

105 Rehabilitative Services - DHR, DYS, DMH, DCA

Rehabilitative services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness, substance abuse, or co-occurring mental illness and substance abuse diagnoses. These services are provided to recipients on the basis of medical necessity.

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Direct services may be provided in the recipient's home, a supervised living situation, or organized community settings, such as community mental health centers, public health clinics, nursing homes, etc. Direct services can be provided in any setting, except in licensed hospital beds, that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Rehabilitative services will be provided to Medicaid recipients on the basis of medical necessity. Although limits are provided for guidance, the limitation(s) noted can be exceeded based on medical necessity. While it is recognized that involvement of the family in the treatment of individuals with mental illness or substance use disorders is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified recipient's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified recipient's treatment needs are not covered by Medicaid. An asterisk denoting this restriction will appear in each service description that makes reference to a recipient's collateral defined as a family member, legal guardian or significant other. Rehabilitation services that are delivered face to face can either be in person or via telemedicine/telehealth, as approved by the Alabama Medicaid Agency.

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The policy provisions for rehabilitative services providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 47.

105.1 Enrollment

DXC enrolls rehabilitative services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, and the *Alabama Medicaid Agency Administrative Code*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are

scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with the Alabama Medicaid Agency as a rehabilitative services provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for rehabilitation-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Rehabilitative services providers are assigned a provider type of 11 (State Rehabilitative Services). The valid specialties for State Rehabilitative Services are:

- Rehabilitative Services - DMH (111)
- Rehabilitative Services – DHR, DYS, DCA (118)
- Psychiatry (Psychiatrist only) (339)

Enrollment Policy for Rehabilitative Services Providers

To participate in the Alabama Medicaid Program, rehabilitative services providers must meet the following requirements. Service providers must demonstrate that they meet the criteria in either (1), (2), OR (3) and both (4) AND (5) below.

Added: [310-board](#)

1. A provider must be certified as a 310-board community mental health center by DMH and must have demonstrated the capacity to provide access to the following services through direct provision or referral arrangements:
 - Inpatient services through referral to community hospitals and through the attending physician for community hospitalizations
 - Substance abuse services including intensive outpatient services and residential services
 - Must submit an application to and receive approval from DMH to provide mental health rehabilitative services under the Medicaid Rehabilitative Option program.
2. For the provision of Substance Abuse Rehabilitative Services an entity:
 - Must be an organization that is currently certified by the Alabama Department of Mental Health (DMH) to provide alcohol and other drug treatment services under the provisions of Chapter 580 of the Alabama Administrative Code; and
 - Must submit an application to and receive approval by DMH to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.

Added: [Must submit an...Rehabilitative Option program](#)

3. The Department of Human Resources (DHR), the Department of Youth Services (DYS), and the Department of Children's Services (DCA) are eligible to be rehabilitative services providers for children under age 21 if they have demonstrated the capacity to provide an array of medically necessary services, either directly or through contract.

Additionally, DHR may provide these services to adults in protective service status. At a minimum, this array includes the following:

- Individual, group, and family counseling
- Crisis intervention services
- Consultation and education services
- Case management services Assessment and evaluation

4. A provider must demonstrate the capacity to provide services off-site in a manner that assures the recipient's right to privacy and confidentiality and must demonstrate reasonable access to services as evidenced by service location(s), hours of operation, and coordination of services with other community resources.
5. A provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Medicaid does not cover all services listed above, but the provider must have demonstrated the capacity to provide these services.

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105.1.1 Minimum Qualifications for Rehabilitative Services Professional Staff (DMH/DHR/DYS)

Replaced section

Rehabilitative Services must be provided by practitioners who meet the following qualifications:

- Rehabilitative Services Professional:
 - A psychologist licensed under Alabama law
 - A professional counselor licensed under Alabama law
 - A graduate level certified social worker licensed under Alabama law
 - A marriage and family therapist licensed under Alabama law
 - A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
 - A Masters Level Clinician is an individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other human service field areas who meets at least one of the following qualifications:
 - Has successfully completed a practicum as a part of the requirement for the degree or
 - Has six months of post master's level clinical experience
- AND
- Has supervision by a master's level or above clinician with two years of postgraduate clinical experience.

- QSAP I (Substance Abuse): A Qualified Substance Abuse Professional I (QSAP I) shall consist of: (i) An individual licensed in the State of Alabama as a: (I) Professional Counselor, Graduate Level Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician; or (ii) An individual who: (I) Has a master's Degree or above from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, or other behavioral health area with requisite course work equivalent to that of a degree in counseling, psychology, social work, or psychiatric nursing, and * (II) Has successfully completed a clinical practicum or has six month's post master's clinical experience; and * (III) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of date of hire.

105.1.2 Minimum Qualifications for Rehabilitative Services Other Eligible Service Providers (DMH Mental Illness, DMH Substance Abuse, DHR, and DYS)

Replaced section

Rehabilitative Services Mental Illness Professional Staff qualifications are as follows (in addition to the practitioners listed in Section 105.1.1):

- A physician licensed under Alabama law to practice medicine or osteopathy
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses
- A pharmacist licensed under Alabama state law may provide medication monitoring
- A Registered Nurse licensed under Alabama state law
- A Practical Nurse licensed under Alabama state law
- Qualified Mental Health Provider – Bachelor's – A person with a Bachelor's Degree in a human services field
- Qualified Mental Health Provider– Non-Degreed – A person with a high school diploma or GED supervised by a Rehabilitative Services Professional
- A Nursing Assistant certified pursuant to Alabama State Law.
- Medication Assistant Certified (MAC) Worker – A person working under a Medication Assistance Supervising (MAS) nurse that meets the Alabama Board of Nursing requirements.
- A Certified Youth Peer Specialist - Youth who has personal experience with children and adolescent's mental health, who is willing to share his/her personal experiences, who has at least a high school diploma or GED, and who has satisfactorily completed a Youth Peer Specialist training program approved by the state. Certified

Peer Specialist must be supervised by a Rehabilitative Services Professional.

- A Certified Adult Peer Specialist who has personal experience with recovery from mental illness, who is willing to share his/her personal experiences, who has at least a high school diploma or GED, and who has satisfactorily completed a Peer Specialist training program approved by the state. A Certified Adult Peer Specialist must be supervised by a Rehabilitative Services Professional.
- A Parent Peer Support Specialist provider who is parenting or has parented a child experiencing mental, emotional or behavioral health disorders and can articulate the understanding of their experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED and has satisfactorily completed a Parent Peer Support Provider training program approved by state. A Parent Peer Support Specialist must be supervised by a Rehabilitative Services Professional.

Rehabilitative Other Eligible Services Substance Abuse Service

Providers are as follows (in addition to the practitioners listed in Section 105.1.1):

- QSAP II shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Is licensed in the State of Alabama as a Bachelor Level Social Worker; or (III) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (IV) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium.
- QSAP III shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual per week until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of hire.

Replaced section

- Qualified Paraprofessionals (QPP) shall have the following minimum qualifications: (i) A high school diploma or equivalent, and (ii) One (1) year of work experience directly related to job responsibilities and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.
- Certified Recovery Support Specialist (CRSS) / SA Peer Support Specialist must meet the following minimum qualifications: (i) Certified by ADMH as a Certified Recovery Support Specialist (CRSS) within six (6) months of date of hire, (ii) and has 2 years verified lived experience and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.
- A physician licensed under Alabama law
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses
- A Pharmacist licensed under Alabama state law.
- A Registered Nurse licensed under Alabama state law.
- A Practical Nurse licensed under Alabama state law.
- Medication Assistant Certified (MAC) Worker – A person working under a Medication Assistance Supervising (MAS) nurse that meets the Alabama Board of Nursing requirements.

