DEPARTMENT OF HEALTH

ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

Adolescent Substance Abuse Treatment Expansion Project

(ASTEP)

Government of the District of Columbia

November 3, 2008

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 disorder. 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 any 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

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Authorization, Re-authorization, Step-Up, Step-Down Form for Youth

1.0 Introduction and Overview

The **Addiction Prevention and Recovery Administration (APRA),** in partnership with the **Medicaid Assistance Administration (MAA)** reimburses medically 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
- 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.

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 quality assurance 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, in whole or in part, 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) 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 he disagrees with a 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 Eligible ASTEP Participants

4.1 General Overview of ASTEP Participant Eligibility

Eligible consumers of APRA reimbursable adolescent substance abuse services are:

- District residents;
- Up to 21 years of age;
- Without private medical insurance, or whose medical insurance does not cover substance abuse treatment services; and
- With an Axis I diagnosis of a substance use disorder.

4.2 District Residency

An adolescent is eligible for APRA reimbursable substance abuse treatment services 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.

4.3 Age Limitations

An adolescent is eligible for APRA reimbursable substance abuse treatment services 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 specified disabilities until the date of the twenty-second (22) birthday.

4.4 Availability of Private Insurance

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

4.5 Diagnosis of Substance Use Disorder

An adolescent is eligible for APRA reimbursable substance abuse treatment services if he or she has a current Axis I diagnosis of substance use disorder.

5.0 Accessing Services

5.1 Access

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 child serving agency (such as the Child and Family Services Agency (CFSA) or Department of Youth Rehabilitative Services (DYRS)), 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 reasonably be interpreted as a request for services.

5.2 Assessment

Once a client has chosen to seek services, he or she will present at an ASTEP provider for an assessment. During client intake, treatment professionals will collect pertinent information in order to determine eligibility for ASTEP participation; including District residency, Medicaid eligibility, and availability of private insurance. Treatment counselors then perform a GAIN-I assessment and collect the client's relevant treatment history in order to determine the presence of an Axis I substance use disorder. If the client meets all criteria for ASTEP participation, this information is used to determine the level of care appropriate for treatment.

5.3 Referral

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 determines the level of care appropriate for treatment. The client is then offered his or her choice of substance use treatment provider. Once the client has selected a treatment program, an ASTEP provider may either begin delivering treatment services or coordinate the client's transfer the client to the substance abuse treatment program of his or her choice. See Section 32: Transferring Clients to Other Substance Abuse Treatment Programs

6.0 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 delivering substance abuse services.

6.1 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 APRA reimbursable substance abuse services 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 guardian.

If the client has been referred to treatment by a District of Columbia government agency, documentation establishing residency is not required.

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

6.2 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 present proof of insurance benefits for substance abuse treatment, the provider must contact the customer service or benefits line and inquire as

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

6.3 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 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 Eligibility Verification System (EVS). See Appendix B: EVS Instructions.

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

6.4 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. After the client has undergone a GAIN assessment performed by a certified GAIN administrator, an interdisciplinary team must review the assessment findings and diagnose an Axis I substance use disorder pursuant to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV).

7.0 Eligibility for APRA Reimbursable Services When the Client is not Eligible for Medicaid Benefits

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

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

If the client is a District of Columbia resident who is not a Medicaid recipient and who does not have private insurance or whose private insurance does not pay for substance abuse treatment services; the provider should designate a case manager to assist the client and/or his or her guardian in submitting an application for Medicaid benefits. See Section 8: Procedures for Submitting an Application for Medicaid Benefits

- If the client is not a Medicaid recipient, a case manager should provide the client and his or her guardian with a copy of 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.

7.2 Eligibility for APRA Reimbursable Services when the Client's Application for Medicaid Benefits is Pending

If the client is a District of Columbia resident who is not a Medicaid recipient and who does not have private insurance or whose private insurance does not pay for substance abuse treatment services and the client has submitted or plans to submit an application for Medicaid benefits; APRA will reimburse participating providers for medically necessary substance abuse treatment services delivered during the period in which the Medicaid application is pending. The provider should complete intake and proceed to screening and assessment.

