IVR system, the provider should note the name of the MCO in order to coordinate care with the client's MCO case manager. The MCO case manager is responsible for assisting the provider in coordinating the client's medical and mental health care.

- If the client is a Fee-for-Service (FFS) Medicaid benefits recipient, the IVR automated system will state that the client is eligible for Medicaid benefits. Thereafter, the provider may complete intake and proceed to screening and assessment.

Figure 9.3: Assessing for Medicaid Eligibility

Hi Kelly! I'm assessing my client's eligibility to participate in the ASTEP program. She says she's a Medicaid recipient, but she doesn't have her card with her. Am I able to complete the intake process and refer her to treatment?

There's no need to send the client home, Michael. After you confirm her eligibility, or the residency of her parent or legal guardian, call the IVR system to confirm Medicaid enrollment.

Make sure you use the exact name that your client used on her Medicaid application, or the system will deny her eligibility. If you run into trouble, double check the spelling or ask the client if she sometimes uses a middle initial.

Thanks Kelly! This information is really helpful.

9.4 Assessing Client for Presence of Axis I Substance Use Disorder

It is the responsibility of the provider to ensure the client has a current diagnosis of an Axis I substance use disorder. The client must be administered a GAIN substance abuse assessment performed by a certified GAIN administrator. After the client has undergone the GAIN assessment, an interdisciplinary team must review the assessment findings and determine whether the client meets the criteria for an Axis I substance use disorder diagnosis pursuant to the most recent edition of the DSM-IV-TR.

10.0 Eligibility for ASTEP Services When the Client is not Enrolled in Medicaid

10.1 Eligibility for ASTEP Services when the Client is not Enrolled in Medicaid

A client whose Medicaid eligibility has not been established is not barred from receiving adolescent substance abuse treatment services through ASTEP if the client satisfies all other requirements for ASTEP participation.

An eligible recipient of adolescent substance abuse services through ASTEP must meet all of the following requirements:

- District residents;
- Younger than the age of 21 or up to 22 years of age with a Social Security Administration determination of disability;
- Without private medical insurance, or whose medical insurance does not cover substance abuse treatment services;
- Who are Medicaid eligible or who have been determined ineligible to receive Medicaid benefits by the Income Maintenance Administration (IMA); and
- With an Axis I diagnosis of a substance use disorder.

10.1.1 Eligibility for ASTEP Services when the Client's Medicaid Application is Pending before the Income Maintenance Administration (IMA)

An ASTEP provider may provide substance abuse treatment services to a client whose Medicaid application is currently pending before the IMA if the client meets all other requirements for ASTEP participation. See Section 10.1 above.

1. If the client meets all other requirements for ASTEP participation, the provider should assist the client and/or his or her legal guardian in submitting a Medicaid benefits application to the IMA. See Section 10.2 below.
2. The provider should then complete client intake and proceed to screening and assessment.
3. After a complete assessment has been performed, an interdisciplinary team of qualified program staff must determine the level of care necessary for treatment.
4. After determining the appropriate level of care for treatment, the provider may begin providing treatment at the clinically indicated level of care or refer the client to the ASTEP provider of his or her choice for treatment.
5. Medicaid will cover the cost of services for Medicaid eligible services for up to 90 days prior to the date of submission of the IMA application, once the individual is approved as a beneficiary.

10.1.2 Eligibility for ASTEP Services when the IMA Determines the Client is not Eligible for Medicaid benefits

An ASTEP provider may provide substance abuse treatment services to a client whose Medicaid application has been denied for Medicaid ineligibility by the IMA if the client meets all other requirements for ASTEP participation. See Section 10.1 above.

1. If the client meets all other requirements for ASTEP participation, the provider should assist the client and/or his or her legal guardian in submitting a Medicaid benefits application to the IMA. See Section 10.2 below.
2. The provider should then complete client intake and proceed to screening and assessment.
3. After a complete assessment has been performed, an interdisciplinary team of qualified program staff must determine the level of care necessary for treatment.
4. After determining the appropriate level of care for treatment, the provider may begin providing treatment at the clinically indicated level of care or refer the client to the ASTEP provider of his or her choice for treatment.
5. If the client, or his or her parent or legal guardian, are determined to be ineligible for Medicaid benefits by the IMA, the provider must make a photocopy of the document denying Medicaid eligibility and submit the invoices for ASTEP substance abuse treatment services to APRA.
6. APRA will reimburse participating ASTEP providers for clinically appropriate substance abuse treatment services provided to eligible ASTEP participants who are not eligible for Medicaid benefits.

10.2 Submitting Medicaid Applications to the Income Maintenance Administration (IMA)

It is the responsibility of the provider to assist all Medicaid eligible clients in submitting an application for Medicaid benefits.

A client whose Medicaid eligibility has not been established is not barred from receiving adolescent substance abuse treatment services if the client satisfies all other requirements for ASTEP participation.

An eligible recipient of adolescent substance abuse services through ASTEP must meet all of the following requirements:

- District residents;
- Younger than the age of 21 or up to 22 years of age with a Social Security Administration determination of disability;
- Without private medical insurance, or whose medical insurance does not cover substance abuse treatment services;

- Who are Medicaid eligible or who have been determined ineligible to receive Medicaid benefits by the Income Maintenance Administration (IMA); and
- With an Axis I diagnosis of a substance use disorder.

If the client is a District of Columbia resident who is not a Medicaid beneficiary and who does not have private insurance or whose private insurance does not pay for substance abuse treatment services, the provider should designate an appropriate staff member, such as a case manager, to assist the client and/or his or her guardian in submitting an application for Medicaid benefits. See Section 11: Procedures for Submitting an Application for Medicaid Benefits

After assisting the client in submitting his or her application, the case manager should routinely follow up with the client regarding the status of his or her application.

After assigning an appropriate staff member to assist the client and/or his or her guardian in submitting an application for Medicaid benefits; the provider should complete intake and proceed to screening and assessment.

Helping a client or a client's family submit a completed application for Medicaid benefits to the IMA is a billable service. Document the time spent assisting the client and submit an invoice to APRA for case management.

11.0 Procedures for Submitting an Application for Medicaid Benefits

If an adolescent, or his or her parent or guardian, is not a Medicaid recipient, he or she may submit a Medicaid benefits application to the Income Maintenance Administration (IMA). A Medicaid application can be downloaded from the Department of Health Services at the following URL: http://dhs.dc.gov/dhs/cwp/view,a,3,q,568277,dhsNav,%7C30980%7C.asp. For IMA services and information, call the IMA Change Center at (202) 727-5355.

It is the responsibility of the provider to designate an appropriate staff member, such as a case manager, to assist the client and/or his or her guardian in submitting an application for Medicaid benefits.

After assisting the client in submitting his or her application, the staff member should routinely follow up with the client regarding the status of his or her application.

12.0 Minimum Data Requirements for Intake and Screening

When a client presents for substance abuse treatment, a substance abuse treatment facility or program shall collect sufficient information on an individual seeking treatment to establish a client profile for purposes of triaging clients based on presenting status, establish a baseline against which treatment outcomes will be measured, and analyze aggregate data on individuals seeking treatment for addiction in the District of Columbia.

Each provider agency must develop a client enrollment form that conforms to APRA's minimum data collection requirements.

An addiction counselor or trained paraprofessional shall collect the following information at enrollment:

- Demographic information including but not limited to photo I.D, primary language, name, age, address, living arrangements, social security number, race/ethnicity, source of referral, sex and sexual orientation, marital status, religion, education/training, employment status, emergency contact, military status, disability status, type of health insurance, and criminal justice involvement;
- The presenting problem including a statement of the circumstances or symptoms prompting the individual to seek services at this time;
- Existing personal support systems;
- Self-reported history of prior medical hospitalizations, substance abuse and psychiatric treatment episodes;
- Self-reported history of chronic medical problems affecting daily life, name and telephone number of primary care physician, and voluntary reporting of the status of HIV testing and results;
- Report of alcohol and/or drug consumption and quantity, type of drug, route of administration, and frequency in last 30 days;
- Record of prior treatment for emotional problems and current mental health status as observed and self-reported, particularly as it relates to current level of danger to self or others; and
- Diagnostic summary of interviewer's impressions and observations.

13.0 Screening and Assessment

A provider must initiate the intake and screening process for a prospective client within 24 hours of a request for services.

13.1 Client Screening for Substance Use

Screening tools and rating scales are often used as an initial evaluation of the types of problems (e.g., substance abuse, mental health, and general life problems) an adolescent may be experiencing. Screening tools do not produce a diagnosis, but rather indicate to a treatment professional that a more comprehensive assessment is needed.

The Global Appraisal of Individual Needs-Short Screener (GAIN-SS) is the recommended screening tool for adolescents presenting for substance abuse treatment services on the basis of a self or parent/guardian referral.

If the adolescent is referred for treatment for substance abuse from another provider, school, or child serving agency, a substance abuse screening may have already been performed and it is therefore unnecessary to re-administer the screening tool. Evidence of a substance abuse problem should accompany the referral documentation. In the case of a referral with appropriate documentation, the provider should begin conducting a comprehensive diagnostic assessment.

13.2 Assessment and Referral to Treatment

The Global Appraisal of Individual Needs (GAIN) assessment instruments are comprehensive biopsychosocial assessment tools. They are a progressive and integrated series of measures and computer applications designed to support a number of treatment practices, including the following: initial screenings; brief interventions; referrals; standardized clinical assessments for diagnosis, placement, and treatment planning; and monitoring of changes in clinical status. The GAIN assessment tool has eight core sections (Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal, and Vocational). Each section contains questions on the recency of problems, breadth of symptoms, and current prevalence as well as lifetime service utilization, recentness of service utilization, and frequency of the latest service utilization.

The GAIN-I is a comprehensive biopsychosocial assessment tool designed to help clinicians gather information for diagnosis, placement, and treatment planning. The GAIN-I shall be used as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement, and other clinical decisions. ASTEP providers shall administer the GAIN-I to new clients initiating substance abuse

treatment or clients returning to substance abuse treatment after an interruption in treatment longer than six months.

The GAIN-Q is a general, quick assessment tool used to make referral and placement decisions for clients who have undergone a GAIN-I assessment in the preceding six months but have subsequently lapsed from treatment for more than two months but less than six months. The GAIN-Q shall be used as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement, and other clinical decisions. ASTEP providers shall administer the GAIN-Q upon the client's return to treatment to determine whether the client is in the clinically appropriate level of care or whether he or she requires a step up or step down to another level of care or a transfer to another provider agency in the ASTEP network.

If the client has lapsed from treatment for less than two months, ASTEP providers shall review the last GAIN assessment performed in order to make a level of care determination.

If the client has lapsed from treatment for more than six months, ASTEP providers shall perform a GAIN-I assessment in order to make a level of care determination.

13.3 Assessment of Treatment Progress

The GAIN-M90 is a general assessment tool designed to assess treatment needs and monitor progress in 90 day increments as the client progresses through treatment. The GAIN-M90 shall be used as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement, and other clinical decisions. ASTEP providers shall administer the GAIN-M90 to assess the client's progress and may be used to determine whether the client is meeting his or her treatment goals or requires a step-up or step-down to another level of care or a transfer to another provider agency in the ASTEP treatment network. ASTEP providers shall administer the GAIN-M90 no more frequently than every 90 days.

13.4 Policies and Procedures for Administering GAIN Instruments

If the screening tool (or referral documentation) reveals evidence of substance use, the provider must request client consent to contact APRA to determine whether the adolescent has previously undergone an assessment for substance use disorder in the District of Columbia through ASTEP. After obtaining the client's consent, the provider must contact APRA to determine the assessment tool administered (GAIN-I, GAIN-Q, or GAIN-M90), the date the assessment was administered, and the name of the ASTEP provider agency that administered the most recent assessment.