Replaced section

Rehabilitative Services DHR/ DYS/DHR Adult Protective Services Professional Staff qualifications are as follows (in addition to the practitioners listed in Section 105.1.1 and Other Eligible Mental Illness Service Providers above)

- A physician licensed under Alabama law to practice medicine or osteopathy
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A pharmacist licensed under Alabama state law may provide medication monitoring
- Senior Social Work Supervisor – Master’s degree in Social Work from a social work program accredited by the Council on Social Work Education. Two years of professional social work experience in child welfare and/or adult services in a public welfare agency.
- Service Supervisor – Bachelor’s degree from an accredited* four year college or university in any major AND three (3) years of professional social work experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations OR Bachelor’s degree from an accredited* four year college or university AND 30 semester or 45 quarter hours in social or behavioral science courses AND two (2) years of

professional social work experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations. A Master’s Degree in Social Work from a social work program accredited* by the Council on Social Work Education will substitute for one year of the required professional experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations.

- Senior Social Worker - Master’s degree in Social Work from a social work program accredited by the Council on Social Work Education. Eligibility for Licensure as issued by the Alabama Board of Social Work Examiners.
- Social Worker - Bachelor’s degree in Social Work from a social work program accredited by the Council on Social Work Education. Eligibility for Licensure as issued by the Alabama Board of Social Work Examiners
- Social Service Caseworker- Bachelor’s degree from an accredited* college or university in a social science OR a Bachelor’s degree from an accredited* college or university with a degree in any major and at least 30 semester or 45 quarter hours in social or behavioral science courses.

105.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Treatment eligibility is limited to individuals with a diagnosis within the range of 290-316 for ICD-9 or F0150-F99 for ICD-10, assigned by a licensed physician, a licensed psychologist, a licensed physician’s assistant, a certified nurse practitioner, or a licensed professional counselor of mental illness or substance abuse as listed in the most current International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM). Medicaid does not cover the Z codes for adult treatment services; however, it does cover intake evaluation and diagnostic assessment even if the resulting diagnosis is a Z code. For treatment services provided to children under 21, or those adults receiving DHR protective services, the only Z code Medicaid covers for reimbursement is Z65.9 unspecified psychosocial circumstance.

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105.2.1 Covered Services

While Medicaid recognizes that family involvement in the treatment of individuals in need of rehabilitative services is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the recipient’s treatment needs. Medicaid does not cover services for non-Medicaid eligible family members independent of meeting the recipient’s treatment needs.

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Only the following rehabilitative services qualify for reimbursement under this program:

- Intake Evaluation

Updated list

- Medical Assessment and Treatment
- Diagnostic Testing
- Crisis Intervention
- Individual Counseling
- Family Counseling
- Group Counseling
- Medication Administration
- Medication Monitoring
- Partial Hospitalization Program
- Adult Intensive Day Treatment
- Adult Rehabilitative Day Program
- Child and Adolescent Mental Illness Day Treatment
- Treatment Plan Review
- Mental Health Care Coordination
- Adult In-home Intervention
- Child and Adolescent In-Home Intervention
- Mental Health and Substance Use Disorders Update
- Behavioral Health Placement Assessment
- Basic Living Skills
- Psychoeducational Services
- Assertive Community Treatment (ACT)
- Program for Assertive Community Treatment (PACT)
- Opioid Use Disorder Treatment
- Child and Adolescent Peer Support Services
- Adult Peer Support Services
- Family Peer Support Services
- Psychosocial Rehabilitation Services – Working Environment
- Screening
- Brief Intervention
- Nursing Assessment and Care
- Outpatient Detoxification
- Therapeutic Mentoring

This section contains a complete description of each covered service along with benefit limitations.

Services must be provided in a manner that meets the supervisory requirements of the respective certifying authority or as authorized by state law.

Updated section

Intake Evaluation (90791-HE 90791-HF)

HE = Mental Illness HF = Substance Abuse

Definition

Initial clinical evaluation of the recipient's request for assistance. Substance abuse recipients undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, recipient's reported physical and medical condition, the need for additional evaluation and/or treatment, and the recipient's fitness for rehabilitative services.

Key service functions include the following:

- A clinical interview with the recipient and/or collateral
- Screening for needed medical, psychiatric, or neurological assessment, as well as other specialized evaluations
- A brief mental status evaluation
- Review of the recipient's presenting problem, symptoms, functional deficits, and history
- Initial diagnostic formulation
- Development of an initial treatment plan for subsequent treatment and/or evaluation
- Referral to other medical, professional, or community services as indicated

Eligible Provider Type (All Agencies)

Clinical evaluation and assessments of a mental illness recipient may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)
- Social Services Caseworker

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit: Episode

Maximum Units: Unlimited

Billing Restrictions: May not be billed in combination with Treatment Plan Review (H0032)

Location

Updated section

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment and that protects the recipient's rights to privacy and confidentiality.

Additional Information

An intake evaluation must be performed for each recipient considered for initial entry into a treatment program. This requirement applies to any organized program or course of covered services that a recipient enters or attends to receive scheduled or planned rehabilitative services. Individuals who are transferred between programs within an agency **do not** require a new intake at the time of transfer.

The intake evaluation process determines the recipient's need for rehabilitative services based upon an assessment that must include relevant information from the following areas:

- Family history
- Educational history
- Relevant medical background
- Employment/Vocational history
- Psychological/psychiatric treatment history
- Military service history
- Legal history
- Alcohol/Drug use history
- Mental status examination
- A description/summary of the significant problems that the recipient experiences

The intake evaluation process also results in the development of a written treatment plan (service plan, individualized family service plan, plan of care, etc.) completed by the fifth recipient visit or within ten working days after admission into a day treatment or residential program. The treatment plan will do the following:

- Identify the clinical issues that will be the focus of treatment.
- Specify those services necessary to meet the recipient's needs.
- Include referrals as appropriate for needed services not provided directly by the agency.
- Identify expected processes/outcomes toward which the recipient and therapist will be working to impact upon the specific clinical issues.
- Be approved in writing by a licensed psychologist, graduate level certified social worker, professional counselor, a marriage and family therapist, a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses, a registered nurse licensed under Alabama law with master's degree in psychiatric nursing, a physician licensed under Alabama law, or a physician

assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners.

Replaced section

- Service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of intake evaluation, crisis intervention and resolution, mental health care coordination, behavioral health placement assessment, and treatment plan review. Changes in the treatment plan must be approved by a person licensed under Alabama law to practice psychology, certified social work, professional counseling, marriage and family therapy, or medicine; or a registered nurse licensed under Alabama law with master's degree in psychiatric nursing. For child and adolescent services or adults receiving DHR protective services, the person who approves the treatment plan must meet the criteria in Requirements for Recipient Intake, Treatment Planning, and Service Documentation section.

Updated section

Medical Assessment and Treatment (H0004-HE H0004-HF)

Definition

Face-to-face contact with a recipient during which a qualified practitioner provides psychotherapy and/or medical management services. Services may include physical examinations, evaluation of co-morbid medical conditions, development or management of medication regimens, the provision of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services, or the provision of educational services related to management of a physical, mental health, or substance use disorder.

Key service functions include the following:

- Specialized medical/psychiatric assessment of physiological phenomena
- Psychiatric diagnostic evaluation
- Medical/psychiatric therapeutic services
- Assessment of the appropriateness of initiating or continuing the use of psychotropic or detoxification medication

Eligible Provider Type -- (All Agencies)

Physician medical assessment and treatment may be performed by a physician licensed under Alabama law to practice medicine or osteopathy, a physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners, or a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses.

<i>Billing Unit:</i>	15 minutes
<i>Maximum Units:</i>	6 per day, 52 per year
<i>Billing Restrictions:</i>	May not be billed in combination with Partial Hospitalization (H0035), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

All services rendered by a physician, physician assistant, or nurse practitioner that meet the definition above should be billed under this code including those rendered via teleconference with a direct service or consultation recipient.

If this service is provided via video telecommunication, it **must** include the option of an interactive audio and video telecommunications system which permits two-way communication between the distant site physician and the Medicaid recipient. This service does **not** include a telephone conversation, electronic mail message, or facsimile transmission between the physician, recipient, or a consultation between two physicians.