7.3 Eligibility for APRA Reimbursable Services when the Client is not Eligible for Medicaid benefits

If the client is a District of Columbia resident who is not eligible for Medicaid benefits and who does not have private insurance or whose private insurance does not pay for substance abuse treatment services; APRA will reimburse participating providers for medically necessary substance abuse treatment services. The provider should complete intake and proceed to screening and assessment.

8.0 Procedures for Submitting an Application for Medicaid Benefits

If the client is a District of Columbia resident who is not a Medicaid recipient and who does not have private insurance or whose private insurance does not pay for substance abuse treatment services and the client has submitted or plans to submit an application for Medicaid benefits; the provider should complete intake and proceed to screening and assessment.

If an adolescent, or his parent or guardian, is not a Medicaid recipient, he or she may submit a Medicaid benefits application to the Income Maintenance Administration (IMA). For social services referral information, please call (202) INFO-211.

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 case manager should routinely follow up with the client regarding the status of his or her application.

9.0 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:

(a) 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;

(b) The presenting problem including a statement of the circumstances or symptoms prompting the individual to seek services at this time;

(c) Existing personal support systems;

(d) Self-reported history of prior medical hospitalizations, substance abuse and psychiatric treatment episodes;

(e) 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;

(f) Report of alcohol and/or drug consumption and quantity, type of drug, route of administration, and frequency in last 30 days;

(g) 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

(h) Diagnostic summary of interviewer's impressions and observations.

10.0 Screening and Assessment

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

10.1 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 and mental health) 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.

10.2 Assessment

The Global Appraisal of Individual Needs-Initial (GAIN-I) is the required initial assessment tool for adolescents seeking substance use treatment in the District of Columbia. The GAIN-I may also be administered where a comprehensive substance abuse assessment is medically necessary. The GAIN-I 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 recentness of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recentness of service utilization, and frequency of recent service utilization. The items are combined into over 100 scales and sub-scales that can be used for Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV) based diagnosis, American Society of Addiction Medicine (ASAM) based level of care placement, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) based treatment planning. GAIN materials are available in hard copy and electronic forms. The GAIN can be administered by computer or with paper and pencil, and clients with sufficient cognitive functioning can self-administer it.

The Global Appraisal of Individual Needs-Quick (GAIN-Q) is the required assessment tool for assessing treatment needs on an ongoing basis.

If the screening tool (or referral documentation) reveals evidence of substance use, the provider must request client consent to contact the Central Intake Division for Youth (CIDY) to determine whether the adolescent has previously undergone an assessment for substance use disorder in the District of Columbia. After obtaining the client's consent, the provider must contact CIDY to determine the assessment tool administered (GAIN-I or GAIN-Q), the date the assessment was administered, and the name of the provider agency that administered the 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 assessments were performed and request copies of the assessments and client case file.

- 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.

10.3 Credentials of Individuals Administering the GAIN Assessment Tool

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

10.4 Client Assessment Database

Each provider is responsible for sending a weekly report to APRA's Central Intake Division for Youth (CIDY) recording the name of each client who underwent a GAIN-I or GAIN-Q assessment, and the date the assessment was performed. The weekly report must be faxed under a cover sheet with no identifying client information. APRA will maintain a central database of client assessment information, including the assessment tool administered (GAIN-I or GAIN-Q), the date the assessment was administered, and the name of the provider agency that administered the assessment.

If the client indicates that an assessment has been performed within the preceding 180 days, the provider must obtain his or her written consent to contact the agency where the assessment was performed and request a copy of the assessment and client case file. See Appendix for Participating Provider Contact Information.

11.0 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.

11.1 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.

11.2 Level I Outpatient Treatment

Low intensive 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.

11.3 Level II Intensive Outpatient Treatment

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.

11.4 Level III Residential Treatment

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.