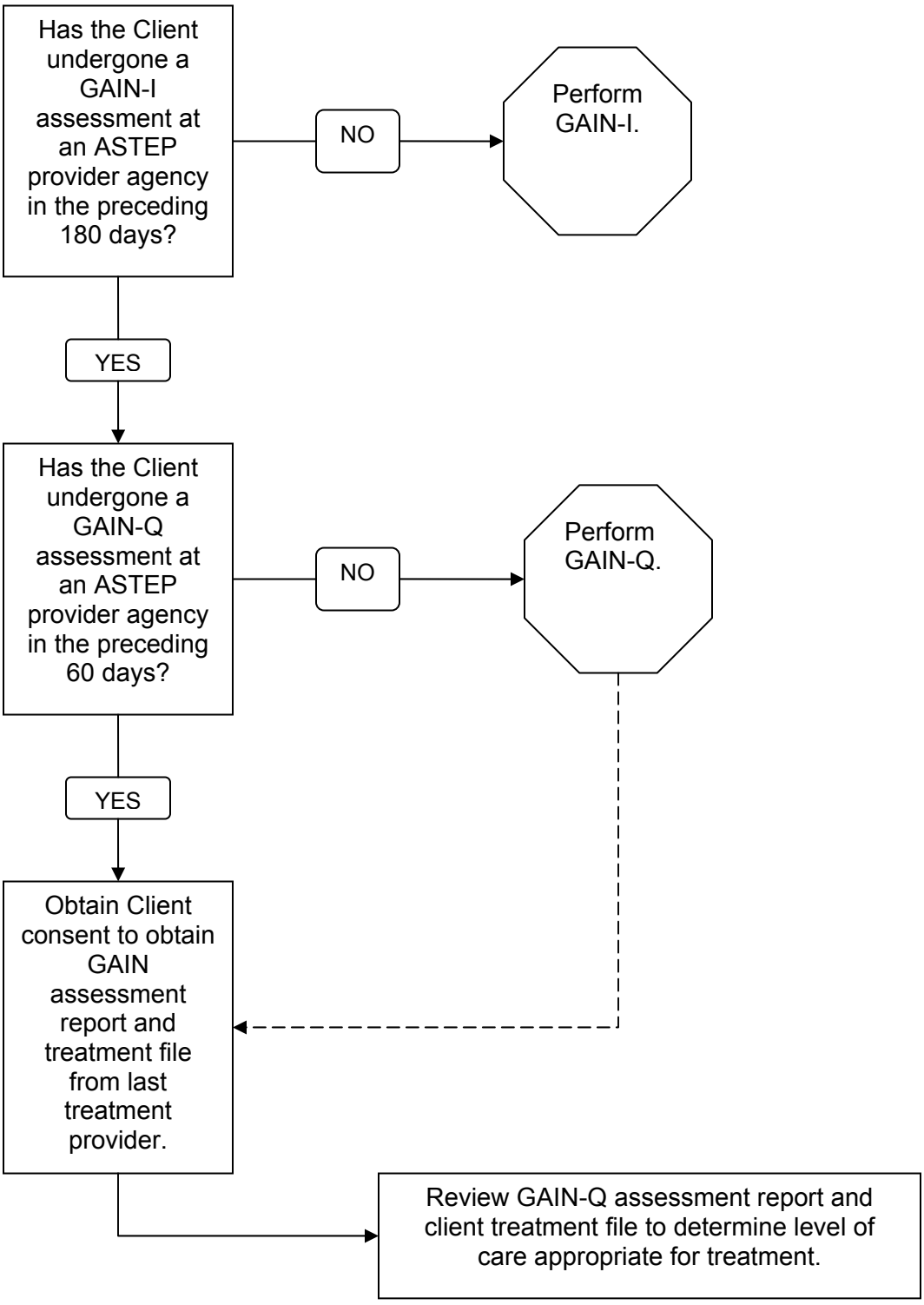
- If the client has undergone a GAIN-I comprehensive diagnostic assessment in the preceding 180 days and a GAIN-Q assessment in the preceding 60 days, the provider must obtain the client's written consent to contact the agency where the

- If the client has undergone a GAIN-I comprehensive diagnostic assessment in the preceding 180 days, but has not undergone a GAIN-Q assessment in the preceding 60 days, then the provider may perform a GAIN-Q assessment to determine the level of care necessary for placement. The provider must administer and score the assessment in accordance with the terms of the agency's GAIN license and usage agreement.

- If a GAIN-I assessment has not been completed within the past 180 days, the provider must perform a GAIN-I assessment in order to determine the level of care necessary for treatment and develop a treatment plan. The provider must administer and score the assessment in accordance with the terms of the agency's GAIN license and usage agreement.

See Figure 13.4: Administering the GAIN Instrument

Figure 13.4 Administering the GAIN Instrument



13.5 Credentials of Individuals Administering the GAIN Assessment Tool

The GAIN assessment tool may only be administered by an individual certified by Chestnut Health Systems.

13.6 Client Assessment Database

Each provider is responsible for sending a weekly report recording the name of each client who underwent a GAIN assessment, and the date the assessment was performed. The weekly report must be faxed under a cover sheet that contains no identifying client information. APRA will maintain a central database of client assessment information, including the assessment tool administered (GAIN-SS, GAIN-I, GAIN-Q, or GAIN-M90), the date the assessment was administered, and the name of the provider agency that administered the assessment. See Figure 13.6: Sample ASTEP Weekly GAIN Assessment Tracking Form

If the client indicates that an assessment has been performed within the preceding 180 days, and the client is able to identify the ASTEP network provider that performed the assessment, the provider must obtain the client's written consent to contact the agency where the assessment was performed and request a copy of the assessment report and client case file.

If the client indicates that an assessment has been performed within the preceding 180 days but is unable to identify the ASTEP network provider that performed the assessment, the provider may contact APRA to research the ASTEP Client Assessment Database to determine the provider agency where the assessment was performed. The provider may then obtain the client's written consent to contact the agency where the assessment was performed and request a copy of the assessment report and client case file.

Figure 13.6: Sample ASTEP Weekly GAIN Assessment Tracking Form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Addiction Prevention and Recovery Administration

NOTE: This form must be faxed or hand delivered

ASTEP Weekly GAIN Assessment Tracking Form

SECTION A:	
PROVIDER NAME	
CONTACT PERSON	

SECTION B:				
Client Name	GAIN Assessment Performed	Date Performed	GAIN Administrator	LOC Referred

14.0 Level of Care Determination

After a complete assessment has been performed, an interdisciplinary team of qualified program staff must determine the level of care necessary for treatment.

14.1 Credentials of Individuals Qualified to Determine Level of Care

Staff qualified to make a level of care determination for substance use disorder include an addiction counselor and one or more of the following: a Licensed Independent Clinical Social Worker (LICSW), a Licensed Professional Counselor (LPC), a licensed nurse practitioner or a registered nurse with a specialty in psychiatry or chemical dependency, a licensed psychologist, or a licensed physician.

The District of Columbia recommends that providers consult the American Society of Addiction Medicine (ASAM) Level of Care placement criteria in order to determine the appropriate level of care necessary for treatment.

14.2 Level I Outpatient Treatment

Level I outpatient treatment is usually the first treatment option for youth needing services. National treatment episode data indicates that 60-70% of clients are referred to outpatient treatment. It is most appropriate for youth in the low to medium range of the severity continuum that are experiencing minimal withdrawal risk and no medical or biomedical conditions. These youth are generally in school and in home environments that are supportive to their recovery, or the youth have the skills to cope with less supportive home environments. These youth are generally sent to treatment by an external motivating entity (juvenile justice, school, family) and need motivating and monitoring strategies to address their impairment in major life activities.

APRA endorses a clinical model for this population that is based on motivationally enhanced cognitive behavioral treatment. The MET/CBT model builds engagement by recognizing existing youth strengths and assets, and soliciting their reports of problems associated with use and reasons for quitting. Additionally, youth are empowered by knowledge and skill rehearsal activities that discuss assertiveness techniques, precursors to use, healthy replacement activities, support networks, problem solving techniques, relapse triggers, and high risk situations. Treatment goals are negotiated, progress reviewed and random urine tests are utilized.

14.3 Level II Intensive Outpatient Treatment

Level II intensive outpatient treatment is appropriate for youth who are in the high range on the alcohol, tobacco, and other drugs problem severity continuum with a level of impairment in major life domains that has the potential to distract from recovery efforts. These youth have a high enough resistance to treatment to require a structured treatment

setting, but not so high as to render outpatient treatment ineffective. These youth may or may not be in school and are generally in home environments that are not supportive of their recovery; however, with structure and support, the youth can cope with remaining in the home and community.

The recommended clinical model for effectively intervening and treating this population is usually in a school or community based program that extends the school day schedule to include a wide array of services aimed at preventing further deterioration of the level of functioning, reducing and eliminating alcohol, tobacco and other drugs use, and supporting the youth's integration of therapeutic gains into his or her daily behavior. Intensive outpatient treatment must be delivered at least three days per week for a minimum of three hours per day. An intensive outpatient treatment program must include assessment, counseling, crisis intervention, and activity therapies or education.

14.4 Level III Residential Treatment

Level III residential treatment is suitable for youth using substances with increasing frequency and at risk of withdrawal syndrome, but without a need for intensive medical monitoring. These youth are experiencing difficulty in many areas of their lives and have often demonstrated an inability to control their alcohol, tobacco, and other drug use and change negative behaviors after participation in less intensive treatment. Their home environments are either dangerous (e.g., on going threats of victimization) and necessitate removal, are not conducive to successful treatment (e.g., frequent use in the home), or there are logistical barriers to outpatient treatment (e.g., lack of access to psychiatric services).

Programs providing residential treatment for youth must comply with all applicable laws and regulations regarding licensing. Residential programs should utilize evidence-based strategies for providing the most effective adolescent substance abuse treatment. Currently, a combination approach utilizing modified therapeutic communities, Twelve Step facilitation, behavioral, family and motivational enhancement treatments have demonstrated the most effective outcomes.

Residential treatment should provide intensive motivating strategies in a structured treatment setting with staff monitoring 24 hours a day, seven days a week. A planned regimen of individual and group counseling is provided to the youth daily. In addition, it is clear that programs are most effective when there is a clear schedule for orientation, treatment, links to the community for transition and continued care phases of the recovery program. Youth do best with a full schedule of daily activities, behavioral levels plan, explicit and consistent rewards for improvement and consequences for inappropriate behaviors, frequent and random therapeutic drug testing and the development of a positive peer culture.

14.5 Level IV Detoxification

Level IV medically managed intensive inpatient treatment is an organized service in which addiction professionals and clinicians provide a planned regimen of 24-hour medically directed evaluation, care, and treatment in an acute care inpatient setting. Clients generally have severe withdrawal or medical, emotional, or behavioral problems that require primary medical and nursing services.

14.6 Evidence-based Treatment Programs

In addition to incorporating MET/CBT principals into their clinical program, ASTEP provider agencies may also adopt other evidence-based treatment practices, to be determined by the provider and approved by APRA.

15.0 Client Rights and Privileges

15.1 Client Rights and Privileges not Subject to Limitation

ASTEP providers must protect the following rights and privileges of each client, without limitation:

- To be admitted and receive services in accordance with the Human Rights Act of 1977, effective December 13, 1977 (D.C. Law 2-38; D.C. Code § 2501 et seq.);
- To receive prompt evaluation, care and treatment, in accordance with the highest quality standards;
- To be evaluated and cared for in the least restrictive environment;
- To have the treatment plan explained and to receive a copy of it;
- To have records kept confidential;
- To be treated with respect and dignity as a human being in a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal, physical, or psychological abuse;
- To be paid commensurate wages for work performed in the program that is unrelated to the patient's treatment, in compliance with applicable local or federal requirements;
- To refuse treatment and or medication;
- To provide consent for all voluntary treatment and services;
- To refuse to participate in experimentation without the informed, voluntary, written consent of the client or a person legally authorized to act on behalf of the client; the right to protection associated with such participation; and the right and opportunity to revoke such consent;
- To be informed, in advance, of charges for services;
- To have the same legal rights and responsibilities as any other citizen, unless otherwise stated by law;
- To request and receive documentation on the performance track record of a program with regard to treatment outcomes and success rates;
- To assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial manner;

- To receive written and verbal information on client rights, privileges, program rules, and grievance procedures in a language understandable to the patient; and
- To receive services that incorporate cultural competence providing, at a minimum, access to sign language/TTI for the deaf or hearing impaired and language services for the monolingual or limited English speaking consumer.

15.2 Client Rights and Privileges Subject to Limitation

The following rights and privileges may be limited on an individual basis after an administrative review with clinical justification documented in the record:

- To have access to one's own record; and
- To be free from chemical or physical restraint or seclusion.

Any limitation of a client's rights shall be re-evaluated at each treatment plan review, or as often as clinically necessary.

As soon as clinically feasible, the limitation of a client's rights shall be terminated and all rights restored.

15.3 Requirement to Notify Clients of Rights and Privileges

ASTEP providers must conspicuously post and distribute a statement of client rights, program rules and grievance procedures. The grievance procedures must inform clients that they may report any violations of their rights to APRA and shall include the telephone numbers for APRA and any other relevant agencies for the purpose of filing complaints.

At the time of admission to a facility or program, staff shall explain and document the explanation of program rules, patient rights, and grievance procedures by use of a form signed by the patient and witnessed by the staff person, to be placed in the patient's record.

15.4 Requirement to Maintain Client Confidentiality

ASTEP providers must implement policies and procedures for the release of identifying information consistent with District and federal laws and regulations regarding the confidentiality of patient records; to include but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R., Part 2).