The origination site **must** be located at one of the following:

- Physician's office,
- Hospital,
- Critical access hospital
- Rural health clinic, or
- Federally qualified health center
- Community Mental Health Center (to include co-located sites with partnering agencies)
- Public Health Department

The distant site is the location of the physician providing the telecommunications professional services. This can be within or outside of the state of Alabama as long as the physician has an Alabama license and is enrolled as an Alabama Medicaid provider.

Standards for Recipient/Provider Participation:

Medicaid covers services provided via telemedicine for eligible recipients when the service is medically necessary, the procedure is individualized, specific, consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the recipient's needs.

In order to participate in the telemedicine program:

- a. Physicians must be enrolled with Alabama Medicaid with a specialty type of 931 (Telemedicine Service).
- b. Physician must submit the Telemedicine Service Agreement/Certification form which is located on the Medicaid website at:
http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx. Select Telemedicine Agreement.
- c. Physician must obtain prior consent from the recipient before services are rendered; this will count as part of each recipient's benefit limit of 14 annual physician office visits currently allowed. A sample recipient consent form is located on the Medicaid website at:
http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx

All confidentiality laws and other requirements that apply to written medical records shall apply to electronic medical records, including the actual transmission of the service and any recordings made during the time of the transmission.

All transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telemedicine services shall implement confidentiality protocols that include, but are not limited to:

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Added: recipient

- specifying the individuals who have access to electronic records;
- usage of unique passwords or identifiers for each employee or other person with access to the recipient records;
- ensuring a system to prevent unauthorized access, particularly via the internet
- ensuring a system to routinely track and permanently record access to such electronic medical information.

In order for providers to qualify for Medicaid reimbursement for telemedicine services, the origination site must be located in the state of Alabama. The distant site can be located within or outside the state of Alabama as long as the physician has an Alabama license and is enrolled as an Alabama Medicaid provider. Each telemedicine site shall have established written quality of care protocols and patient confidentiality guidelines to ensure telemedicine services meet the requirements of state and federal laws and professional care standards for recipients.

The physician shall make the protocols and guidelines available for inspection at the telemedicine site, and to the Medicaid Agency upon request.

The physician shall keep a complete medical record on all telemedicine services provided to recipients with documentation of the use of telemedicine technology documented in the record. This will include the treatment plan, progress notes, and treatment plan reviews.

An appropriately trained staff or employee familiar with the recipient's treatment plan or familiar to the recipient must be immediately available in-person to the recipient receiving a telemedicine service to attend to any urgencies or emergencies that may occur during the service. "Immediately available" means the staff or employee must be either in the room or in the area outside the telemedicine room in easy access for the recipient.

If the recipient chooses to waive this requirement, the health care provider administering the telemedicine service shall document this fact in the medical record.

Additionally, in providing telemedicine services, health care providers shall ensure that the telecommunication technology and equipment used at the recipient site, and at the physician site, is sufficient to allow the health care practitioner to appropriately evaluate, diagnose, or treat the recipient for services billed to Medicaid.

Health care physicians and health care facilities shall follow all applicable state and federal laws and regulations governing their practice, including, but not limited to, the requirements for maintaining confidentiality and obtaining informed consent. They shall also verify recipient eligibility prior to administering medical treatments.

Informed Consent:

Prior to an initial telemedicine service, the physician who delivers the service to a recipient shall ensure that the following written information is provided to the recipient in a form and manner which the recipient can understand, using reasonable accommodations when necessary, that:

- S/he retains the option to refuse the telemedicine service at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the recipient would otherwise be entitled;
- Alternative options are available, including in-person services, and these options are specifically listed on the recipient's informed consent statement;
- All existing confidentiality protections apply to the telemedicine consultation;
- S/he has access to all medical information resulting from the telemedicine consultation as provided by law for patient access to his/her medical records;
- The dissemination of any recipient identifiable images or information from the telemedicine consultation to anyone, including researchers, will not occur without the written consent of the recipient;
- S/he has a right to be informed of the parties who will be present at each end of the telemedicine consultation and s/he has the right to exclude anyone from either site; and
- S/he has a right to see an appropriately trained staff or employee in-person immediately after the telemedicine consultation if an urgent need arises, or to be informed ahead of time that this is not available.

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recipient's

The physician shall ensure that the recipient's informed consent has been obtained before providing the initial service. The recipient's signature indicates that s/he understands the information, has discussed this information with the physician or his/her designee, and understands the informed consent may apply to follow-up health services with the same physician. The physician providing the telemedicine service, or staff at the recipient site, shall retain the signed statement and the statement must become a part of the recipient's medical record. A copy of the signed informed consent must also be given to the recipient.

If the recipient is a minor or is incapacitated or is mentally incompetent such that s/he is unable to sign the statement, the recipient's legally authorized representative shall sign the informed consent statement to give consent, and retention and distribution of the consent form shall follow previously noted protocol.

Modifiers:

In addition to modifier HE or HF, all procedure codes billed for telemedicine services must be billed with modifier **GT** (via interactive audio and video telecommunications system). The Agency will **not** reimburse providers for origination site or transmission fees.

January 2019

105-15

Updated section**Diagnostic Testing done by physician or psychologist (96130-HE 96130-HF 96131-HE 96131-HF 96136-HE 96136-HF, 96137-HE 96137-HF)***Definition*

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour** in a face-to-face interaction between the recipient and the psychologist or psychiatrist and interpretation of the test results to assist with a definitive diagnosis. Once the diagnosis has been confirmed, this information is used to guide proper treatment by the development of an individualized, person-centered treatment plan.

Eligible Staff - DMH Mental Illness, DMH Substance Abuse, DHR/DYS/

Procedure codes 96130, 96131, 96137, 96138 -Diagnostic testing may only be performed by:

- A psychiatrist licensed under Alabama law

OR

- A psychologist licensed under Alabama law

<i>Billing Unit:</i>	One hour (96130, 96131) Thirty Minutes (96136, 96137)
<i>Maximum Units:</i>	96130 1 per year 96131 7 per year 96136 1 per year, 96137 11 per year
<i>Billing Restrictions:</i>	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

*Additional Information***Professional and Technical Activities Performed by the Psychologist**

Please note that the new codes **do not** crosswalk on a one-to-one basis with the deleted codes. The single code, 96101, will now be billed using up to four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring (96136, 96137).

- Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision-making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).

- The **first hour** of psychological evaluation is billed using 96130 and **each additional hour** needed to complete the service is billed with the add-on code 96131.
- CPT Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.
- Evaluation services must always be performed by the professional prior to test administration, and may be billed on the same or different days.
- Test administration and scoring services **performed by the psychologist** includes time spent to administer and score a minimum of two (2) psychological tests.
 - The first **30 minutes** of test administration and scoring is billed using 96136 and **each additional 30-minute** increment needed to complete the service is billed with code 96137.
 - CPT time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing (at this time). Billing should reflect the **total** time for face-to-face administration, scoring, interpretation and report writing. The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes.

Updated section

Diagnostic Testing done by technician (96130-HE 96130-HF 96131-HE 96131-HF 96138-HE 96138-HF 96139-HE 96139-HF)

Definition

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour** in a face-to-face interaction between the recipient and the technician and interpreted by a qualified health care professional to assist with a definitive diagnosis. Once the diagnosis has been confirmed, this information is used to guide proper treatment by the development of an individualized, person-centered treatment plan.

Eligible Staff – DMH Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure codes 96130, 96131, 96138, 96139 -Diagnostic testing may be performed by: a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional licensed, (operating within their scope of practice)
- An individual possessing a master’s degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other human service field areas and who meets at least one of the following qualifications:
 - Has successfully completed a practicum as a part of the requirements for the degree
 - Has six months of post master’s level clinical experience supervised by a master’s level or above clinician with two years of postgraduate clinical experience.

Eligible Staff – DMH Substance Abuse Services

Procedure codes 96130, 96131, 96138, 96139 - Diagnostic testing may be performed by a Rehabilitative Services Professional as consistent with the individual’s training, experience and the scope of practice established by his/her respective professional discipline and Alabama law.