11.5 Level IV Detoxification

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.

12.0 Client Choice of Provider

The Choice in Drug Treatment program mandates that all substance abuse treatment clients be offered their choice of treatment provider.

A client may obtain services from any participating provider with an executed Human Care Provider Agreement (HCPA) with APRA and current Chapter 23 certification status. 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 participating 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.

- 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 that agency must coordinate the client's transfer to his or her provider of choice. See Section 32: Transferring Clients to Other Substance Abuse Treatment Programs

13.0 Treatment Plan

13.1 Development of treatment plan

A treatment plan must be developed within 10 days of completing an assessment. 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.

13. 2 Review of the treatment plan

A case manager should 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.

- 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.

- The interdisciplinary team shall conduct an annual assessment of any person receiving ongoing services during the previous 12 months.

14.0 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. In the event that an assessment was performed and client placement made by APRA staff or a satellite intake provider, then a substance abuse treatment provider shall be responsible for establishing an interdisciplinary team to complete any incomplete assessments;
- Treatment/Rehabilitation planning;
- Clinical case management;
- Individual and group addiction counseling;
- Individual and group psychotherapy as specified in the patient'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.

15.0 Individual Addiction Counseling Services

15.1 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.

15.2 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 individual 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; or,
- 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.).

16.0 Group Addiction Counseling Services

16.1 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;
- Encouraging and modeling productive and positive interpersonal communication; and
- Developing motivation and action by group members through peer pressure, structured confrontation, and constructive feedback.

16.2 Credentials of Individuals Delivering Group Addiction Counseling Services

- Only an individual trained to provide addiction-focused therapies shall provide group-counseling services.
- 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.
- 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 individual 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; or,
    - 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.).

17.0 Family Counseling Services

17.1 Family Counseling Services

Family therapy is defined as planned, goal-oriented therapeutic interaction of a qualified individual with the client and/or one or more members of the client's family in order to address and resolve the family system's dysfunction 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 living in the same household with the client, who has a significant relationship with the client, may be considered a family member.

- 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.
- At least one (1) family member who participates in therapy sessions shall agree to activities he or she will do if client relapses.

17.2 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.

17.2 Credentials of Individuals Delivering Family Counseling Services

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

Family therapy shall be performed by a person who:

- Is certified by the American Association of Marriage and Family Therapists; or

- Is a licensed clinical social worker and has one (1) year of supervised experience in family counseling or specializes in family counseling; or
- Has a master's degree in psychology or counseling and one (1) year supervised experience in family counseling or specializes in family counseling.

18.0 Case Management Services

18.1 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.

18.2 Requirement to Provide Case Management Services

Addiction counseling is not considered a case management service or activity. Individuals 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.

18.3 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 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 rehabilitation 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 rehabilitation plan;
- Attending periodic meetings with designated team members and the client in order to review and update monitoring activities and the rehabilitation plan;
- Participation in the annual assessment;
- Advocating 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;
- Locating and coordinating services and resources to resolve a client's crisis;
- Providing experiential training to clients in life skills and resource acquisition;
- Providing information and education to a client in accordance with the rehabilitation plan; and
- Planning for discharge.
- Delivering aftercare services

18.3 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); or
- A Licensed Professional Counselor;

- A registered nurse, certified in chemical dependency; or
- 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.

19.0 Group Education Services

19.1 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 patients.

- A substance abuse treatment facility or program shall provide basic information to patients 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.

19.2 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.

19.3 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.

20.0 Therapeutic Assistant Services

20.1 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 patients who need the protection and structure of staff twenty-four (24) hours a day.

20.2 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.

20.3 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.

21.0 Nursing Services

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

- Health assessments of patients 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.

22.0 Submitting Claims for Reimbursement to APRA

Providers must request a voucher from APRA in order to be reimbursed for medically necessary services provided to eligible clients. A provider may request a voucher electronically through the APRA Client Information System (ACIS).