15.5 Requirement to Develop and Implement Grievance Procedures

ASTEP providers must develop and implement written grievance procedures to ensure a prompt, impartial review of any alleged or apparent incident of violation of rights or

confidentiality. The procedures shall be consistent with the principles of due process and shall include but not be limited to:

- The completion of the investigation of any allegation or incident within thirty (30) calendar days;
- Providing a copy of the investigation report to APRA within twenty-four (24) hours of completing the investigation of any complaint; and
- Cooperating with APRA in completion of any inquiries related to clients' rights conducted by APRA staff.

16.0 Client Choice of Provider

All clients must be offered their choice of substance abuse treatment provider.

As required by the Choice in Drug Treatment Act of 2000, a client may obtain services from any participating ASTEP provider. Therefore, there will be no direct or indirect referral arrangements between substance use treatment providers and other providers of substance abuse treatment services which might interfere with a client's freedom of choice.

After determining the client's substance abuse diagnosis (and mental health diagnosis if applicable) and identifying the appropriate level of care, the client must be advised as to the available treatment providers within the ASTEP provider network that offer the appropriate level of care to treat his or her substance use disorder.

- If the client elects to undergo substance abuse treatment with the agency where he or she has presented for treatment, the provider should begin delivering treatment services pursuant to the treatment plan established by the interdisciplinary team.

- If the client selects a different provider agency within the ASTEP provider network than the agency where he or she has presented for intake and assessment, then the agency where the client presented for an assessment and referral must coordinate the client's transfer to his or her provider of choice for treatment. See Section 32: Transferring Clients to Other Substance Abuse Treatment Programs

17.0 Treatment Plan

17.1 Development of treatment plan

A treatment plan must be developed for each client based on a comprehensive assessment within 10 days of admission into treatment, unless the client is admitted into a non-hospital detoxification program where the length of stay is expected to be fewer than 10 days.

The treatment plan must be developed by an interdisciplinary team made up of an addiction counselor and one or more of the following: a Licensed Independent Clinical Social Worker (LICSW), a Licensed Professional Counselor (LPC), a licensed nurse practitioner or a registered nurse with a specialty in psychiatry or chemical dependency, a licensed psychologist, or a licensed physician.

The client must participate in the development of the treatment plan and, once complete, the client must sign and date a copy of the plan. The client's parent or guardian should also participate in the development of the treatment plan, if the client consents to such participation and family involvement is appropriate.

The treatment plan should include, but not be limited to, the following: the client's presenting problem, goals, objectives, date for reevaluation of each goal, progress toward identified goals, and the person responsible for helping the client obtain his or her goals. The treatment plan should also address the client's transition plans for reintegration into the community after discharge from treatment.

17. 2 Review of the treatment plan

A program staff member, who may be an addiction counselor, a case manager, or another qualified employee, will be assigned to coordinate the development, implementation, and required revision of the client's treatment plan. A rehabilitation team including at least one addiction counselor and the assigned case manager must meet and review the treatment plan on a regular basis with the client.

- If the client has been referred to Level III treatment for 30 days or less, the treatment plan must be reviewed at least every 15 days. The treatment plan should be reviewed more frequently if changes in the client's functioning and/or rehabilitation activities occur before the end of the 15 day period.

- If the client has been referred to Level II treatment or Level III treatment for 30 days or more, the treatment plan must be reviewed at least every 30 days. The treatment plan should be reviewed more frequently if changes in the client's functioning and/or rehabilitation activities occur before the end of the 30 day period.

- If the client has been referred to Level I treatment, the treatment plan must be reviewed at least every 90 days. The treatment plan should be reviewed more frequently if changes in the client's functioning and/or rehabilitation activities occur before the end of the 90 day period.

17.3 Review of the treatment record

The interdisciplinary team shall evaluate and document, on the client's treatment plan, his or her progress toward the treatment and rehabilitation goals, the appropriateness of the services being provided, and the need for the client's continued participation in specific program levels and services.

17.4 Annual Treatment Assessment

- The interdisciplinary team shall conduct an annual assessment of any person receiving ongoing services during the previous 12 months. The written assessment shall include:
    - A summary of the initial presenting problem and the strengths and needs at the time of admission,
    - A summary of the services delivered during the past year and the client's response and progress,
    - A description of the client's current social, family, education, vocational, and legal status; personal support systems; use of community resources; emotional and behavioral status; and substance abuse patterns, and
    - The identification of current needs and problems that may warrant continued service delivery.

- A revised treatment plan shall be developed as part of the annual assessment.

18.0 Core Service Requirements

Substance abuse treatment programs shall provide, at a minimum, the following core services on-site, either directly or through consultant/contract agreement, in such a manner as to ensure seamless care:

- Intake services designed to establish a client profile for purposes of triaging clients based on presenting status, establish a baseline against which treatment outcomes will be measured, and analyze aggregate data on individuals seeking treatment for addiction in the District of Columbia;
- An assessment to determine placement of an applicant in the appropriate level of care in a substance abuse treatment program;
- Treatment/Rehabilitation planning;
- Clinical case management;
- Individual and group addiction counseling;
- Individual and group psychotherapy as specified in the client's rehabilitation plan;
- Family therapy as specified in the rehabilitation plan;
- Group education;
- Therapeutic assistant services for residential treatment facilities or programs;
- Registered/licensed nursing services as applicable to the level of care provided;
- Medical services on a frequency and accessibility level appropriate for the level and modality of care provided;
- Drug screening and other laboratory services; and
- Discharge and aftercare planning services.

19.0 Individual Addiction Counseling Services

19.1 Individual Addiction Counseling

Individual addiction counseling may include face-to-face interaction with a client for the purpose of assessment or supporting the client's recovery.

Key service functions of individual addiction counseling include, but are not limited to:

- Exploration of an identified problem and its impact on individual functioning;
- Examination of attitudes and feelings;
- Identification and consideration of alternatives and structured problem-solving;
- Decision-making; and
- Application of information presented in the substance abuse treatment facility or program to the individual's life situations in order to promote recovery and improve functioning.

19.2 Credentials of Individuals Delivering Individual Addiction Counseling Services

Only an individual trained to provide addiction-focused therapies shall perform addiction counseling.

Individual and group addiction counseling services shall be provided by the following:

- A licensed professional counselor, licensed psychologist, licensed independent clinical social worker (LICSW), licensed psychiatric or chemical dependency nurse, or physician licensed in the District who has at least one (1) year of full-time experience in the treatment or rehabilitation of substance abuse;
- An addiction counselor with credentials consistent with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Code § 2-3301 et seq.);
- A licensed graduate social worker (LGSW) under the supervision of an LICSW; or
- A licensed psychiatrist.

20.0 Group Addiction Counseling Services

20.1 Group Addiction Counseling

Key service functions of group counseling shall include, but are not limited to:

- Facilitating individual disclosure of issues that permits generalization of the issue to the larger group;
- Promoting positive help-seeking and supportive behaviors; and
- Encouraging and modeling productive and positive interpersonal communication.

20.2 Credentials of Individuals Delivering Group Addiction Counseling Services

- Only an individual trained to provide addiction-focused therapies shall provide group-counseling services.
- Individual and group addiction counseling services shall be provided by the following:
    - A licensed professional counselor, licensed psychologist, licensed independent clinical social worker (LICSW), licensed psychiatric or chemical dependency nurse, or physician licensed in the District who has at least one (1) year of full-time experience in the treatment or rehabilitation of substance abuse;
    - An addiction counselor with credentials consistent with the District of Columbia Health Occupations Revisions Act of 1985, as amended, effected March 25, 1986 (D.C. Law 6-99; D.C. Code § 2-3301 et seq.);
    - A licensed graduate social worker (LGSW) under the supervision of an LICSW; or.
    - A licensed psychiatrist.
- The usual and customary size of group counseling sessions shall not exceed fifteen (15) persons per group facilitator in order to promote participation, disclosure and feedback.

21.0 Family Counseling Services

21.1 Family Counseling Services

Family therapy is defined as planned, goal-oriented therapeutic interaction with the client and/or one or more members of the client's family in order to address and resolve the family system's dynamics as it relates to the client's substance abuse problem in accordance with the client's rehabilitation plan.

Family therapy may be provided in the facility, program, or home setting.

An individual who has a significant relationship with the client; who may include a parent, guardian, or another individual, may be considered a family member. Family members need not live in the home with the client.

- In order for the service to qualify as family therapy, at least one (1) of the participating family members shall be age five (5) or older.

21.2 Requirements for Family Counseling Services

Key service functions of family therapy may include, but are not limited to:

- Utilization of generally accepted principles of family therapy to influence the family;
- Examination of family interaction styles and identifying patterns of behavior;
- Development of a need or motivation for change in family members;
- Development and application of skills and strategies for improvement in family functioning;
- Identification and treatment of domestic violence and child abuse and neglect; and
- Generalization and stabilization of change through insight, structure and enhanced skills to promote healthy family interaction independent of formal helping systems.

21.3 Credentials of Individuals Delivering Family Counseling Services

Family therapy shall be performed by a person licensed by the District of Columbia Department of Health, Health Professional Licensing Administration to perform marriage and family therapy.

22.0 Case Management Services

22.1 Case Management Services

The term case management refers to interventions designed to help substance abusers access needed social services. Since addiction affects so many facets of the addicted person's life, a comprehensive continuum of services promotes recovery and enables the client to fully integrate into society as a healthy, substance-free individual. The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community. Treatment must be structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse. Case management can help accomplish all of the above. Case managers should participate in the treatment planning process.

22.2 Requirement to Provide Case Management Services

Addiction counseling is not considered a case management service or activity. An individual performing both addiction counseling and case management as part of his or her normal duties must maintain records that clearly document separate time spent on each of these functions; such as work logs, encounter reports, and documentation in the clients' records.

- Case management must be provided to all clients unless specific documentation is entered in the client's record to indicate that such services are not clinically indicated.
- The case manager must document the services delivered in the client's record and legibly sign each entry.
- The case manager's supervisor must provide regular case and chart review, meet face-to-face, and co-sign chart entries at least monthly to indicate compliance with the treatment plan.

22.3 Eligible Case Management Services

Eligible case management services include, but are not limited to:

- Identification of all types of services necessary to preserve or improve functional status in the community;
- Coordination of off-site services related to mental health and medical treatment, housing, legal, transportation, education, employment, vocational rehabilitation, child care, financial assistance, and other social services;

- Monitoring the client's compliance with on and off-site appointments, and monitoring the client's level of participation in activities defined in the treatment plan as necessary to achieve specified outcomes;
- Participation by the case manager in the interdisciplinary team meetings in order to identify strengths and needs related to developing and updating the treatment plan;
- Attending periodic meetings with designated team members and the client in order to review and update monitoring activities and the treatment plan;
- Participation in the annual assessment;
- Advocate for the quality of services to which the individual is entitled;
- Monitoring service delivery by providers external to the substance abuse treatment facility or program and ensuring communication and coordination of services;
- Contacting individuals who have unexcused absences from program appointments or from other critical off-site service appointments in order to re-engage the person and promote recovery efforts;
- Locate and coordinate services and resources to resolve a client's crisis;
- Provide experiential training to clients in life skills and resource acquisition;
- Provide information and education to a client in accordance with the treatment plan;
- Plan for discharge; and
- Deliver aftercare services

22.4 Credentials of Individuals Performing Case Management

Case management services shall be provided by a person who:

- Has a bachelor's degree from an accredited college or university in social work, counseling, psychology or closely related field; or
- Has at least four (4) years of relevant, qualifying full time equivalent experience in human service delivery and demonstrated skills in developing positive and productive community relationships, and the ability to negotiate complex service systems to obtain needed services and resources for individuals.

A clinical case manager may be supervised by an individual with the following credentials:

- A Licensed Independent Clinical Social Worker (LICSW);
- A Licensed Professional Counselor;

- A registered nurse, certified in chemical dependency;
- A supervisory certified addiction counselor (CAC); or
- An individual with a Bachelor's degree from an accredited college or university in social work, counseling, psychology, or a closely related field, and at least two (2) full years of experience in providing clinical case management services.

WHAT IS CASE MANAGEMENT?

The Duties and skills of a case manager may include:

- Assist the client in submitting an application for Medicaid or other benefits (social security, unemployment, veteran's benefits, etc.).
- Coordinate the client's transfer to another ASTEP provider for substance abuse treatment.
- Coordinate transition to adult treatment in anticipation of client's 21st birthday.
- Make telephone calls or send emails to coordinate the client's appointments for physical, mental health, educational, vocational, or other appointments.
- Research and make connections to programs that meet the client's treatment needs; such as vocational rehabilitation services, transitional housing programs, child care, etc.
- Arrange the client's transportation to appointments; such as doctor's visits, visits with his or her social worker, job interviews, or tutoring sessions.
- Attend appointments with the client to ensure linkages to other services.
- Contact the client's social worker, case worker, attorney, or probation official to provide treatment updates (with the client's consent).
- Write reports or letters of recommendation on the client's behalf (with the client's consent).
- Testify on the client's behalf in a court case.
- Develop a discharge plan; including coordinating aftercare services to promote sobriety for your client.
- Provide HIV/AIDS and other infectious disease education, promote HIV/AIDS and other infectious disease testing, and refer the client for screening/testing if your agency is unable to provide this service.