<i>Billing Unit:</i>	One hour (96130, 96131) Thirty Minutes (96138, 96139)
<i>Maximum Units:</i>	96130 1 per year 96131 7 per year 96138 1 unit per year 96139 11 units per year
<i>Billing Restrictions:</i>	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient’s rights to privacy and confidentiality.

*Additional Information*Updated
section**Professional Services Performed by the Psychologist and Technical Services Performed by Technician**

Please note that the new codes **do not** crosswalk on a one-to-one basis with the deleted codes. The single code, 96101, will now be billed using up to four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring (96138, 96139).

- Psychological Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision-making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).
 - The first **hour** of psychological evaluation is billed using 96130 and **each additional hour** needed to complete the service is billed with the add-on code 96131.
 - CPT Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.
- Evaluation services must always be performed by the professional prior to test administration, and may be billed on the same or different days.
- Test administration and scoring services **performed by the Technician** includes time spent to administer and score a minimum of two (2) psychological tests.
 - The first **30 minutes** of test administration and scoring is billed using 96136 and **each additional 30-minute** increment needed to complete the service is billed with code 96137.
 - CPT time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Updated section

Diagnostic Testing administered by a computer (96146-HE 96146-HF)

Definition

Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only

Eligible Staff – DMH Mental Illness, DMH Substance Abuse, DHR/DYS/, DHR Adult Protective Services

Diagnostic testing-procedure code 96146 must be administered by a computer and interpreted by a *computer*.

Billing Unit: One

Maximum Units: 1 per year

Billing Restrictions: None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Crisis Intervention (H2011)**Definition**

Immediate emergency intervention with a recipient, or the recipient's collateral* (in person or by telephone) to ameliorate a maladaptive emotional/behavioral reaction by the recipient. Service is designed to resolve crisis and develop symptomatic relief, increase knowledge of resources to assist in mitigating a future crisis, and facilitate return to pre-crisis routine functioning. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural and formal support systems; and referral to alternate services at the appropriate level.

Key service functions include the following:

- Specifying factors that led to the recipient's crisis state, when known
- Identifying the maladaptive reactions exhibited by the recipient
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the recipient for treatment at an alternative setting, when indicated

Eligible Provider Type - All State Agencies

Crisis intervention and resolution may be performed by a person who possesses any one or more of the following qualifications:

- - Rehabilitative Services Professional (all types)
 - Qualified Mental Health Provider – Bachelor's
 - Social Service Caseworker
 - Certified Peer Specialist (Youth, Peer, and Parent)
 - QSAP II
 - QSAP III
 - Certified Recovery Support Specialist (CRSS)

Eligible Provider Type - DHR/ DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit: 15 minutes

Maximum Units: 12 per day, 4380 per calendar year

Billing Restrictions: May not be billed in combination with In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ)

Location

Updated section

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional information

If the recipient is unable to sign a receipt for service or if the service is rendered by phone, the documentation in the recipient's record should so indicate. The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Individual Counseling - (90832, 90834, 90837-HE 90832, 90834, 90837-HF)*Definition*

The utilization of professional skills by a qualified practitioner to assist a recipient in a face-to-face, one-to-one psychotherapeutic encounter in achieving specific objectives of treatment or care for a mental health and/or a substance use disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to a mental health and/or substance use disorder, and restoration of the individual to a level of functioning capable of supporting and sustaining recovery. Individual Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the recipient's treatment plan
- On-going assessment of the recipient's presenting condition and progress made in treatment

Eligible Provider Type – All State Agencies

- *Rehabilitative Services Professional*
- *QSAP II*

Billing Unit: 1 unit

Maximum Unit: 1 per day, 52 per year

Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional information

The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Max Unit = 1 per day

Billing = 1 of the following codes:

- Code 90832 = therapy given for 16 to 37 minutes
- Code 90834 = therapy given for 38 to 52 minutes
- Code 90837 = therapy given for 53 minutes or greater

January 2019

105-23

Updated section

**Family Counseling 90846-HE 90846-HF (without patient present)
90847-HE 90847-HF (with patient present)
90849-HE 90849-HF (multiple family group)**

Definition

A recipient focused intervention that may include the recipient, his/her collateral* and a qualified practitioner. This service is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental health and/or substance use disorder that interferes with the recipient's personal, familial, vocational, and/or community functioning.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the recipient's treatment plan
- On-going assessment of the recipient's presenting condition and progress being made in treatment

Eligible Provider Type – All State Agencies

Family counseling may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional
- QSAP II

MI:

Billing Unit: 1 episode=minimum of 60 minutes
Maximum Units: 1 episode per day, 104 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

SA:

Billing Unit: 1 episode=minimum of 60 minutes (90846-HF/
90847HF)
1 episode=minimum of 90 minutes (90849-HF)
Maximum Units: 1 episode per day, 104 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional information

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session.

When a family consists of a Medicaid eligible adult and child(ren) and the therapy is *not* directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is *not* eligible and the family therapy is directed to the adult and *not* the child, the service may *not* be billed using the child's recipient id number.

If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's recipient id number **must** be used for billing purposes. When a specific child is identified as the primary patient of treatment, that child's recipient ID number **must** be used for billing purposes. A family may be biological, foster, adoptive or other family unit.

A family is *not* a group and providers may *not* submit a claim for each eligible person attending the same family therapy session.

All members of the family in attendance for the session will sign/mark the signature log or progress note to document their participation in the session (in addition to the therapist documenting their presence/participation).

The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Updated section**Group Counseling (90853-HE, 90853-HF)***Definition*

The utilization of professional skills by a qualified practitioner to assist two or more unrelated recipients in a group setting in achieving specific objectives of treatment or care for mental health or substance use disorder. Services are generally directed toward alleviating maladaptive functioning and behavioral, psychological, and/or emotional disturbances, and utilization of the shared experiences of the group's members to assist in restoration of each participant to a level of functioning capable of supporting and sustaining recovery. Group Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic service strategies. Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the recipient's treatment plan
- On-going assessment of the recipient's presenting condition and progress being made in treatment

Eligible Provider Type— All State Agencies

Group counseling may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional
- QSAP II

MI:

Billing Unit: 1 episode=minimum of 60 minutes
Maximum Units: 1 episode per day, 104 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

SA:

Billing Unit: 1 episode=minimum of 90 minutes
Maximum Units: 1 episode per day, 104 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Deleted: client

Added:
recipient

Deleted: client

Additional information

The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR Protective Services.

Added:
recipient's

Updated section

**Medication Administration 96372-HE 96372-HF (Injectable meds)
H0033-HE H0033-HF (oral meds)**

Definition

Administration of oral or injectable medications under the direction of a physician, physician assistant, or certified registered nurse practitioner.

Eligible Provider Type— All State Agencies

Medication administration may be performed by a person who possesses any one or more of the following qualifications:

- A registered nurse licensed under Alabama law
- A licensed practical nurse licensed under Alabama law under the direction of a physician
- MAC Worker

Billing Unit Episode

Maximum Units 1 per day, 365 per year

Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

This service does not include the intravenous administration of medications, nor does it include the preparation of medication trays in a residential setting. Procedure codes 96372 HE, 96372 HF, H0033 HE, or H0033 HF may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Utilization will be monitored through retrospective reviews.

Medication Monitoring (H0034)*Definition*

Face-to-face contact between the recipient and a rehabilitative services, or child and adolescent services/adult protective services professional, pharmacist, RN, or LPN for the purpose of reviewing the medication efficacy; monitoring compliance with dosage instructions; educating the recipient and/or collateral of expected effects of medications; assessing the recipient's need to see the physician; and recommending changes in the medication regimen.

Eligible Provider Type – All State Agencies

Medication monitoring for mental illness and child and adolescent services/adult protective services recipients may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional
- QSAP II
- QSAP III
- Registered Nurse licensed under Alabama law
- Licensed Practical Nurse licensed under Alabama law
- Pharmacist licensed under Alabama law

Billing Unit 15 minutes

Maximum Units 2 per day, 52 per year

Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ), Opioid Use Disorders Program (H0020).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The code Z 65.9 unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Updated section

Partial Hospitalization Program (H0035)

Definition

A physically separate and distinct organizational unit that provides intensive, structured, active, clinical treatment, less than 24 hours per day, with the goal of acute symptom remission, immediate hospital avoidance, and/or reduction of inpatient length of stay, or reduction of severe persistent symptoms and impairments that have not responded to treatment in a less intensive level of care.