After completing all relevant data fields in ACIS, a voucher number will be generated. A provider must submit four documents in order to constitute a proper invoice package for payment:

- 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, amount due, and signature and date for the authorized vendor, contract administrator, and program official (DOH). The provider should submit a photocopy of the summary invoice to their assigned contract representative.
- 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 should submit a photocopy of the HCFA 1500 to their assigned contract representative.
- Voucher and/or Request for Reauthorization of SA Services forms – These documents must be included for all clients. The provider must attach a photocopy of the voucher and/or request for reauthorization to the matching HCFA 1500. The provider should submit a photocopy of the voucher and/or request for reauthorization to their assigned contract representative.
- 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. This spread sheet must reconcile to all HCFA 1500s submitted for payment for the billing period. The spreadsheet should follow the order of the HCFA 1500 forms. The Excel spreadsheet will 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.

23.0 Submitting Claims for Reimbursement to D. C. Medicaid

Providers must submit claims for Medicaid-eligible services delivered to Medicaid recipients to ACS.

Providers must supply their own standard claim form for the services provided.

Electronic Billing

DC Medicaid will accept transmission of claims electronically. Currently, DC Medicaid receives claims in the following media:

- EDI
- WINASAP2003

ACS/EDI supports this function. Electronic claim submission provides for timely submission and processing of claims. It also reduces the rate of pended and denied claims.

Providers who are interested in receiving electronic billing instructions should indicate this interest on their enrollment application. Permission from the DC Medicaid Program is required prior to submitting electronic claims. Procedures specific to electronic billing are sent to providers approved to submit claims in this manner.

24.0 Submitting Claims for Reimbursement to Private Insurers

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

25.0 Billing Limitations for Covered Services

25.1 Substance Use Disorder Assessment

The GAIN-I is the required diagnostic tool to assess for the presence of substance use disorder for adolescents requiring substance use disorder treatment in the District of Columbia. An adolescent is entitled to two (2) comprehensive diagnostic assessments per twelve (12) month period.

The GAIN-Q is the required diagnostic tool to assess treatment needs on an ongoing basis for adolescents requiring substance use disorder treatment in the District of Columbia. An adolescent is entitled to a treatment status assessment every sixty (60) days, up to six (6) per twelve (12) month period.

25. 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.

25.3 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. 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. Re-authorization required after 90 units.
- 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 the first ninety units of treatment. See Section 30.0: Submitting Requests for Re-authorization of Level II Intensive Outpatient Substance Abuse Treatment

25.5 Case Management

An adolescent 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.

25.6 Family Counseling

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.

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

- A provider may bill for 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.

26.0 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.

26.1 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.

26.2 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. 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. Re-authorization required after 90 units.
- 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 the first ninety units of treatment.**

26.3 Level III Residential Treatment

Level III Residential Treatment is not currently a Medicaid reimbursable service for adolescents enrolled in a Medicaid MCO. 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-CIDY. See Section 31: Submitting Requests for Authorization of Level III Residential Substance Abuse Treatment Services.

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

Providers must request a voucher from APRA in order to be reimbursed for services provided to non-Medicaid eligible clients who meet the criteria for APRA reimbursable services. A provider may request a voucher electronically through the APRA Client Information System (ACIS).

27.1 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.

27.2 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. 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. Re-authorization required after 90 units.
- 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 the first ninety units of treatment.**

27.3 Level III Residential Treatment

Level III Residential Treatment is not currently a Medicaid reimbursable service for adolescents enrolled in a Medicaid MCO. 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-CIDY. See Section 31: Submitting Requests for Authorization of Level III Residential Substance Abuse Treatment Services.

28.0 Submitting Claims for Reimbursement to APRA for non-Medicaid Eligible Clients and Clients with Pending Medicaid Applications

For clients whose applications for Medicaid benefits are pending and who meet the criteria for APRA reimbursable substance abuse treatment services, providers must request a voucher from APRA in order to be reimbursed. Providers must request a voucher from APRA in order to be reimbursed for services provided to non-Medicaid eligible clients who meet the criteria for APRA reimbursable services and clients with pending Medicaid applications. A provider may request a voucher electronically through the APRA Client Information System (ACIS).