23.0 Group Education Services

23.1 Group Education Services

- The usual and customary size of group educational sessions shall not exceed thirty-five (35) persons in order to promote participation.

- A substance abuse treatment facility or program shall develop a schedule and curriculum for delivery of group education services addressing topics and material relevant to the clients.
- A substance abuse treatment facility or program shall provide basic information to clients regarding:
    - The progressive nature of dependency and the disease model, to include 12 step programs, principles and availability of self-help groups, and health and nutrition;
    - Support for the personal recovery process, including overcoming denial, recognizing feelings and behavior, promoting self-awareness and self-esteem, encouraging personal responsibility and constructively using leisure time;
    - Skill development, such as communication skills, stress reduction and management, conflict resolution, decision-making, assertiveness training, and parenting;
    - The promotion of positive family relationships and relationships with significant others;
    - Relapse prevention;
    - The effects of alcohol and other drug abuse upon pregnancy and child development;
    - HIV/AIDS, including related conditions, risk factors, preventive measures and the availability of diagnostic testing;
    - Substance abuse and mental health conditions; and
    - Parenting and child development, as appropriate.

23.2 Requirements for Group Education Services

- Key service functions of group education may include but are not limited to:
    - Classroom style didactic lectures to present information about a topic and its relationship to substance abuse;

- Presentation of audiovisual materials that are educational in nature with required follow-up discussion;
- Promotion of discussion and questions about the topic presented to those in attendance; and
- Generalization of the information and demonstration of its relevance to recovery and enhanced individual functioning.

23.3 Requirements for Individuals Delivering Group Education Services

- Group education services shall be provided by an individual who:
  - Demonstrates competency and skill in educational techniques;
  - Has knowledge of chemical dependency and its relationship to the topic(s) being taught; and
  - Is present throughout the group education session.

24.0 Therapeutic Assistant Services

24.1 Therapeutic Assistant Services

Therapeutic assistant services, provided in a residential setting, shall include the following activities:

- Training in activities of daily living;
- Instruction and supervision of therapeutic recreation activities; and
- Protective supervision during evening, overnight, and weekend hours for clients who need the protection and structure of staff twenty-four (24) hours a day.

24.2 Credentials of Individuals Qualified to Deliver Therapeutic Assistant Services

A therapeutic assistant is required to have a high school degree or GED, and at least twenty (20) hours of in-service training per year regarding rehabilitation issues for substance abuse.

24.3 Credentials of Individuals Qualified to Supervise Therapeutic Assistant Services

A therapeutic assistant shall at a minimum be supervised by a Level II Certified Addictions Counselor.

25.0 Nursing Services

Only licensed registered and/or practical nurses shall provide nursing services that include, but are not limited to:

- Health assessments of clients and children, as appropriate;
- Health screenings and referrals for examination by a physician;
- Health education for participants and staff;
- Collection of health data;
- Appropriate treatment intervention;
- Administration of medication;
- Observation of medication use by individuals and proper documentation;
- Health care counseling, especially in the areas of high-risk sexual behavior and the possibility of HIV positives; and
- Infection control.

26.0 Submitting Claims for Reimbursement to APRA

Providers must submit claims for reimbursement to the Contracting Officer's Technical Representative (COTR) assigned by APRA. A proper invoice package for payment must include:

- Summary Invoice – An invoice must contain the name of the provider, remittance address, invoice number, billing period, invoice date, contract or purchase order number, description of service(s) provided, the amount due, and signature and date for the authorized vendor, contract administrator, and program official (DOH). The provider must submit a photocopy of the summary invoice to their assigned COTR.
- Health Insurance Claim Form 1500 (HCFA 1500) – The HCFA 1500 must be completed with all client and provider information, to include the date that services were rendered, the number of units provided to the client, and the billing code. The provider must submit a photocopy of the HCFA 1500 to their assigned COTR.
- Voucher and/or Request for Reauthorization of Substance Abuse Services forms – These documents must be included for all clients. The provider must attach a photocopy of the original voucher and/or any approved requests for authorization or reauthorization of substance abuse services to the matching HCFA 1500. The provider must submit a photocopy of the voucher and/or request for reauthorization of substance abuse services to their assigned COTR.
- Excel Spreadsheet – The spreadsheet is a reconciliation of all clients for the billing period. The spreadsheet lists the voucher number, client ID number, billing code, number of units used, and the total dollar amount invoiced for services. This spread sheet must reconcile to all HCFA 1500s submitted for payment for the billing period. The spreadsheet must follow the order of the HCFA 1500 forms. The Excel spreadsheet must be submitted to APRA electronically at the time the provider invoices APRA. APRA will not pay the invoice until it receives a copy of the electronic spreadsheet.

Please refer to your program's assigned COTR for additional information regarding submitting claims to APRA for reimbursement.

27.0 Submitting Claims for Reimbursement to D. C. Medicaid

Medicaid reimbursed claims are processed by ACS for the Department of Health Care Finance. Please refer to the D.C. Medicaid Clinic Billing Manual available at www.dc-medicaid.com, on the left side menu, for additional information regarding submitting claims to ACS for Medicaid reimbursement.

The following ACS administered hotlines are available to DC Medicaid enrolled providers:

Provider Inquiry **PO Box 34734** **Washington, DC 20043-4734**	(202) 906-8319 (inside DC metro area) (866) 752-9233 (outside DC metro area) (202) 906-8399 (Fax)	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Provider Enrollment **PO Box 34761** **Washington, DC 20043-4761**	(202) 906-8318 (inside DC metro area) (866) 752-9231 (outside DC metro area) (202) 906-8399 (Fax) **www.dc-medicaid.com**	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
ACS EDI Gateway Services	(866) 407-2005 **http://www.acs-gcro.com**	Hours of Operation Monday - Friday 8:00 am - 5:00 pm

28.0 Submitting Claims for Reimbursement to Private Insurers

For clients with private insurance, please follow the insurer's claims billing protocols.

ASTEP providers may not submit claims to APRA for reimbursement of services billable to private insurance, Medicaid, or other third party payers.

If an investigation by APRA shows that a provider intentionally billed or accepted payment for services billable to private insurance, Medicaid, or a third-party payer, APRA will initiate administrative remedies pursuant to the provider's HCPA and Chapter 23 regulations. See Section 3: APRA Regulations for Participating Providers.

29.0 Billing Limitations for Covered Services

29.1 Substance Use Disorder Assessment

29.1.1 Global Appraisal of Individual Needs-Initial (GAIN-I)

The GAIN-I is the required diagnostic tool to assess for the presence of substance use disorder and determine the level of care appropriate for treatment for adolescents in the District of Columbia. The GAIN-I shall be used as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement, and other clinical decisions. An adolescent client is entitled to two (2) comprehensive diagnostic assessments per twelve (12) month period.

29.1.2 Global Appraisal of Individual Needs (GAIN-Quick/M-90)

The GAIN–Q is the required diagnostic tool to determine the level of care appropriate for treatment for adolescent clients who have lapsed from treatment for two (2) to six (6) months. The GAIN-Q shall be used as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement, and other clinical decisions.

The GAIN-M90 is the required diagnostic tool to assess treatment needs on an ongoing basis for adolescent clients who have been engaged in treatment for at least 90 days. The GAIN-M90 shall be used as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement, and other clinical decisions.

An adolescent is entitled to a combined total of no more than six (6) GAIN-Q and GAIN-M90 assessments per twelve (12) month period.

29. 2 Level I Outpatient Treatment

An adolescent who is undergoing Level I Outpatient Treatment may receive:

- A maximum of eight (8) 15 minute units of any combination of individual, group, or family counseling with the client present per day.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.

29.3 Level II Intensive Outpatient Treatment

Intensive outpatient treatment must be delivered at least three (3) days per week for a minimum of three (3) hours per day, not to exceed six (6) hours per day. An Intensive Outpatient Treatment program must include assessment, counseling, crisis intervention, and activity therapies or education.

An adolescent client who is undergoing Level II Intensive Outpatient Treatment may receive:

- A maximum of 90 units of Level II Intensive Outpatient Treatment to be administered within 120 calendar days. Re-authorization is required after the expiration of 90 units of treatment or 120 calendar days.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.
- A provider may bill for family counseling without the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- A provider may not bill for any units of service for family counseling with the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- **Intensive Outpatient Treatment must be reauthorized after expiration of the first 90 units of treatment or 120 calendar days.**

Intensive Outpatient Treatment must be reauthorized after the first 90 units of treatment or 120 calendar days. See Section 35.0: Submitting Requests for Re-authorization of Level II Intensive Outpatient Substance Abuse Treatment

29.4 Case Management

An adolescent client undergoing Level I, Level II, or Level III substance abuse treatment may receive case management services to directly support the implementation of his or her treatment plan. The client may receive:

- A maximum of sixteen (16) 15 minute units of case management services per week.

29.5 Family Counseling

An adolescent client who is undergoing Level I Outpatient Treatment may receive:

- A maximum of eight (8) 15 minute units of any combination of individual, group, or family counseling with the client present per day.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.

An adolescent who is undergoing Level II Intensive Outpatient Treatment may receive:

- A maximum of six (6) 15 minute units of family counseling without the client present per week.
  - A provider may bill for family counseling without the client present on the same day that the provider bills for Level II Intensive Outpatient treatment.
  - A provider may not bill for any units of service for family counseling with the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.

30.0 Submitting Claims for Reimbursement to D. C. Medicaid for Medicaid Recipients

Providers must submit claims for Medicaid-eligible services delivered to Medicaid recipients to ACS. See Section 27: Submitting Claims for Reimbursement to D.C. Medicaid

30.1 Level I Outpatient Treatment

An adolescent client who is undergoing Level I Outpatient Treatment may receive:

- A maximum of eight (8) 15 minute units of any combination of individual, group, or family counseling with the client present per day.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.

30.2 Level II Intensive Outpatient Treatment

Intensive outpatient treatment must be delivered at least three (3) days per week for a minimum of three (3) hours per day, not to exceed six (6) hours per day. An Intensive Outpatient Treatment program must include assessment, counseling, crisis intervention, and activity therapies or education.

An adolescent client who is undergoing Level II Intensive Outpatient Treatment may receive:

- A maximum of 90 units of Level II Intensive Outpatient Treatment to be administered within 120 calendar days. Re-authorization is required after the expiration of 90 units of treatment or 120 calendar days.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.
- A provider may bill for family counseling without the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- A provider may not bill for any units of service for family counseling with the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- **Intensive Outpatient Treatment must be reauthorized after expiration of the first 90 units of treatment or 120 calendar days.**

30.3 Level III Residential Treatment

Level III Residential Treatment is not a Medicaid reimbursable service. APRA will reimburse providers for medically necessary Level III Residential Treatment for adolescent clients eligible to participate in ASTEP. A provider seeking to place or transfer a client to Level III Residential Treatment must submit a request for authorization to APRA. See Section 34: Submitting Requests for Authorization of Level III Residential Substance Abuse Treatment Services.

Figure 30: Who Gets the Bill When the Client is Medicaid Eligible?

Hi Carol! I just checked the IVR line and my client is Medicaid eligible. Who should I send the bill to?

Great question, Phyllis! Does the client need Outpatient or Intensive Outpatient treatment? If it's Level I or Level II treatment, send the bill to Medicaid. If the client needs Residential treatment, contact APRA to get prior approval for Level III treatment. Then send the bill to APRA.

What about case management? Who pays for that? This client needs transportation to meetings with his social worker and I would like to refer him to a recovery support program for life skills counseling and a recovery mentor. I think the additional one-on-one support will really help him.

It sounds like the interdisciplinary team has created a really great treatment plan, Carol! Send the bill for case management to APRA. And if you have any questions about submitting bills to APRA, just call our agency's assigned APRA contracting representative.

31.0 Submitting Claims for Reimbursement to APRA for non-Medicaid Eligible Clients

Providers must submit claims for substance abuse treatment services provided to clients who are not Medicaid eligible but who meet all other requirements for ASTEP participation to APRA. See Section 26: Submitting Claims for Reimbursement to APRA.

31.1 Level I Outpatient Treatment

An adolescent client who is undergoing Level I Outpatient Treatment may receive:

- A maximum of eight (8) 15 minute units of any combination of individual, group, or family counseling with the client present per day.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.