Key service functions include the following services, which must be available with the program as indicated by individual recipient need:

- Initial screening to evaluate the appropriateness of the recipient's participation in the program
- Development of an individualized program plan
- Individual, group, and family counseling
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving; as opposed to basic living skills, such as money management, cooking, etc.)
- Medication administration
- Medication monitoring
- Psychoeducational services
- Patient education closely related to the presenting problems, such as diagnosis, symptoms, medication, etc., rather than academic training

Eligible Provider Type – DMH Mental Illness Services/DMH Substance Abuse Services:

MI: The program must have a multi-disciplinary treatment team under the direction of a psychiatrist, certified registered nurse practitioner, or physician's assistant. The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, the treatment team will include a:

- Physician, Physician assistant, OR Licensed Certified Registered Nurse Practitioner (CRNP); and
- Rehabilitative Services Professional; and
- Licensed practical nurse, and/or
- Qualified Mental Health Provider- Bachelor's OR Qualified Mental Health Provider – Non-Degreed OR Certified Adult Peer Specialist

SA: The program must be staffed and have a program coordinator as specified in current and subsequent revisions of regulations established for this service by the Alabama Department of Mental Health Substance Abuse Services Administrative Code.

- Rehabilitative Services Professional
- QSAP II
- QSAP III
- Peer Support Specialist
- QPP
- Licensed Practical Nurse

Billing Unit: A minimum of 4 hours

Maximum Units: 1 per day, 130 days per year

Billing Restrictions: May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Physician Medical Assessment and Treatment (H0004), Medication Administration (96372 HE, 96372 HF, H0033), Medication Monitoring (H0034), Intensive Day Treatment (H2012), and Rehabilitative Day Program (H2017). These restrictions apply while a recipient is attending/actively enrolled in Partial Hospitalization whether or not the restricted services occur on the same day as Partial Hospitalization.

Deleted: client
 Added: recipient

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment and that protects the recipient's rights to privacy and confidentiality.

Deleted: client
 Added: recipient

Additional Information

H0035 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 130 units per year. Utilization will be monitored through retrospective reviews.

Deleted: client
 Added: recipient's

Added: Mental Illness

Adult Mental Illness Intensive Day Treatment (H2012)

Definition

Deleted: acquisition/

Added: services

Deleted: client

Added: recipient's

Deleted: client

Added: recipient

Deleted: client

Added: recipient's

Deleted: Activity/creational therapy...field trips)

An identifiable and distinct program that provides highly structured services designed to bridge acute treatment and less intensive services, such as Rehabilitative Day Program and Outpatient services, with the goals of community living skills enhancement, increased level of functioning, and enhanced community integration. Intensive Day Treatment shall constitute active, intermediate level treatment that specifically address the recipient's impairments, deficits, and clinical needs.

The following services must be available within the program as indicated by individual recipient need:

- Initial screening to evaluate the appropriateness of the recipient's participation in the program
- Development of an individualized program
- Individual, group, and family counseling
- Social skills training (e.g., conversation and interpersonal skills)
- Coping skills training (e.g., stress management, symptom management, problem solving)
- Utilization of community resources
- Family education closely related to the presenting problems such as diagnosis, symptoms, medication, coping skills, etc.)
- Basic living skills (e.g., Adult Basic Education, GED, shopping, cooking, housekeeping, grooming)
- Medication administration
- Medication monitoring
- Recipient education closely related to presenting problems, such as diagnosis, symptoms, medication, etc. rather than academic training

Updated section

Eligible Provider Type– DMH Mental Illness Services

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Rehabilitative Services Professional (all types)

As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:

- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Peer Specialist - Adult

Billing Unit: One hour

Maximum Units: 4 per day, 1040 hours per year

Billing Restrictions: May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Medication Administration

(96372 HE, 96372 HF, H0033), Medication Monitoring (H0034), Partial Hospitalization Program (H0035), and Rehabilitative Day Program (H2017). These restrictions apply while a recipient is attending/actively enrolled in Intensive Day Treatment whether or not the restricted services occur on the same day as Intensive Day Treatment.

Deleted: ~~client~~
 Added: recipient

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Deleted: ~~client~~
 Added: recipient
 Deleted: ~~client~~
 Added: recipient

Updated section

Adult Rehabilitative Day Program (H2017)

Definition

An identifiable and distinct program that provides long-term recovery services with the goals of improving functioning, facilitating recovery, achieving personal life goals, regaining feelings of self-worth, optimizing illness management, and helping to restore a recipient to productive participation in family and community life. The Rehabilitative Day Program constitutes active structure, rehabilitative interventions that specifically address the individual's life goals, builds on personal strengths and assets, improves functioning, increases skills, promotes a positive quality of life, and develops support networks. The Rehabilitative Day Program should provide (1) and (2) below and at least one more service from the following list of services based on the needs and preferences of recipients participating in the program.

Key service functions include the following:

1. Initial screening to evaluate the appropriateness of the recipient's participation in the program
2. Development of an individualized program plan
 - Individual, group, and family counseling
 - Psychoeducational services
 - Basic living Skills
 - Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, a problem solving)
 - Medication administration
 - Medication monitoring
 - Utilization of community resources

Eligible Provider Type – DMH Mental Illness

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Rehabilitative Services Professional (all types)

As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:

- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Peer Specialist - Youth
- Certified Peer Specialist - Adult

Billing Unit: 15 minutes
Maximum Units: 16 per day, 4160 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization Program (H0035) or Adult Mental Illness Intensive Day Treatment (H2012).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Deleted: client

Added:
recipient

Deleted: client

Added:
recipient's

Updated section**Child and Adolescent Mental Illness Day Treatment (H2012-HA)***Definition*

A combination of goal-oriented rehabilitative services designed to improve the ability of a recipient to function as productively as possible in their regular home, school, and community setting when impaired by the effects of a mental or emotional disorder. Programs that provide an academic curriculum as defined by or registered with the State Department of Education and that students attend in lieu of a local education agency cannot bill Medicaid for the time devoted to academic instruction.

Key service functions include the following:

- Initial screening to evaluate the appropriateness of the recipient's participation in the program
- Development of an individualized program plan
- Individual, group and family counseling
- Psychoeducational Services.
- Basic Living Skills
- Coping skills training closely related to presenting problems (e.g., stress management, assertiveness training, and problem solving)
- Medication Administration
- Medication Monitoring

Eligible Provider Type – DMH Mental Illness, DHR

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Rehabilitative Services Professional (all types)

As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:

- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Peer Specialist - Youth
- Certified Peer Specialist - Parent

<i>Billing Unit:</i>	One hour
<i>Maximum Units:</i>	4 per day, 1040 per year
<i>Billing Restrictions:</i>	May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Medication Administration (96372 HE, 96372 HF, H0033), Medication Monitoring (H0034). These restrictions apply while a recipient is actively enrolled in Day Treatment whether or not the restricted services occur on the same day as Day Treatment.

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Deleted: ~~client~~
Added: recipient

Deleted: ~~client~~

Added: recipient's

Updated section**Treatment Plan Review (H0032)***Definition*

Review and/or revision of a recipient's individualized mental health and/or substance use disorder treatment plan by a qualified staff member who is not the primary therapist nor directly involved in providing services to the recipient. This review will evaluate the recipient's progress toward treatment objectives, the appropriateness of services being provided, and the need for a recipient's continued participation in treatment. This service does not include those activities or costs associated with direct interaction between a recipient and his or her primary therapist regarding the recipient's treatment plan. That interaction must be billed through an alternative service, such as individual counseling.