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**
- **whose substance abuse services were not medically necessary.**

28.1 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.

28.2 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. 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. Re-authorization required after 90 units.
- 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 the first ninety units of treatment.**

28.3 Level III Residential Treatment

Level III Residential Treatment is not currently a Medicaid reimbursable service for adolescents enrolled in a Medicaid MCO. 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-CIDY. See Section 31: Submitting Requests for Authorization of Level III Residential Substance Abuse Treatment Services.

29.0 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.

Providers must request a voucher from APRA in order to be reimbursed for case management services. A provider may request a voucher electronically through the APRA Client Information System (ACIS).

The client may receive:

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

30.0 Submitting Requests for Re-authorization of Level II Intensive Outpatient Substance Abuse Treatment Services

An adolescent undergoing Level II Intensive Outpatient treatment may receive a maximum of 90 units of Level II Intensive Outpatient Treatment. A provider must request re-authorization to provide Level II Intensive Outpatient treatment after 90 units. 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 Central Intake Division for Youth (CIDY).

- 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.

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

PROCEDURES:

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 consent to extend Intensive Outpatient treatment must be reflected in his or her treatment plan and the client must sign a document reflecting his consent.

2. Any provider requesting extension of Level II Intensive Outpatient Treatment services should submit a Request for Authorization or Re-authorization for Youth with additional supportive documentation; to include but not limited to, updated treatment plan, case notes, psychiatric evaluations, toxicology screens, etc. to:

APRA Central Intake Division for Youth (CIDY)
3720 Martin Luther King Jr. Ave., SE 2nd Floor
Washington, DC 20032
Fax: (202) 645-8426
Phone: (202) 645-0344
Hours of Operation: 8:30am – 4:30pm

3. Requests received Monday thru Friday will receive a response from CIDY within three (3) business days.

4. If necessary, CIDY may contact the provider to request additional clinical information. If the additional documentation requested by CIDY is not received within three (3) business days of the request, the request is subject to denial.

5. Once the requested documentation is received and reviewed by CIDY the provider will be contacted with a disposition of the request within three (3) business days.

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

Physician
Licensed Psychologist
Registered Nurse
Licensed 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 CIDY, a copy of the original request and supporting documentation challenging the denial should be sent to the Medical Director within three (3) business days of the denial. A decision will be rendered and forwarded to the Provider within three (3) business days. Please forward all Appeal requests to:

Addiction Prevention and Recovery Administration
Attention: Medical Director
1300 First Street, NE 2nd Floor
Washington, DC 20002
Fax: (202) 535-1314

31.0 Submitting Requests for Authorization/Re-authorization of Level III Non-Hospital Residential Substance Abuse Treatment Services

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 the Central Intake Division for Youth (CIDY).

- 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.

PROCEDURES:

1. Any decision to place a client in or transfer a client to Level III Residential Treatment must be made by the interdisciplinary team. The client must participate in the modification to his or her treatment plan. 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 his or her 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 residential treatment services should submit the Request for Authorization or Re-authorization for Youth with additional supportive documentation; to include but not limited to, updated treatment plan, case notes, psychiatric evaluations, toxicology screens, etc. to:

APRA Central Intake Division for Youth (CIDY)

3720 Martin Luther King Jr. Ave., SE 2nd Floor
Washington, DC 20032
Fax: (202) 645-8426
Phone: (202) 645-0344
Hours of Operation: 8:30am – 4:30pm

3. Requests received Monday thru Friday will receive a response from CIDY within three (3) business days.

4. If necessary, CIDY may contact the provider to request additional clinical information. If the additional documentation requested by CIDY is not received within three (3) business days of the request, the request is subject to denial.

5. Once the requested documentation is received and reviewed by CIDY the provider will be contacted with a disposition of the request within three (3) business days.