31.2 Level II Intensive Outpatient Treatment

Intensive outpatient treatment must be delivered at least three (3) days per week for a minimum of three (3) hours per day, not to exceed six (6) hours per day. An Intensive Outpatient Treatment program must include assessment, counseling, crisis intervention, and activity therapies or education.

An adolescent client who is undergoing Level II Intensive Outpatient Treatment may receive:

- A maximum of 90 units of Level II Intensive Outpatient Treatment to be administered within 120 calendar days. Re-authorization is required after the expiration of 90 units of treatment or 120 calendar days.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.
- A provider may bill for family counseling without the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- A provider may not bill for any units of service for family counseling with the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- **Intensive Outpatient Treatment must be reauthorized after expiration of the first 90 units of treatment or 120 calendar days.**

31.3 Level III Residential Treatment

Level III Residential Treatment is not a Medicaid reimbursable service. APRA will reimburse providers for medically necessary Level III Residential Treatment for adolescent clients eligible to participate in ASTEP. A provider seeking to place or transfer a client to Level III Residential Treatment must submit a request for authorization to APRA. See Section 34: Submitting Requests for Authorization of Level III Residential Substance Abuse Treatment Services.

Figure 31: Who Gets the Bill When the Client is Not Medicaid Eligible?

Hi Anna! I just finished meeting with a client who really needs treatment, but her mother has a letter from the IMA that says she isn't eligible for Medicaid coverage. She doesn't have health insurance and her mother says she can't afford to pay for treatment out of pocket. How can I help this family get the treatment she needs?

I completely understand, Carlos. Nearly all of the children who participate in ASTEP are Medicaid eligible, so encountering a family who isn't does not happen often. Check Section 4 of the ASTEP Manual to make sure she is eligible to participate in ASTEP. If she is, send the bill to APRA.

I can bill APRA for any level of care?

Absolutely! You can begin providing Outpatient or Intensive Outpatient treatment right away. If the client needs to be referred for Residential treatment, contact APRA for prior approval first. And don't forget, APRA will also reimburse for case management services.

Thanks Anna! This was really helpful. The next time I encounter an ASTEP client who isn't Medicaid eligible, I'll know to send the bill directly to APRA.

32.0 Submitting Claims for Reimbursement for Clients with Pending Medicaid Applications

Medicaid will cover the cost of services for Medicaid eligible substance abuse services for up to 90 days prior to the date of submission of the IMA application, once the individual is approved as a beneficiary. Providers must submit claims for Medicaid-eligible substance abuse services delivered to Medicaid recipients to ACS. See Section 27: Submitting Claims for Reimbursement to D.C. Medicaid.

APRA will reimburse participating ASTEP providers for clinically appropriate substance abuse treatment services provided to eligible ASTEP participants who are not eligible for Medicaid benefits. Providers must submit claims for substance abuse treatment services delivered to clients who are not Medicaid eligible but who meet all other requirements for ASTEP participation to APRA. See Section 26: Submitting Claims for Reimbursement to APRA.

For clients whose applications for Medicaid benefits are pending and who meet the criteria for ASTEP participation, providers may submit claims for Level III Residential Treatment and case management to APRA. See Section 26: Submitting Claims for Reimbursement to APRA.

APRA will not reimburse the provider for services delivered to a client:

- **who is not a District resident;**
- **whose private insurance reimburses for adolescent substance abuse treatment; or**
- **whose substance abuse services are not clinically or medically necessary.**

32.1 Level I Outpatient Treatment

An adolescent client who is undergoing Level I Outpatient Treatment may receive:

- A maximum of eight (8) 15 minute units of any combination of individual, group, or family counseling with the client present per day.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.

32.2 Level II Intensive Outpatient Treatment

Intensive outpatient treatment must be delivered at least three (3) days per week for a minimum of three (3) hours per day, not to exceed six (6) hours per day. An Intensive Outpatient Treatment program must include assessment, counseling, crisis intervention, and activity therapies or education.

An adolescent who is undergoing Level II Intensive Outpatient Treatment may receive:

- A maximum of 90 units of Level II Intensive Outpatient Treatment to be administered within 120 calendar days. Re-authorization is required after the expiration of 90 units of treatment or 120 calendar days.
- A maximum of six (6) 15 minute units of family counseling without the client present per week.
- A provider may bill for family counseling without the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- A provider may not bill for any units of service for family counseling with the client present on the same day that the provider bills for Level II Intensive Outpatient Treatment.
- **Intensive Outpatient Treatment must be reauthorized after expiration of the first 90 units of treatment or 120 calendar days.**

32.3 Level III Residential Treatment

Level III Residential Treatment is not a Medicaid reimbursable service. APRA will reimburse providers for medically necessary Level III Residential Treatment. A provider seeking to place or transfer a client to Level III Residential Treatment must submit a request for authorization to APRA. See Section 34: Submitting Requests for Authorization of Level III Residential Substance Abuse Treatment Services.

Figure 32: Who Gets the Bill When the Client's Medicaid Application is Pending?

Hi James, I have a billing question. When my client first entered treatment, I helped his grandmother submit a Medicaid application to the IMA. She's his primary guardian. I've been providing individual, group, and family counseling and case management services for almost a month and they haven't heard anything from the IMA. Who do I send the bill for treatment?

That's not unusual, Mary. It usually takes more than a month for the application to process. In the meantime, continue to provide treatment. Medicaid will cover the cost of services for Medicaid eligible substance abuse services for up to 90 days prior to the date of submission of the IMA application, once the individual is approved as a beneficiary. Just remember to call the IVR line on a regular basis to check the client's Medicaid eligibility. You can send the bill for case management services to APRA.

What do I do if another month passes and the IVR line still doesn't confirm Medicaid eligibility? Who gets the bill then?

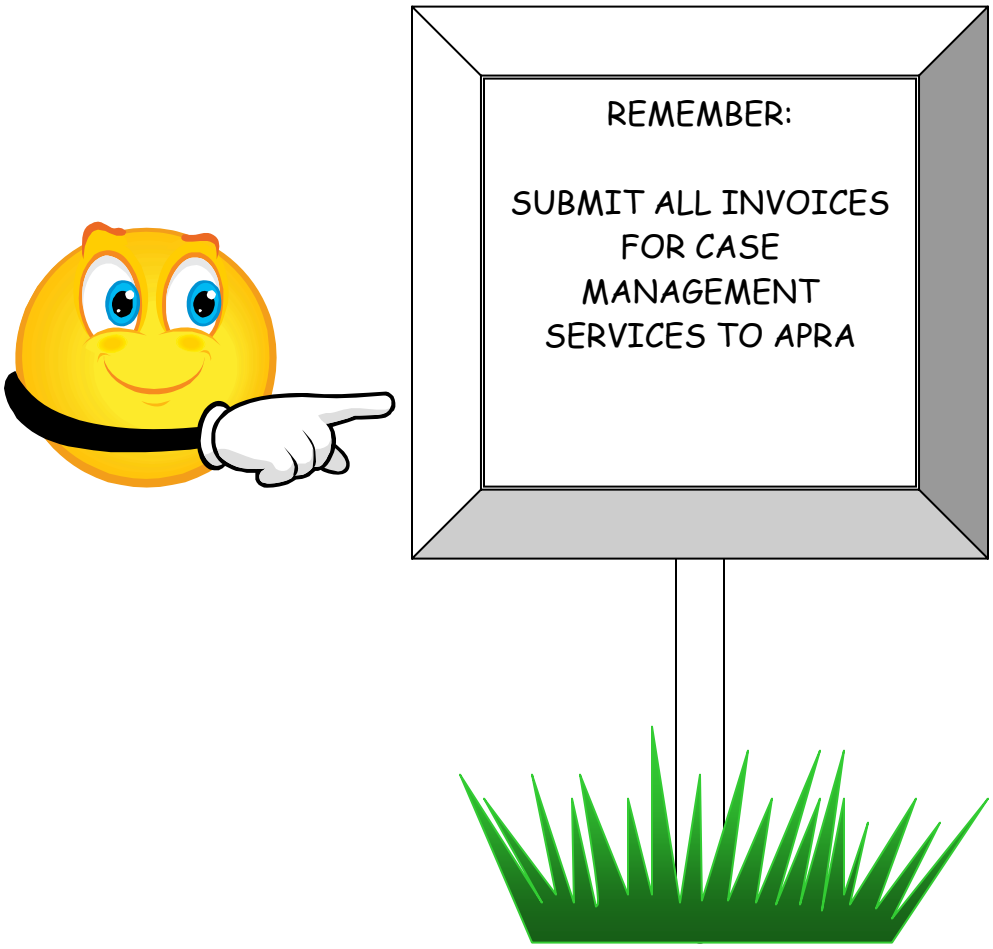
I completely understand your concern, Mary. Nearly all of the clients who participate in ASTEP are Medicaid eligible, so encountering a family who isn't does not happen often. Check Section 4 of the ASTEP Manual to make sure the client is eligible to participate in ASTEP, and if he is, submit the bill and a copy of the IMA Medicaid benefits rejection letter to APRA. APRA will reimburse for substance abuse treatment services provided to District residents who are not Medicaid eligible who meet all other requirements for ASTEP participation.

33.0 Submitting Claims for Reimbursement to APRA for Case Management Services

APRA will reimburse providers for eligible case management services designed to directly support the implementation of a client's treatment plan. See Section 26: Submitting Claims for Reimbursement to APRA.

The client may receive:

- A maximum of sixteen (16) 15 minute units of case management services per week.



34.0 Submitting Requests for Authorization of Level III Non-Hospital Residential Substance Abuse Treatment Services

34.1 General Provisions

To ensure that all services are clinically appropriate and reflect best practices, all requests for Level III non-hospital residential substance abuse treatment services must be approved or denied by APRA.

- Any request for a client who requires initial placement in Level III non-hospital residential substance abuse treatment must be requested within 24 hours of the completion of an assessment.

- Any request for a client who requires transfer from another level of care to Level III non-hospital residential substance abuse treatment must be requested at least fifteen (15) business days prior to the expiration of the current authorization or to the scheduled date of transfer.

- Any request for residential substance abuse treatment services that requires authorization and has not been submitted within the required period is subject to disapproval and may result in non-payment.

- Any request made on the expiration date will be denied, and any services provided past that date will not be reimbursed.

34.2 Submitting Requests for Level III Residential Non-Hospital Substance Abuse Treatment Services

1. Any decision to place a client in or transfer a client to Level III Non-Hospital Residential Treatment must be made by the interdisciplinary team. The client must participate in the development or modification of his or her treatment plan. The client's parent or guardian may also participate in the development of the treatment plan, if the client consents to such participation and family involvement is appropriate. The client's consent to placement or transfer must be reflected in the client's treatment plan and the client must sign a document reflecting consent.

2. The provider must obtain the client's consent to consent to transfer his records to another program and a signed Authorization to Disclose Confidential Information (or an equivalent form furnished by the provider) must be retained in the client's records.

3. Any provider requesting authorization for Level III Non-Hospital Residential Treatment services must submit a Request for Authorization, Re-authorization, Step-up,

Step-down for Youth with additional supportive documentation; to include but not limited to, updated treatment plan, a photocopy of the voucher for services (if applicable), case notes, psychiatric evaluations, toxicology screens, most recent GAIN assessment, etc. to:

Attention: Reauthorization Committee
Addiction Prevention and Recovery Administration
1300 First Street NE
Washington, DC 20002
Contact: Reauthorization Committee Coordinator
Phone: (202) 727-8945
Fax: (202) 535-2318
Hours of Operation: 8:30am – 4:30pm

3. Requests received Monday thru Friday will receive a response from APRA within two (2) business days.

4. If necessary, APRA may contact the provider to request additional clinical information. If the additional documentation is not received within two (2) business days of the request, the Request for Authorization, Re-authorization, Step-up, Step-down for Youth is subject to denial.

5. Once the requested documentation is received and reviewed by the Reauthorization Committee the provider will be contacted with a disposition of the Request for Authorization, Re-authorization, Step-up, Step-down for Youth within two (2) business days.

6. Only individuals with the following credentials are authorized to sign the request form:

Physician
Licensed Psychologist
Registered Nurse
Licensed Independent Clinical Social Worker (LICSW)
Licensed Professional Counselor (LPC)

Any request containing the signature of a person who does not possess a credential listed above will not be processed.

7. To appeal the decision of the Reauthorization Committee a copy of the original request and supporting documentation challenging the denial should be sent to the Appeals Officer within two (2) business days of the denial. A decision will be rendered and forwarded to the Provider within two (2) business days. Please forward all Appeal requests to:

Addiction Prevention and Recovery Administration
Attention: Appeals Officer
1300 First Street, NE 2nd Floor
Washington, DC 20002
Fax: (202) 535-2318

Figure 34: Submitting Requests for Residential Treatment to APRA

Client assessed

Within 24 hours of the assessment, interdisciplinary team recommends Level III treatment. Client agrees to proposed treatment plan. ASTEP program sends Request for authorization of Level III treatment to APRA.