Eligible Provider Type – All State Agencies

Treatment plan review, for mental illness, substance abuse, and child and adolescent services/adult protective services recipients, may be performed by a person who possesses any one or more of the following qualifications:

- Physician
- Physician Assistant
- Certified Registered Nurse Practitioner (CRNP)
- Rehabilitative Services Professional (licensed only)
- Service Supervisor
- Senior Social Work Supervisor

Billing Unit: 15 minutes

Maximum Units: 1 event with up to 2 units per quarter, 8 per year

Billing Restrictions: May not be billed in combination with Intake Evaluation (90791), Child and Adolescent In-Home Intervention (H2022-HA), ACT (H0040), and PACT (H0040-HQ).

Location

This service may be provided wherever the recipient's clinical record is stored. This service may be billed while a recipient is in an inpatient setting since it is not a face to face service.

Additional Information

The recipient's treatment plan must be reviewed at least every three months. In cases where only an intake or diagnostic assessment is provided with no further treatment, treatment plan reviews are not covered. One treatment plan review will be covered following a three-month interval of no services delivered; any subsequent reviews with no intervening treatment are disallowed.

Providers must document this review in the recipient's clinical record by noting on the treatment plan that it has been reviewed and updated or continued without change. Medicaid covers this service for mental illness and substance use disorder diagnoses only. The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services. The person who completes the treatment plan review for DHR children, adolescents, or adults must meet the criteria in Section 105.2.3.

Deleted: ~~client~~

Added:
recipient's

Updated section

Mental Health Care Coordination (H0046)

Definition

Services to assist an identified Medicaid recipient to receive coordinated mental health services from external agencies, providers or independent practitioners.

Key service functions include written or oral interaction in a clinical capacity in order to assist another provider in addressing the specific rehabilitative needs of the recipient, as well as to support continuation of care for the recipient in another setting.

Eligible Provider Type – All State Agencies

- Rehabilitative Services Professional (all types)
- Social Service Caseworker

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit: 15 minutes

Maximum Units: 24 per day, 312 per year

Billing Restrictions: ACT (H0040), PACT (H0040-HQ), In-Home Intervention (H2021, H2022-HA)

Location

There are no excluded settings. This service may be billed while a recipient is in an inpatient setting since it is not a face to face service.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Consults may be billed for the staff time spent obtaining prior authorizations and overrides for prescription medications. In addition to the eligible staff listed above LPNs may bill for their time directly related to performing this activity. LPNs **are not** eligible to bill for consults for any other type of activity. Acceptable documentation can be a progress note entered in the recipient's record or the approved authorization/override form filed in the record and dated and signed by the staff member performing the work.

(Adult) In-Home Intervention (H2021)**Definition**

Home based services provided by a treatment team (two-person team) to serve individuals who refuse other outpatient services and/or who need temporary additional support due to increased symptoms or transition from a more intense level of services, to defuse an immediate crisis situation, stabilize the living arrangement, and/or prevent out of home placement of the recipient.

Key service functions include the following when provided by a team composed of a Rehabilitative Services Professional (master's level clinician) and either a Qualified Mental Health Provider – Bachelor's or a Certified Peer Specialist - Adult:

- Individual or family counseling
- Crisis intervention
- Mental Health Care Coordination
- Basic Living Skills
- Psychoeducational Services
- Case Management
- Medication Monitoring
- Medication Administration
- Peer Services (only when team member is a Certified Peer Specialist – Adult)

Key service functions include the following when provided by a team composed of a Registered Nurse and a Qualified Mental Health Provider – Bachelor's or a Certified Peer Specialist - Adult:

- Crisis Intervention
- Mental health Care Coordination
- Basic Living Skills
- Psychoeducational Services
- Case Management
- Medication Monitoring
- Medication Administration
- Peer Services (only when team member is a Certified Peer Specialist – Adult)

Eligible Provider Type – DMH Mental Illness

In-home intervention for mental illness recipients are provided by a two-person team minimally composed of the following:

- A rehabilitative services professional (Master's level) or
- A registered nurse licensed under Alabama law and either
- A Qualified Mental Health Provider – Bachelor's or
- A Certified Peer Specialist - Adult

Updated section

All team members must successfully complete an approved case management-training program.

Maximum Units: 24 per day, 2016 per year

Billing Restrictions: May not be billed in combination with Individual Counseling (90832), Family Counseling (90846, 90847, 90849), Mental Health Care Coordination (H0046), Case Management, Family Support (H2027), Basic Living Skills (H0036) or Medication Monitoring (H0034)

Location

Please note that in-home intervention, while by definition and practice is usually provided in the recipient's home, infrequently may be provided in other locations. Such exceptions will not render the service ineligible for billing as In-Home Intervention.

When the Adult In-Home Intervention team members are together in the same location providing services as a team, H2021 must be billed and unbundled services cannot be billed for that time period. When the team members work independently of each other, each team member must document as to the specific service rendered and bill under the applicable code [i.e. Individual Counseling (90804), Mental Health Care Coordination (H0046), etc.] and the billing restrictions will not apply. Travel time to and from the service location must be excluded from the billing.

Utilization will be monitored through retrospective reviews.

Child and Adolescent In-Home Intervention (H2022-HA)**Definition**

Structured, consistent, strength-based therapeutic intervention provided by a team for a child or youth with a serious emotional disturbance (SED) and his or her family for the purpose of treating the child's or youth's behavioral health needs. In-Home Intervention also addresses the family's ability to provide effective support for the child or youth, and enhances the family's capacity to improve the child's or youth's functioning in the home and community. Services are directed towards the identified youth and his or her behavioral health needs and goals as identified in the treatment plan or positive-behavior support plan are developed by a qualified behavioral clinician where appropriate. Services include therapeutic and rehabilitative interventions, including counseling and crisis intervention services, with the individual and family to correct or ameliorate symptoms of mental health conditions and to reduce the likelihood of the need for more intensive or restrictive services.

These services are delivered in the family's home or other community setting and promote a family-based focus in order to evaluate the nature of the difficulties, defuse behavioral health crises, intervene to reduce the likelihood of a recurrence, ensure linkage to needed community services and resources, and improve the individual child's/adolescent's ability to self-recognize and self-managed behavioral health issues, as well as the parents' or responsible caregivers' skills to care for their child's or youth's mental health conditions. The In-Home Intervention team provides crisis services to children and youth served by the team.

Key service functions include the following:

- Individual Counseling
- Family Counseling
- Psychoeducation
- Basic Living Skills
- Crisis intervention (24 hour availability)
- Medication Monitoring
- Mental Health Care Coordination
- Treatment Plan Review

Eligible Provider Type – DMH Mental Illness

In-home intervention for mental illness recipients may be provided by a two-person team minimally composed of the following:

- A rehabilitative services professional staff and either
 - A Qualified Mental Health Provider – Bachelor's
- or
- Certified Peer Specialist - Parent

All team members must successfully complete an approved case management-training program.

Updated section

Billing Unit: One day (children)

Billing Restrictions: May not be billed in combination with Crisis Intervention (H2011), Individual Counseling (90804), Family Counseling (90846, 90847, 90849), Treatment Plan Review (H0032), Mental Health Care Coordination (H0046), Psychoeducation (H2027), Basic Living Skills (H0036) or Medication Monitoring (H0034) while a family is enrolled in In-Home intervention.

Location

Please note that In-Home intervention, while by definition and practice is usually provided in the child or adolescent consumer's home, infrequently may be provided in non-traditional settings including educational, child-welfare, family court, local parks, or clinic, etc. Such exceptions will not render the service ineligible for billing.

Additional Information

- Medicaid covers this service for mental illness diagnoses only.
- Only persons who meet the definition for Serious Emotional Disturbance (SED) and who are at imminent danger of removal from the home are eligible for this service.
- The team will primarily be together during the provision of services to children and their families, but some of the services have to be provided separately.
- These services should be billed on a per diem basis while the family is enrolled and receiving in-home intervention services even though a service might not be provided every day.
- Span-billing may be utilized by multiplying the appropriate number of units for the month by the daily rate.
- Covered for children and adolescents only (age 5 to 18 years of age).
- Covered for transitional age young adults (age 18 to 26 years of age).
- The active caseload for a team will not exceed six (6) families.
- In-home must be available other than 8:00 A.M. to 5:00 P.M.
- The intensive nature of this service should be reflected in the average hours of direct service per family per week.
- In-Home Intervention should follow service delivery patterns taught in the DMH approved In-Home Training Program to maintain the consistency and fidelity of the model.