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

Physician
Licensed Psychologist
Registered Nurse
Licensed 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 CIDY, a copy of the original request and supporting documentation challenging the denial should be sent to the Medical Director within three (3) business days of the denial. A decision will be rendered and forwarded to the Provider within three (3) business days. Please forward all Appeal requests to:

Addiction Prevention and Recovery Administration
Attention: Medical Director
1300 First Street, NE 2nd Floor
Washington, DC 20002
Fax: (202) 535-1314

32.0 Transferring Client to Other Substance Abuse Treatment Programs

A change in the level of care required to deliver effective treatment may require referring a client to another substance use treatment program within the participating provider network. 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. The following service limitations are applicable to 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, the provider must request an extension from APRA-CIDY.
- Clients may be referred to Level III Residential Treatment after prior authorization of APRA-CIDY.

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, a case manager must coordinate the transfer to another agency in such a manner as to avoid interruption of treatment.

PROCEDURES:

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 should 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 his 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

3. A provider referring a client to another program must submit a Request for Authorization or Re-authorization for Youth with additional supportive documentation; to include but not limited to: updated treatment plan, case notes, psychiatric evaluations, toxicology screens, etc. to the program where the client has requested a transfer.

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

33.0 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.

33.1 Requirement to Assess for Co-Occurring Mental Health Disorders

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

In the event that the initial screening indicates the presence of a mental health disorder, a licensed psychiatric social worker, licensed psychiatric nurse, or licensed psychologist or psychiatrist should be 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.

33.2 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

33.3 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.

34.0 Referring Client to Level IV Detoxification

34.1 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.

34.2 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 the Central Intake Division for Youth (CIDY).

- 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 consent to placement or transfer must be reflected in the client's treatment plan and the client must sign a document reflecting his or her 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 or Re-authorization for Youth with additional

supportive documentation; to include but not limited to, updated treatment plan, case notes, psychiatric evaluations, toxicology screens, etc. to:

APRA Central Intake Division for Youth
3720 Martin Luther King Jr. Ave., SE 2nd Floor
Washington, DC 20032
Fax: (202) 645-8426
Phone: (202) 645-0344
Hours of Operation: 8:30am – 4:30pm

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

4. If necessary, CIDY may contact the provider to request additional clinical information. If the additional documentation requested by CIDY is not received within one (1) business days of the request, the request is subject to denial.

5. Once the requested documentation is received and reviewed by CIDY the provider will be contacted with a disposition of the request 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 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 CIDY, a copy of the original request and supporting documentation challenging the denial should be sent to the Medical Director 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: Medical Director
1300 First Street, NE 2nd Floor
Washington, DC 20002
Fax: (202) 535-1314

35.0 Discharge from Treatment

35.1 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.
  - Prior to a client's discharge from a substance abuse treatment facility or program, an aftercare plan shall be developed.

35.2 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 rehabilitation 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.

35.3 Entering Client Data into the APRA Discharge Portal

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 Treatment Episode Data Set (TEDS) information from all DTCP providers. APRA has created a web-based system to facilitate TEDS data collection. Please refer to the Treatment Episode Data Set (TEDS) Portal: Implementation and Quick Reference Guide distributed to your provider agency for step-by-step instructions on submitting client data into the APRA Discharge Portal.

All ASTEP providers are required to input client discharge data into the APRA Discharge Portal on at least a monthly basis.

36.0 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.

37.0 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

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: EVS Instructions

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

To access the District of Columbia Government Medicaid Recipient **Eligibility Verification System** (EVS), dial the following telephone number:

(202) 610-1847

After dialing the number, EVS will answer the call and respond with:

DC MEDICAID ELIGIBILITY SYSTEM

The system will then prompt you with:

PLEASE ENTER YOUR PROVIDER NUMBER

You should respond by using a touch-tone phone to enter your nine-digit provider identification number.