APRA will approve or deny request for authorization within 2 business days. With APRA approval, client may begin treatment.

ASTEP program should provide Level III Residential treatment or provide case management services to connect client to Residential Treatment at another ASTEP program.

The ASTEP program providing treatment services should connect client and family to services that support the client's treatment plan.

After 15 days of treatment, the ASTEP program providing treatment should send APRA a Request for Reauthorization of Level III treatment if continued residential treatment is appropriate.

After 30 days of residential treatment, the ASTEP program providing treatment should send APRA a request to step the client down from Level III treatment. Provide case management services to coordinate a seamless transition to a lower level of care. Connect the client and his or her family to recovery support services.

35.0 Submitting Requests for Reauthorization of Level II Intensive Outpatient Treatment

To ensure that all services are clinically appropriate and reflect best practices, all requests for reauthorization of Level II Intensive Outpatient treatment must be approved or denied by APRA.

35.1 General Provisions

- Please review your agency's HCPA to determine the exceptions and limitations for ASTEP services. Services provided in excess of the stated limitations or maximum allowable units of service without authorization will not be reimbursed. Services provided in the absence of a valid voucher will not be reimbursed.

- Any request for reauthorization of services that has not been submitted within the required period is subject to disapproval and may result in non-payment.

- Any requests made on the expiration date of the current voucher will be denied, and any services provided past that date will not be reimbursed.

35.2 Submitting Requests to Reauthorize Level II Intensive Outpatient Treatment

A client undergoing Level II Intensive Outpatient treatment may receive a maximum of 90 units of Level II Intensive Outpatient Treatment within 120 calendar days. After the expiration of 90 units of service or 120 calendar days, a provider must request re-authorization to provide Level II Intensive Outpatient Treatment. All requests to deliver Level II Intensive Outpatient substance abuse treatment services beyond the first 90 units of treatment must be approved or denied by APRA's Reauthorization Committee.

- Any request for an extension of Intensive Outpatient Treatment must be submitted at least ten (10) business days prior to the expiration of the first 90 units of service to avoid interruptions in treatment.

1. Any decision to extend Level II Intensive Outpatient Treatment must be made by the interdisciplinary team. The client must participate in the modification to his or her treatment plan. The client's parent or guardian may also participate in the development of the treatment plan, if the client consents to such participation and family involvement is appropriate. The client's consent must be reflected in his or her treatment plan and the client must sign a document reflecting consent.

2. Any provider requesting extension of Level II Intensive Outpatient Treatment services must submit a Request for Authorization, Re-authorization, Step-up, Step-down for Youth with additional supportive documentation; to include but not limited to, updated treatment plan, a photocopy of the voucher for services (if applicable), case

notes, psychiatric evaluations, toxicology screens, the most recent GAIN assessment, etc. to:

Attention: Reauthorization Committee
Addiction Prevention and Recovery Administration
1300 First Street NE
Washington, DC 20002
Contact: Reauthorization Committee Coordinator
Phone: (202) 727-8945
Fax: (202) 535-2318
Hours of Operation: 8:30am – 4:30pm

3. Requests received Monday thru Friday will receive a response within two (2) business days.

4. If necessary, APRA may contact the provider to request additional clinical information. If the additional documentation is not received within two (2) business days of the request, the Request for Authorization, Re-authorization, Step-up, Step-down for Youth is subject to denial.

5. Once the requested documentation is received and reviewed by APRA, the provider will be contacted with a disposition of the Request for Authorization, Re-authorization, Step-up, Step-down for Youth within two (2) business days.

6. Only individuals with the following credentials are authorized to sign the request form:

Physician
Licensed Psychologist
Registered Nurse
Licensed Independent Clinical Social Worker (LICSW)
Licensed Professional Counselor (LPC)

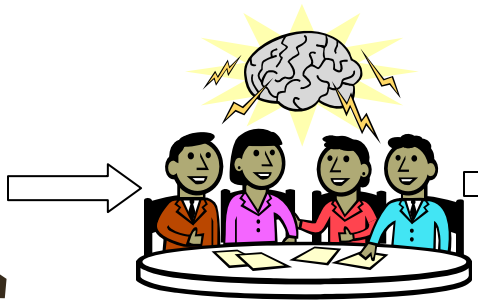
Any request containing the signature of a person who does not possess a credential listed above will not be processed.

7. To appeal the decision, a copy of the original request and supporting documentation challenging the denial should be sent to the Appeals Officer within two (2) business days of the denial. A decision will be rendered and forwarded to the Provider within two (2) business days. Please forward all appeal requests to:

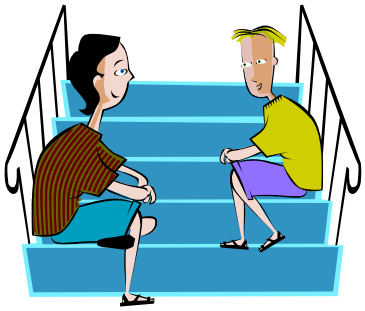
Addiction Prevention and Recovery Administration
Attention: Appeals Officer
1300 First Street, NE 2nd Floor
Washington, DC 20002
Fax: (202) 535-2318

Figure 35: Submitting Requests for Reauthorization of Intensive Outpatient Treatment

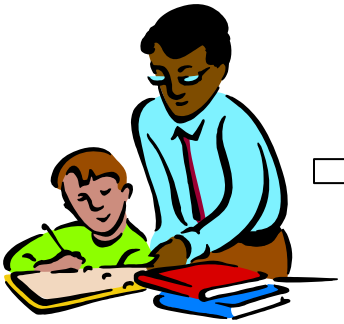
Client assessed



Within 24 hours of the assessment, interdisciplinary team recommends Level II treatment. Client agrees to proposed treatment plan.



The ASTEP program providing treatment may provide Intensive Outpatient treatment services.



The ASTEP program providing treatment should provide case management services to connect client and family to services that support the client's treatment plan.

After 110 calendar days (or 10 days before providing the 90th unit of IOP service), the ASTEP program providing treatment should send APRA a Request for Reauthorization for Intensive Outpatient treatment.

APRA will approve or deny the request within 2 business days.

If APRA approves the Request, the ASTEP program providing treatment should continue to provide Level II treatment services. If the Request is denied, coordinate the client's transition to Level I treatment services. Provide case management to coordinate the client's transition into Outpatient treatment.

36.0 Step-Up, Step Down, or Transfer to Other Substance Abuse Treatment Programs

36.1 General Provisions

- Please review your agency's HCPA to determine the exceptions and limitations for ASTEP services. Services provided in excess of the stated limitations or maximum allowable units of service without authorization will not be reimbursed. Services provided in the absence of a valid voucher will not be reimbursed.

- Any request for step-up, step-down, or transfer that has not been submitted within the required period is subject to disapproval and may result in non-payment.

- Any requests made on the expiration date of the current voucher will be denied, and any services provided past that date will not be reimbursed.

36.2 Request to Step-Up, Step-Down, or Transfer to another program

A client may require a change in the level of care in order to receive the maximum benefit from treatment. A change in the level of care may include either an increase to more intensive treatment services or a step-down to a less intense level of care.

In addition, a client may require transfer to another program for a variety of reasons; including proximity to work, school, or home, dissatisfaction with service, or other reasons. If the client requests a transfer to another treatment program, staff at the program where the client is currently receiving treatment must coordinate the transfer and transition into another program in the ASTEP network in such a manner as to avoid interruption of treatment.

The following service limitations are applicable to transfers from one ASTEP provider to another and changes in the level of care.

- Clients may be referred to Level I Outpatient Treatment without prior authorization.

- Clients may receive 90 units of Level II Intensive Outpatient Treatment without prior authorization; however, if the client is currently receiving Level II Outpatient Treatment and requires extension of Intensive Outpatient Treatment beyond the first 90 units of treatment or the first 120 calendar days of treatment, the provider must request a transfer to another Level II Intensive Outpatient treatment program in the ASTEP network and reauthorization of Level II Intensive Outpatient treatment from APRA's Reauthorization Committee.

- Clients may be referred to Level III Residential Treatment after receiving prior authorization from APRA.

36.3 Procedures for submitting a Request for Step-Up, Step-Down, or Transfer

1. Any decision to transfer a client to another substance abuse treatment program must be made by the interdisciplinary team. The client must participate in the modification to his or her treatment plan. The client's parent or guardian may also participate in the development of the treatment plan, if the client consents to such participation and family involvement is appropriate. The client's consent to transfer to another program must be reflected in the client's treatment plan and the client must sign a document reflecting consent.

2. The provider must obtain the client's consent to consent to transfer his records to another program and a signed Authorization to Disclose Confidential Information (or an equivalent form furnished by the provider) must be retained in the client's records.

3. The client's case manager must contact the program director of the provider agency where the client is to be transferred. See Appendix: Adolescent Substance Abuse Treatment Providers

4. A provider referring a client to another Level I Outpatient treatment program or Level II Intensive Outpatient treatment program within the first 90 units of treatment or the first 120 calendar days of treatment must submit one copy of the Request for Authorization, Re-authorization, Step-up, Step-down for Youth with additional supportive documentation; to include but not limited to: updated treatment plan, a photocopy of the voucher for services (if applicable), case notes, psychiatric evaluations, toxicology screens, etc. to the APRA Reauthorization Committee and one copy to the program where the client has requested a transfer.

Please review Section 31: Submitting Requests for Reauthorization of Level II Intensive Outpatient Treatment for procedures related to step-up or transfer to Level II treatment beyond the first 90 units or 120 days of Level II treatment.

Please review Section 30: Submitting Requests for Authorization of Level III Non-Hospital Residential Substance Abuse Treatment Services for procedures related to step-up or transfer to Level III treatment.

5. Requests for transfers to another provider agency must be made in a timely manner in order to avoid interruptions in service delivery.

Figure 36: Checklist for Submitting Requests for Authorization, Reauthorization, Step-Up, Step Down

The Request Form:

Did I fill out every section of the Request form?

Section A

- Did I include the date the client first began receiving services from my program?
- Did I include the client's expected date of discharge from my program?

Section C

- Did I write out the client's initial diagnosis **and** current diagnosis?
- Did I write out a diagnosis for each DSM-IV Axis?
- Did I write out the client's GAF score?

Section D

- Did I state the level of care the client is currently receiving from my program?
- Did I state the level of care I am requesting for the client?

Section K

- If a transfer is clinically indicated, have I stated the name of the program that will be providing the next phase of treatment?

Can the person(s) reviewing this Request read my handwriting?

Did a qualified clinician sign the form?

Am I submitting this form on time?

Required Documents

Did I attach a copy of the client's initial GAIN assessment report?

Did I attach a copy of the client's initial treatment plan?

Did I attach a copy of the client's proposed treatment plan?

Helpful Advice

Does Section I (Clinical History) describe the type of treatment the client received and the client's response to treatment?

Does Section K (Clinical Justification) explain why the services being requested are clinically necessary?

Does Section L (New Treatment Plan) explain how the suggested changes to the client's treatment plan will address the client's current substance abuse and related problems?

Could the person(s) reviewing this Request make a decision in my favor based solely on what I have written on the Request form?

37.0 Referring Client to Mental Health Treatment Programs

Providers may have the capacity to serve clients with a dual diagnosis of substance use disorder and mental health disorder if it is determined that the facility can adequately address the mental health needs of the client within the context of substance use treatment. If it is determined that the client requires mental health services that the provider does not have the capacity to provide, a referral must be made to an appropriate mental health provider.

37.1 Requirement to Assess for Co-Occurring Mental Health Disorders

APRA requires that all clients undergo screening and assessment for mental health disorders. The GAIN-I assessment tool has the capacity to identify the presence of mental health disorders.

In the event that the GAIN assessment tool, combined with clinical judgment, indicates the presence of a mental health disorder, a licensed psychiatric social worker, licensed psychiatric nurse, or licensed psychologist or psychiatrist should be made available to complete and interpret the assessment.

If a qualified mental health professional is not available to complete the assessment, providers must refer the client to a qualified mental health professional; to include a licensed psychiatric social worker, licensed psychiatric nurse, or licensed psychologist or psychiatrist) to complete the mental health assessment.