- Treatment Plan must be completed within 30 days of the first face-to-face contact with the consumer. The Treatment Plan should address the treatment needs identified by the approved assessment tool.
- Signatures for services are secured on the day the service is delivered.
- In-Home Intervention Services are discontinued and enrollees are referred to other services when the team is no longer a two-person team. Examples would include the loss of one of the team members, extended illness, maternity leave, etc. exceeding a two week period.
- Utilization will be monitored through retrospective reviews.

Updated section

Behavioral Health Placement Assessment (H0002-HE)

Definition

A structured face-to-face interview process conducted by a qualified professional for the purpose of identifying a recipient's presenting strengths and needs and establishing a corresponding recommendation for placement in an appropriate level of care. This process may incorporate determination of the appropriateness of admission/commitment to a state psychiatric hospital or a local inpatient psychiatric unit.

Key service functions include the following:

- A clinical assessment of the recipient's need for local or state psychiatric hospitalization
- An assessment of whether the recipient meets involuntary commitment criteria, if applicable
- Preparation of reports for the judicial system and/or testimony presented during the course of commitment hearing
- An assessment of whether other less restrictive treatment alternatives are appropriate and available
- Referral to other appropriate and available treatment alternatives

Eligible Provider Type – DMH Mental Illness, DHR/ DHR Adult Protective Services

Behavioral Health Placement Assessment may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)
- Licensed registered nurse

Billing Unit: 30 minutes

Maximum Units: 4 per day, 16 per year

Billing Restrictions: None

Location

Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Updated section

Additional Information

Providers may bill for time spent in court testimony while a recipient is in an inpatient unit.

Updated section

Basic Living Skills (H0036 – Individual; H0036-HQ – Group)

Definition

Psychosocial services provided to an individual or group to restore skills that enable a recipient to establish and improve community tenure and to increase his or her capacity for age-appropriate independent living. This service also includes training about the nature of illness, symptoms, and the recipient's role in management of the illness.

Key services functions include the following:

- Training and assistance in developing or maintaining skills such as personal hygiene, housekeeping, meal preparation, shopping, laundry, money management, using public transportation, medication management, healthy lifestyle, stress management, and behavior education appropriate to the age and setting of the recipient
- Patient education about the nature of the illness, symptoms, and the recipient's role in management of the illness

Eligible Provider Type– All State Agencies

Basic living skills may be provided by an individual supervised by a staff member who meets at least one of the following qualifications:

- Rehabilitative Services Professional (all types),
- Licensed Registered nurse,
- Social Service Caseworker,
- Qualified Mental Health Provider – Bachelor's, or
- Qualified Mental Health Provider – Non-Degreed
- QSAP II
- QSAP III
- QPP

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

<i>Billing Unit:</i>	15 minutes
<i>Maximum Units:</i>	2080 units per year
	20 per day (individual)
	8 per day (group)
<i>Billing Restrictions:</i>	May not be billed in combination with In-Home Intervention (H2021,H2022-HA), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Deleted: client,
client

Added:
recipient,
recipient's

Updated section

Psychoeducational Services (H2027 – Individual; H2027-HQ – Group)

Definition

Structured, topic specific educational services provided to assist the recipient and the families* of recipients in understanding the nature of the identified behavioral health disorder, symptoms, management of the disorder, how to help the recipient be supported in the community and to identify strategies to support restoration of the recipient to his/her best possible level of functioning.

Key service functions include, as appropriate, but are not limited to education about the following:

- The nature of the illness
- Expected symptoms
- Medication management
- Ways in which the family member can cope with the illness

Eligible Provider Type– All State Agencies

Psychoeducational services may be provided by an individual supervised by a staff member who meets at least one of the following qualifications:

- Rehabilitative Services Professional (all types),
- Social Service Caseworker,
- Licensed Registered Nurse
- Qualified Mental Health Provider – Bachelor's, or
- Qualified Mental Health Provider – Non-Degreed
- QSAP II
- QSAP III

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit: 15 minutes

Maximum Units: 416 units per year

8 per day for services provided to an individual recipient's family

8 per day for services provided to a group of recipients' families

Billing Restrictions: May not be billed in combination with In-Home Intervention (H2021, H2022-HA) Family Counseling (90846 HE, 90846 HF,

90847 HE, 90847 HF, 90849 HE, 90849 HF), ACT (H0040), PACT (H0040-HQ)

Location

Services can be delivered in any setting that is convenient for both the family and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Deleted:
client

Added:
recipient's

Updated section

Assertive Community Treatment (ACT) (H0040) **Program for Assertive Community Treatment (PACT) (H0040-HQ)**

Definition

Treatment services provided primarily in a non-treatment setting by a member of an ACT or PACT team, staffed pursuant to ADMH regulations promulgated in the Alabama Administrative Code for adult recipients with serious mental illness or co-occurring substance use and mental health disorders who are in a high-risk period due to an exacerbation of the behavioral health disorder and/or returning from an episode of inpatient/residential psychiatric care, or who are consistently resistant to traditional clinic-based treatment interventions and are difficult to engage in an ongoing treatment program.

Key service functions include, but are not limited to, the following:

- Intake
- Medical assessment and treatment
- Medication administration
- Medication monitoring
- Individual, group, and/or family counseling
- Crisis intervention
- Mental health care coordination
- Case management
- Psychoeducational Services
- Basic living skills

The only services that may be billed in addition to ACT or PACT are Partial Hospitalization (H0035), Intensive Day Treatment (H2012), and Rehabilitative Day Program (H2017). Billing in combination with Rehabilitative Day Program should occur only on a transitional basis (within 14 calendar days) as a recipient moves from a team intervention to a less acute array of individually delivered services.

Eligible Provider Type– DMH Mental Illness

The program must be staffed by an assigned team with a minimum of three FTE staff. The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

Of the three FTE staff, it is required to have a least:

- *1 full-time Rehabilitative Services Professional (master's level clinician)*
- *1 full-time Qualified Mental Health Provider – Bachelor's, and*
- *.50 FTE of either an RN or LPN.*

There must be an assigned (ACT or PACT) team that is identifiable by job title, job description, and job function. The team must be staffed in accordance with DMH certification standards. Each member of the team must be known to the recipient and must individually provide services to each recipient in the team's caseload. The team will conduct a staffing of all assigned cases at least twice weekly. The caseload cannot exceed a 1:12 staff to recipient ratio on an ACT team where the part-time psychiatrist is not

counted as one staff member or a 1:10 staff to recipient ratio on a PACT team.

Updated section

<i>Billing Unit:</i>	One day
<i>Maximum Units:</i>	365 days per year
<i>Billing Restrictions:</i>	May not be billed in combination with Intake Evaluation (90791), Physician Medical Assessment and Treatment (H0004), Medication Administration (96372-HE), Medication Monitoring (H0034), Basic Living Skills (H0036), Family Support (H2027), Individual (90804-HE), Family (90846-HE, 90847-HE, 90849-HE), Group Counseling (90853-HE), Crisis Intervention (H2011), Mental Health Care Coordination (H0046) , or Treatment Plan Review (H0032) .

Location

The only excluded settings are nursing homes. ACT and PACT services may be billed on a daily basis even though the recipient might not be seen or contacted by the team each day. ACT and PACT services may be billed while a recipient is hospitalized briefly for stabilization or medical treatment. Services can be delivered in any setting that is convenient for both the family and staff member, that affords an adequate service environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

Documentation of the required staffing and all recipient contacts by ACT and PACT team members shall be included in the recipient's medical record. All service documentation shall follow the guidelines in Section 105.2.3. Recipient signatures are not required for ACT and PACT key service functions; however, services which are provided outside the ACT and PACT benefit will require recipient signatures. H0040 and H0040-HQ may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per calendar year. Utilization will be monitored through retrospective reviews.