If no data is entered within the specified time period, or if insufficient data is entered, the system will respond with:

INELIGIBLE PROVIDER NUMBER

PLEASE REPEAT YOUR ENTRY

You will be given three (3) opportunities to enter a valid provider number. After three (3) invalid provider numbers have been entered, the call will be disconnected. After you have verified your provider number, you should redial EVS to verify the information.

Once a valid provider number has been entered, you will be prompted with:

PLEASE ENTER YOUR RECIPIENT NUMBER

The recipient identification number, an eight (8) digit code, should be entered exactly as it appears on the Medical Assistance Card. After entering the eighth digit, the system will respond:

PLEASE ENTER THE LAST NAME CODE

Respond by entering the numeric representation of the first letter of the recipient's last name. The numeric sequence for the last name is generated in the following manner:

1. Depress the key containing the desired letter. For example, for a last name beginning with an *A*, the first digit of the key will be 2.

2. Press a 1, 2, or 3 depending upon the letter's position on the telephone button. For example, the letter *A* is the first character on button 2; therefore, the second digit of the key is 1. The entire key for *A* is 21. Similarly, *B* is 22 and *C* is 23. Since the characters *Q* and *Z* do not appear on the keypad, the sequences of 11 for *Q*, and 12 for *Z* should be used to enter these alphabetic characters.

The following table may be used to enter the name keys for EVS:

A	**21**	**J**	**51**	**S**	**73**
B	**22**	**K**	**52**	**T**	**81**
C	**23**	**L**	**53**	**U**	**82**
D	**31**	**M**	**61**	**V**	**83**
E	**32**	**N**	**62**	**W**	**91**
F	**33**	**O**	**63**	**X**	**92**
G	**41**	**P**	**71**	**Y**	**93**
H	**42**	**Q**	**11**	**Z**	**12**
I	**43**	**R**	**72**		

If you make an error entering the last name codes, the system will re-prompt with:

INVALID RECIPIENT NUMBER

PLEASE REPEAT YOUR ENTRY

At this point, you should re-enter the Recipient Number. The system will prompt you as it did during the initial attempt to verify the data.

Upon successfully entering the last name code, the system will prompt you with the following:

PLEASE ENTER THE FIRST NAME CODE

You should respond by entering the numeric representation of the first letter of the first name. The algorithm used to enter the first name code is the same as for the last name code. Please refer to the table above for assistance translating the name to a numeric representation.

If an error is made when entering the first name, the system will re-prompt with:

INVALID RECIPIENT NUMBER

PLEASE REPEAT YOUR ENTRY

Now you must enter the recipient number and follow the process for entering the last name and first name. The system will prompt you through the process as it did during the first entry.

You will be given three (3) opportunities to enter a valid recipient identification number with valid name codes. After entering three invalid recipient identification numbers with name codes, the call will be disconnected.

If the recipient number exists in the database and matches the name code entered, the system will respond with one of the following messages based on the information available for the recipient:

- Eligible Medicaid HMO, including the name and telephone number of the Managed Care Organization
- Eligible Medicaid and Medicare
- Eligible Medicaid and Third Party
- Eligible Medicaid
- Eligible Medicaid Restricted
- Eligible for Pregnancy Related Services Only

The system will then prompt you with:

ENTER NEXT RECIPIENT

To verify another recipient, begin by entering the recipient number and follow the instructions above. Otherwise press asterisk (*) to end the call. A maximum of five (5) recipients can be verified during a single call.

If you encounter problems accessing the EVS system, call the Recipient Eligibility Help Desk (EVS backup) at 1-866-752-9233.

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.

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.

VERIFICATION OF CHOICE

Drug Treatment Choice Program

□ I was offered a choice in the Drug Treatment Choice Program

□ I was not offered a choice in the Drug Treatment Choice Program

____

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 _______
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

NOTE: This form must be faxed or hand delivered

Office of Clinical Services
Assessment and Referral Center/Central Intake Division-Youth
Addiction Prevention and Recovery Administration

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

Office of Clinical Services
Assessment and Referral Center
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	