37.2 Referring Clients Enrolled in Medicaid MCOs to Mental Health Services

If a client is enrolled in a Medicaid MCO, the provider must contact the client's MCO case manager to coordinate mental health treatment. The Medicaid MCOs are responsible for the following services:

MCOs are responsible for covering and furnishing the following mental health treatment services:

- Diagnostic and Assessment Services
- Medication/Somatic Treatment
- Individual counseling
- Family counseling
- Crisis services including mobile crisis/emergency services provided by DMH, or Core Services Agencies certified by DMH to provide this service.
- Day Services
- Intensive Day Treatment
- Inpatient psychiatric facility services for individuals under age twenty-one (21).

- All mental health services for Enrollees that are included in an IEP or IFSP during holidays, school vacations, or sick days from school.
- Patient Psychiatric Residential Treatment Facility services (PRTF) for individuals less than age 22 years;
- Inpatient Hospitalization and Emergency Department services

37.3 Referring Clients not Enrolled in a Medicaid MCO to Mental Health Services

If a client is not enrolled in a Medicaid MCO, the provider must contact the Department of Mental Health (DMH) Access HelpLine at 1 (888) 7WE-HELP or 1-888-793-4357. This 24-hour, seven-day-a-week telephone line is staffed by mental health professionals who can refer a caller to immediate help or ongoing care.

38.0 Referring Client to Level IV Detoxification

38.1 Referring Clients Enrolled in a Medicaid MCO to Detoxification Services

If a client is enrolled in a Medicaid MCO, the provider must contact the client's MCO case manager to coordinate Level IV Detoxification services.

38.2 Referring Clients not Enrolled in a Medicaid MCO to Detoxification Services

If a client is not enrolled in a Medicaid MCO, any request for referral or transfer to Level IV Detoxification services must be approved or denied by APRA.

- Any request for a client who requires initial placement in Level IV Detoxification must be requested within 24 hours of the completion of an assessment.

- Any request for a client who requires transfer from another level of care to Level IV Detoxification services must be requested at 24 hours prior to the expiration of the current authorization or to the scheduled date of transfer.

- Any request for detoxification services that requires authorization and has not been submitted within the required period is subject to disapproval and may result in non-payment.

- Any request made on the expiration date will be denied, and any services provided past that date will not be reimbursed.

PROCEDURES:

1. Any decision to place a client in or transfer a client to Level IV Detoxification must be made by the interdisciplinary team. The client must participate in the modification to his or her treatment plan. The client's parent or guardian may also participate in the development of the treatment plan, if the client consents to such participation and family involvement is appropriate. The client's consent to placement or transfer must be reflected in the client's treatment plan and the client must sign a document reflecting consent.

2. The provider must obtain the client's consent to consent to transfer his records to another program and a signed Authorization to Disclose Confidential Information (or an equivalent form furnished by the provider) must be retained in the client's records.

3. Any provider requesting authorization for Level IV Detoxification services should submit the Request for Authorization, Re-authorization, Step-up, Step-down for Youth with additional supportive documentation; to include but not limited to, updated treatment plan, a photocopy of the voucher for services (if applicable), case notes, psychiatric evaluations, toxicology screens, etc. to:

Attention: Reauthorization Committee
Addiction Prevention and Recovery Administration
1300 First Street NE
Washington, DC 20002
Contact: Reauthorization Committee Coordinator
Phone: (202) 727-8945
Fax: (202) 535-2318
Hours of Operation: 8:30am – 4:30pm

3. Requests received Monday thru Friday will receive a response within one (1) business day.

4. If necessary, APRA may contact the provider to request additional clinical information. If the additional documentation requested is not received within one (1) business days of the request, the Request for Authorization, Re-authorization, Step-up, Step-down for Youth is subject to denial.

5. Once the requested documentation is received and reviewed by APRA the provider will be contacted with a disposition of the Request for Authorization, Re-authorization, Step-up, Step-down for Youth within one (1) business days.

6. Only individuals with the following credentials are authorized to sign the request form:

Physician
Licensed Psychologist
Registered Nurse
Licensed Independent Clinical Social Worker (LICSW)
Licensed Professional Counselor (LPC)

Any request containing the signature of a person who does not possess a credential listed above will not be processed.

7. To appeal the decision a copy of the original request and supporting documentation challenging the denial should be sent to the Appeals Officer within one (1) business day of the denial. A decision will be rendered and forwarded to the Provider within one (1) business days. Please forward all Appeal requests to:

Addiction Prevention and Recovery Administration
Attention: Appeals Officer
1300 First Street, NE 2nd Floor
Washington, DC 20002
Fax: (202) 535-2318

39.0 Discharge from Treatment

39.1 Written Discharge Policies and Procedures

- A substance abuse treatment facility or program shall develop criteria and implement written policies and procedures regarding:
    - Termination or removal from the program;
    - Discharge planning;
    - Discharge or completion of the program; and
    - Re-entry following termination or discharge.

An aftercare plan shall be developed prior to a client's discharge from a substance abuse treatment facility or program.

39.2 Discharge Summary

- The client's record shall contain a discharge summary that summarizes information regarding the client's condition from the time of first contact through treatment termination. The discharge summary shall minimally include and address the following:
    - Admission date and referral source;
    - Initial assessment, including present problems;
    - Initial diagnosis;
    - Significant findings;
    - Course and progress of treatment towards the goals in the treatment plan;
    - Outcomes at the time of discharge, in relation to identified problems;
    - Final assessment, including prognosis;
        - Final diagnosis;
        - Recommendations and referrals made as stated in the continuing care or aftercare plan;
        - Discharge date and reason; and,
        - Follow-up plans.
- If a client voluntarily terminates involvement with a substance abuse treatment facility or program against the advice of staff, the discharge summary shall include a statement that explains the circumstances under which the client was terminated.
- If a client is involuntarily terminated for non-compliance as specified in the facility's or program's policies and procedures, the discharge summary shall

include a statement that explains the circumstances under which the client was terminated and the conditions that must be met by the client for readmission.

- The discharge summary shall be completed and entered into the client's record no later than fifteen (15) days after the client's discharge from a substance abuse treatment facility or program and shall be signed by the primary care counselor, the clinical case manager, and the supervisor. The discharge date shall be considered the date on which services were last provided.

39.3 Reporting Client Data to APRA

In order to establish a baseline against which treatment outcomes will be measured and analyze aggregate data on individuals seeking substance abuse treatment in the District of Columbia, APRA collects client and program data from all ASTEP providers.

All ASTEP providers are required to submit client and program data to APRA in the form and according to the timelines prescribed by APRA.

See Figure 39: Sample APRA Monthly Data Reporting Form for Youth Providers

Figure 39: Sample APRA Monthly Data Reporting Form for Youth Providers

APRA MONTHLY DATA REPORTING FORM FOR YOUTH PROVIDERS

AGENCY NAME			
ADDRESS			
CONTACT PERSON			
PHONE NUMBER		**DATE**	

MEASURES	#	MEASURES	#		#
# of youth seen this calendar month		# of youth referred by:			
# of new clients this month		CFSA		Latin American	
# of youth between the ages of 13-15		DYRS		Genesis	
# of youth between the ages of 16-18				Genesis Level II	
# of youth between the ages of 19-21				Level I	
# of youth screened using the GAI				Level II	
# of youth intake leted				Other	
# of youth to co GAIN-I					
# of youth to c GAIN-C					
# of youth to co M90					
#of youth rec ing mpreh ive ssment					
# of youth wi ment plans					
# of counseling sessions scheduled		# of youth referred to:			
# of counseling sessions attended		Mental Health Services		Second Genesis Level II	
# of youth who reported becoming pregnant while in treatment		Federal City- Level I		Other	
# of youth who successfully completed treatment		Federal City-Level II			
# of trainings staff attended this month		Family Preservation			
# of new youth with Medicaid		Latin American Youth			
# of new youth with private insurance		Second Genesis Level I			
# of new youth with no insurance					
#of non-insured youth who were enrolled in Medicaid					
# of parents/guardians who attended family meetings/counseling this month					
# of urinalysis conducted this month					
# of positive urinalysis screens this month					
# of youth offered HIV/AIDS education and testing					

40.0 Continuing Care Plans

- A provider must develop and implement policies and procedures to ensure continuity of care when developing continuing care plans for clients who will need additional treatment after discharge.
- A written continuing care plan must be developed in partnership with the client before discharge when the need for treatment at a higher or lower level of care is indicated by the client's progress or lack of progress in meeting goals established in the treatment plan. The plan shall be based on a review of the treatment plan and an updated assessment to determine the appropriate placement for the client to receive ongoing structured care.
- The provider shall facilitate arrangements for the client to be admitted to an appropriate program consistent with the assessed need. See Section 22: Submitting Requests for Authorization or Reauthorization of Services or Transfer to Another Program.
- The continuing care plan shall be signed and dated by the client and the counselor.
- A copy of the continuing care plan shall be provided to the client and added to the client's record.
- The continuing care plan shall indicate the requirements that must be met for re-admission to the facility or program.
- The facility or program shall accompany, transport or arrange transportation to the new facility or program for any client in need.
- The facility or program shall follow up and document in the client's record confirmation of a successful referral or the client's failure to comply with the established plan.

41.0 Aftercare Plan

- The facility or program shall develop policies and procedures for developing client aftercare plans to effectively transition clients into the community after discharge.
- The client shall participate in the development of the aftercare plan. The lack of client participation shall be documented.
- The aftercare plan shall identify supportive community services or other planned activities designed to sustain therapeutic gains, maintain sobriety, and promote further recovery.
- The aftercare plan shall include procedures for collecting information from the client regarding outcomes of care for a minimum period of four (4) months after discharge. Except for substance abuse detoxification facilities or programs, staff shall attempt a minimum of three (3) follow-up contacts during the specified four (4) month period.
- Documentation of both successful and unsuccessful follow-up contacts shall be recorded in the client's record. This documentation shall include at least the following:
    - Types, dates and times of contact or attempted contact;
    - Reasons for unsuccessful contact, if applicable;
    - Summaries of the contacts, including the client's progress or regression since discharge and in which areas; and,
    - Plan for future follow-up contacts, if applicable.

Appendix A: Contact Information for Formal Appeal of APRA Decision

If you disagree with an administrative decision made by APRA or one if its designees pursuant to Section 3 of this manual, you may file a formal appeal. A provider must forward APRA a copy of any formal appeal submitted to the Director of the Department of Health.

Director
District of Columbia Department of Health
825 North Capital Street, N.E.
Suite 4400
Washington D.C. 20002

Telephone Number: (202) 442-5955
Fax Number: (202) 442-4795

Senior Deputy Director
Addiction Prevention and Recovery Administration
District of Columbia Department of Health
1300 First Street N.E.
Third Floor
Washington, D.C. 20002

Telephone Number: (202) 727-8857
Fax Number: (202) 727-0092

Appendix B: IVR Instructions

It is the responsibility of the provider to ensure the client is eligible for Medicaid.

Using the IVR System

To access the District of Columbia Government Medicaid Interactive Voice (IVR) Response System, dial **202-906-8319** (inside DC Metro area) or **866-752-9233** (outside DC Metro area) from your touch-tone phone. Select one of the following options and follow the prompts:

Press 1 - To verify recipient eligibility and claims status. The system will prompt you to enter your nine (9)-digit Medicaid provider number or 10-digit National Provider Identifier (NPI) followed by the pound (#) key.

Press 1 - For recipient eligibility

The system will prompt you to enter the recipient's eight (8)-digit ID followed by the pound (#) key and the recipient's eight (8)-digit date of birth in MMDDYYYY format;

Or
Enter the recipient's nine (9)-digit social security number and the recipient's eight (8)-digit date of birth in MMDDYYYY format.

If the recipient number exists in the database, the system will respond with a message about the patient's eligibility.

Press 2 - For claim status

The system will prompt you to enter the 17-digit transaction control number (TCN) followed by the pound (#) key and the recipient's eight (8)-digit ID followed by the pound (#) key;

Or
Enter the recipient's eight (8)-digit ID number followed by the pound (#) key, the recipient's eight (8)-digit date of birth in MMDDYYYY format, the eight (8)-digit date of service begin date in MMDDYYYY format and the eight (8)-digit date of service end date in MMDDYYYY format if different from the date of service begin date.

Press 2 - If you are a new provider and would like to enroll or if you are changing your provider number.

Press 3 - For EDI Technical Support Services

Press 4 - For all other questions

Appendix C: Sample Forms

APRA has included the following sample forms, which ASTEP provider programs may use to support their program operations. Use of the following forms is optional; however, programs must comply with all District and federal regulations regarding client confidentiality and patient rights. In addition, providers must certify that clients have been offered their choice of ASTEP provider when making placement decisions.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Federal regulations provide for the confidentiality of alcohol and drug abuse patient records. Providers are required to adhere to the following federal regulation (42 C.F.R. 2.22):

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:
(1) The patient consents in writing:
(2) The disclosure is allowed by a court order; or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

REQUEST FOR RELEASE OF INFORMATION/AUTHORIZATION

Purpose: To obtain authorization for the release and disclosure of protected health information. Also, to document the verification of the identity and authority of a person or entity you wish to disclose the protected health information.

☐ **Client** ☐ **Third Party** ☐ **Courts** ☐ **Other**_____

☐ **Payment:** **Purpose is to obtain information regarding insurance coverage for substance abuse treatment that may be available under my insurance plan.**

(*Required field)

*Effective Date: _____/_____/_____ *Expiration Date: ____/____/____

Section A: Client Information *Identification Number: _____

*Name: _____

*Address:_____

City_____ State_____ ZIP code_____

Telephone: _____ Fax:_____ E-mail_____

*DOB:_____/_____/_____ *Gender: Male ☐ Female ☐

Legal Personal representatives signing on behalf of the individual must complete the following:

Legal Personal Representative's Name:

_____

***Address:**_____

City:_____ **State:**_____ **ZIP code**_____

Authority to Act as Personal Representative: _____

Telephone:_____

Section B: Recipient/Requester Information: Name and Address of Person ***and*** Entity to whom the Protected Health Information is to be disclosed:

*Name:_____

Company, Organization or Government Agency with which the person claims affiliation:

_____

*Address: _____

City_____State_____ZIP Code_____

Telephone:_____ Fax:_____
F

_____
E-mail:

_____

E-mail:_____

Section C: Release Authorization

I understand that my records are protected under the federal regulations regarding Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action or actions have been taken in reliance on it, and that in any event, this consent expires automatically as follows:

_____

(Give the date, and as needed, the specifics of event or condition when this consent expires)

I authorize the Addiction Prevention and Recovery Administration (APRA) to disclose to the party as named in *Section B: Requestor Information*. I also understand that this information cannot be redisclosed without my written authorization.

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (Act). Disclosures may only be made pursuant to a valid authorization by the client, or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

Client Signature:_____ Date: _____

Section D: Disclosure Information

*Protected Health Information to be Disclosed: _____

_____

*Purpose of the Disclosure: Describe the purpose for disclosing the protected health information, or attach a copy of any written request or information.

_____

_____

How did you verify the recipient's identity and authority?

_____

Repetitive Disclosure:

☐ Check if this disclosure is one of a series of repetitive accountable disclosures for a single purpose to the same person or entity.

_____

Signature of Staff Member making disclosure: _____

Print name: _____ Title: _____

Date: _____

Recommendation: _____

_____

Section E: Privacy Officer Approval

Privacy Officer Signature: _____ Date: _____

Accept ☐ **Deny** ☐

Comments: _____

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include completed form in the individual's records.

CLIENT BILL OF RIGHTS

A substance abuse treatment facility or program shall protect the following rights and privileges of each patient, without limitation:

(a) To be admitted and receive services in accordance with the Human Rights Act of 1977, effective December 13, 1977 (D.C. Law 2-38; D.C. Code § 2501 et seq.);

(b) To receive prompt evaluation, care and treatment, in accordance with the highest quality standards;

(c) To be evaluated and cared for in the least restrictive environment;

(d) To have the rehabilitation plan explained and to receive a copy of it;

(e) To have records kept confidential;

(f) To be treated with respect and dignity as a human being in a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal, physical, or psychological abuse;

(g) To be paid commensurate wages for work performed in the program which is unrelated to the client's treatment, in compliance with applicable local or federal requirements;

(h) To refuse treatment and or medication;

(i) To provide consent for all voluntary treatment and services;

(j) To refuse to participate in experimentation without the informed, voluntary, written consent of the client or a person legally authorized to act on behalf of the client; the right to protection associated with such participation; and the right and opportunity to revoke such consent;

(k) To be informed, in advance, of charges for services;

(l) To have the same legal rights and responsibilities as any other citizen, unless otherwise stated by law;

(m) To request and receive documentation on the performance track record of a program with regard to treatment outcomes and success rates;

(n) To assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial manner;

(o) To receive written and verbal information on client rights, privileges, program rules, and grievance procedures in a language understandable to the client; and

(p) To receive services that incorporate cultural competence providing, at a minimum, access to sign language/TTI for the deaf or hearing impaired and language services for the monolingual or limited English speaking consumer.

The facility or program shall have policies and procedures on rights and privileges of each client, with limitations. The following rights and privileges may be limited on an individual basis after an administrative review with clinical justification documented in the record:

(a) To have access to one's own record; and

(b) To be free from chemical or physical restraint or seclusion.

Any limitation of a client's rights shall be re-evaluated at each rehabilitation plan review, or as often as clinically necessary.

As soon as clinically feasible, the limitation of a client's rights shall be terminated and all rights restored.

A substance abuse treatment facility or program shall post conspicuously a statement of client rights, program rules and grievance procedures. The grievance procedures must inform clients that they may report any violations of their rights to the Department and shall include the telephone numbers of the Department, and any other relevant agencies for the purpose of filing complaints.

At the time of admission to a facility or program, staff shall explain and document the explanation of program rules, client rights, and grievance procedures by use of a form signed by the client and witnessed by the staff person, to be placed in the client's record.

A substance abuse treatment facility or program shall implement policies and procedures for the release of identifying information consistent with District laws and regulations regarding the confidentiality of client records and "Confidentiality of Alcohol and Drug Abuse Patient Records" 42 CFR, Part 2.

A substance abuse treatment facility or program shall develop and implement written grievance procedures to ensure a prompt, impartial review of any alleged or apparent incident of violation of rights or confidentiality. The procedures shall be consistent with the principles of due process and shall include but not be limited to:

(a) The completion of the investigation of any allegation or incident within thirty (30) calendar days;

(b) Providing a copy of the investigation report to the Department within twenty-four (24) hours of completing the investigation of any complaint; and

(c) Cooperating with the Department in completion of any inquiries related to clients' rights conducted by Department staff.

Client Signature Date

Counselor Signature Date

VERIFICATION OF CHOICE

□ My addiction professional offered me a choice of ASTEP provider.

I choose: (circle one)

Federal City-Clean & Sober Streets
Latin American Youth Center
Second Genesis

I choose this ASTEP provider because:

_____

_____

□ I was not offered a choice of ASTEP provider

_____

Client Signature Date

Client Comments:

_____

_____

_____

_____

_____

Counselor Signature Date

Counselor Comments:

_____

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT

This is to acknowledge that I have received a copy of:

Confidentiality of Alcohol and Drug Abuse Patient Records (Form) _____
Client Bill of Rights _____
Request for Release of Information/Authorization _____
Verification of Choice _____

Print Name_____ Signature_____

Date _____

Relationship if other than client_____

_____ I refuse to sign this acknowledgement form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Addiction Prevention and Recovery Administration

NOTE: This form must be faxed or hand delivered

INSTRUCTIONS TO COMPLETE

ADULT/ YOUTH Authorization, Reauthorization, Step-up, Step-down Form

SECTION A:	
VOUCHER #	Enter current voucher number for client.
DOB	Enter date of birth for client.
APRA CLIENT ID #	Enter APRA assigned client identification number.
START DATE	Enter the date client entered the program.
DISCHARGE DATE	Enter the projected date of discharge from your program.
TOTAL # OF DAYS/SESSIONS	Enter the total number of sessions the client received authorization for Level I services or the total number of days the client received authorization for Level II or Level III services.

SECTION B:	
PROVIDER NAME	Enter the provider name.
CONTACT PERSON	Enter the name of the person APRA should contact regarding this form.
DATE OF REQUEST	Enter the date of request for services.

SECTION C:	
INITIAL DIAGNOSIS	Indicate the diagnosis the client received when he/she first entered services. Enter DSM IV-TR code number **AND** description to record diagnosis.

CURRENT DIAGNOSIS	Indicate any changes in the diagnosis if the initial diagnosis has changed. Enter "SAME" if there is no change in diagnosis.
AXIS I, II, III, IV	Use the DSM IV-TR to determine diagnosis.
AXIS V	Indicate the client's Global Assessment of Functioning (GAF) Score for their initial diagnosis **AND** current diagnosis. Use the highest recorded GAF score during the prior twelve-month period for the initial Axis V diagnosis.

Revised October 30, 2008

SECTION D:	
LOC PROVIDED	Indicate the services client received while enrolled in your program.
LOC REQUESTED	Indicate the level of care you are requesting for the client.
LEVEL IV Detoxification	
LEVEL III Sub-Acute Non Hospital Medically Monitored Detox	
LEVEL III Non Hospital Residential Treatment Program	
LEVEL III Day Treatment/Partial Hospitalization Program	
LEVEL II Intensive Outpatient	
LEVEL I Outpatient	

SECTION E:	
TOTAL # OF DRUG SCREENS	Enter total number of drug screens the client received.
TOTAL # OF POSITIVE DRUG SCREENS	Enter the total number of positive drug screens the client received.
OVERALL PROGRESS AT ___ DAY INTERVAL (15,30,45)	

SECTION F:	
ASSESSMENT SUMMARY	Attach a copy of the client's initial assessment (GAIN report or ASI).
INITIAL TREATMENT PLAN	Attach a copy of the client's initial treatment plan for the client.

SECTION G:	
PRESENTING PROBLEM	Enter the presenting problem in this section. Indicate why the client initiated services.

SECTION H:	
MEDICAL/PSYCHIATRIC HISTORY	Beginning with the most recent, enter the medical/psychiatric history of the client in this section. Indicate any hospitalizations, and/or history of suicidal/homicidal ideation/attempts.

SECTION I:	
CLINICAL HISTORY	Beginning with the most recent treatment history, enter the type(s) of treatment client received, client's response to treatment, and any significant clinical information.

SECTION K:	
CLINICAL JUSTIFICATION FOR CHANGE IN TREATMENT	Indicate why it is clinically necessary for a change in treatment.

SECTION L:	
NEW TREATMENT PLAN	Indicate suggested changes in the revised treatment plan that reflects and supports the desired course of treatment.

SECTION M:	
PREPARERS' NAME (PRINTED)	Print the name of the person who completed this form.

PREPARER SIGNATURE	Provide the signature for the person who completed this form.
CREDENTIALED PROFESSIONAL (PRINTED)	Print the name of the credentialed professional who reviewed and approved this form. Include their credentials.
CREDENTIALED PROFESSIONAL SIGNATURE	Provide the signature for the person who approved this form.
DATE	Enter submission date.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Addiction Prevention and Recovery Administration

NOTE: This form must be faxed or hand delivered

Youth Authorization, Reauthorization, Step-up, Step-down Form

SECTION A:							
VOUCHER #				APRA Client ID #			
DOB		START DATE		DISCHARGE DATE		TOTAL # OF DAYS/SESSIONS	

SECTION B:	
PROVIDER NAME	
CONTACT PERSON	
DATE OF REQUEST	

SECTION C:			
	INITIAL DIAGNOSIS (include code #)		CURRENT DIAGNOSIS (include code #)
AXIS I		AXIS I	
AXIS II		AXIS II	
AXIS III		AXIS III	
AXIS IV		AXIS IV	
AXIS V	(Highest level in past year)	**AXIS V**	**(Must indicate change in GAF score)**

SECTION D:		
LEVEL OF CARE (LOC)	**LOC PROVIDED**	**LOC REQUESTED**
LEVEL IV Detoxification		
LEVEL III Sub-Acute Non-Hospital Medically Monitored Detox		
LEVEL III Non Hospital Residential Treatment Program		
LEVEL III Day Treatment/Partial Hospitalization Program		
LEVEL II Intensive Outpatient		
LEVEL I Outpatient		

SECTION E:			
TOTAL # OF DRUG SCREENS		**TOTAL # OF POSITIVE DRUG SCREENS**	
OVERALL PROGRESS AT ____ DAY INTERVAL (15, 30, 45, etc.)			
☐ Marked Improvement	☐ Moderate Improvement	☐ No Change	
☐ Marked Regression	☐ Moderate Regression	☐ Unknown	

SECTION F:	
ASSESSMENT SUMMARY	☐ **Attached**
INITIAL TREATMENT PLAN	☐ **Attached**

SECTION G:
PRESENTING PROBLEM (Initial presenting problem)

SECTION H:
MEDICAL/PSYCHIATRIC HISTORY (include hospitalizations, suicidal and homicidal ideation)

SECTION I:
CLINICAL HISTORY

SECTION J:
CLINICAL JUSTIFICATION FOR CHANGE IN TREATMENT (include # of sessions/days requested)

SECTION K:
NEW TREATMENT PLAN (please attach a copy of the proposed treatment plan)

SECTION L:	
PREPARER'S NAME (PRINTED)	
PREPARER SIGNATURE	
CREDENTIALED PROFESSIONAL (PRINTED)	
CREDENTIALED PROFESSIONAL SIGNATURE	
DATE	