Updated section

Opioid Use Disorder Treatment (H0020)

Definition

The administration of medication, including the use of FDA approved medications for the use of opioid use disorders, to recipients who have a diagnosed opioid use disorder. Medication is administered to support the recipient's efforts to restore adequate functioning in major life areas that have been debilitated as a result of opioid addiction. This service includes medication administration and concurrent related medical, clinical and case management services.

Eligible Provider Type – DMH Substance Abuse

The program must be staffed and have a Program Coordinator as specified in current and subsequent revisions of:

- (1) State regulations established for this service by the Alabama Department of Mental Health and published in the Alabama Administrative Code; and
- (2) Federal regulations established for this service by the Substance Abuse and Mental Health Services Administration

Eligible Provider Type for Administration of Medication:

- Physician
- Physician's Assistant
- CRNP
- RN
- LPN

Billing Unit: One day

Maximum Units: 365 per year

Billing Restrictions: None

Location

Services can be delivered in any setting that is acceptable for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

Additional Information

H0020 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Please utilize the AM modifier when billing for Buprenorphine. Utilization will be monitored through retrospective reviews.

Outpatient Detoxification (H0013, H0014)

Added new
section

Definition

Face-to-face interactions with a recipient for the purpose of medically managing mild to moderate withdrawal symptoms from alcohol and/or other drugs in an ambulatory setting. Services are provided in regularly scheduled sessions under a defined set of policies, procedures, and medical protocols by authorized medical personnel.

Eligible Provider Type – DMH Substance Abuse

The program must be staffed and have a Program Coordinator as specified in current and subsequent revisions of regulations established for this service by the Alabama Department of Mental Health Substance Abuse Services Administrative Code.

Eligible Provider Type:

- Rehabilitative Services Professional
- QSAP II
- QSAP III
- SA Peer Support Specialist
- QPP, with specialized training
- Licensed Registered Nurse
- Licensed Practical Nurse

Billing Unit: 1 day;

Maximum Units: 25 days per year

Added new section

Peer Support Services (H0038-HE, H0038-HF, H0038-HQ)

Definition

Peer Support Service (Adult/Child and Adolescent/Family/Recovery Support Specialist) – Peer Support services provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists (Adult, Youth, Family Peer Specialists, Recovery Support Specialist). Peer Support service actively engages and empowers an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote recovery, resiliency and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions. Peer supports provide effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan. Family peer specialists assist children, youth, and families to participate in the wraparound planning process, access services, and navigate complicated adult/child-serving agencies.

Eligible Provider Type – DMH Mental Illness, DMH Substance Abuse, DHR

MI: Certified Peer Specialist – Youth

Certified Peer Specialist – Adult

Certified Peer Specialist – Parent

DMH – SA: Certified Recovery Support Specialist (CRSS)

Billing Unit: 15 minutes

Maximum Units: Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services.

Psychosocial Rehabilitation Services – Working Environment (H2025-HE, H2025-HF)

Added new section

Definition

Psychosocial services that provide rehabilitative supports with the goal of restoring skills needed to be prepared for community-living activities that may result in employability, promote recovery/wellness, prevent the escalation of a mental health condition into a crisis situation or into a chronic/significantly disabling disorder, improve community-based functioning, alleviate symptoms, and decreasing isolation. The goal of the service is to help recipients be prepared for community-living/activities that may ultimately result in employability. This service does not include educational, vocational or job training services.

Eligible Staff – DMH Mental Illness, DMH Substance Abuse

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

- Rehabilitative Services Professional (all types)
- Qualified Mental Health Provider – Bachelor’s
- Qualified Mental Health Provider – Non-Degreed
- Certified Peer Specialist
- QSAP II
- QSAP III
- QPP (Qualified Paraprofessionals)

Billing Unit: 15 minutes.

Maximum Units: 32 units per day, 320 units per month

Added new
section

Screening (H-0049-HF)

Definition

An encounter in which a brief, valid, questionnaire is administered by trained personnel to examine the context, frequency, and amount of alcohol or other drugs used by a recipient. This process seeks to identify recipients who have an alcohol or drug use disorder or are at risk for development of such. The service includes feedback on the screening results, and recommendations and referral for additional services, if indicated. This is a covered service for recipients whose use of alcohol and/or drugs has adversely impacted functioning in a major life area.

Eligible Staff – DMH Substance Abuse, DHR

- Rehabilitative Services Professional
- QSAP II
- QSAP III
- QPP, with specialized training

Billing Unit: Episode

Maximum Units: 2 units per year

Brief Intervention (H0050-HF)Added new
section

Definition

A brief motivational encounter conducted after a recipient has completed an approved alcohol and drug screening procedure in which a potential alcohol or drug use problem was identified. During this brief encounter, a trained clinician provides feedback on the recipient's alcohol and/or drug use patterns, expresses concerns about the pattern of use as clinically indicated, provides advice in regard to strategies to eliminate or cut back in regard to destructive alcohol/drug use patterns, assists in development of an action plan, and initiates referrals as appropriate.

Eligible Provider Type – DMH Substance Abuse, DHR

- Rehabilitative Services Professional
- QSAP II
- QSAP III
- QPP, with specialized training

Billing Unit: 15 minutes

Maximum Units: 8 units per year

Added new section

Nursing Assessment and Care (T1001-HE, T1001-HF, T1002-HE, T1002-HF, T1003-HE, T1003-HF, 96150-HE, 96150-HF, 96151-HE, 96150-HF)

Definition

Nursing Assessment and Care services are face-to-face (in person or via telemedicine/telehealth) contacts with an individual to monitor, evaluate, assess, establish nursing goals, and/or carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health conditions of an individual as specified in the individualized recovery plan. It includes providing special nursing assessments to observe, monitor and care for physical, nutritional and psychological issues or crises manifested in the course of the individual's treatment; to assess and monitor individual's response to medication to determine the need to continue medication and/or for a physician referral for a medication review; assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication; consultation with the individual's family and/or significant others for the benefit of the client about medical and nutritional issues; to determine biological, psychological, and social factors which impact the individual's physical health and to subsequently promote wellness and healthy behavior and provide medication education and medication self-administration training to the individual and family.

Eligible Provider Type – All State Agencies

- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Nursing Assistant
- MAC Worker

Billing Unit: 15 minutes

Maximum Units: 2 units per day in a specialized level of care; 732 units per year

Therapeutic Mentoring (H2019 – HN)Added new
section**Definition**

Therapeutic Mentoring Services provide a structured one on one intervention to a child or youth and their families that is designed to ameliorate behavioral health-related conditions that prevent age-appropriate social functioning. This service includes supporting and preparing the child or youth in age-appropriate behaviors by restoring daily living, social and communication skills that have been adversely impacted by a behavioral health condition. These services must be delivered according to an individualized treatment plan and progress towards meeting the identified goals must be monitored and communicated regularly to the clinician so that the treatment plan can be modified as necessary. Therapeutic mentoring may take place in a variety of settings including the home, school or other community settings. The therapeutic mentor does not provide social, educational, recreational or vocational services.

Eligible Provider Type – All State Agencies

- Rehabilitative Services Professional (all types)
- Social Service Caseworker
- Licensed Registered Nurse
- Qualified Mental Health Provider – Bachelor's Or,
- Qualified Mental Health Provider – Non-Degreed

Billing Unit: 15 minutes**Maximum Units:** 416 per year (416 units per year for individual and 416 units per year for group)

8 units (unit = 15 minutes) per day, individual

8 units (unit = 15 minutes) per day, group

105.2.2 Reimbursement

The Medicaid reimbursement for each service provided by a rehabilitative services provider is based on the following criteria and does not exceed the lowest of the following amounts:

- The customary charges of the provider but not more than the prevailing charges in the locality for comparable services under comparable circumstances
- The amount billed
- The fee schedule established by Medicaid as the maximum allowable amount
- Reimbursement for services provided by state agencies is based on actual costs as follows:
 - Agencies must submit an annual cost report not later than 60 days following the close of the fiscal year. This report must indicate not only the costs associated with providing the services, but also statistical data indicating the units of service provided during the fiscal year.
 - Medicaid will review cost reports for reasonableness and an average cost per unit of service will be computed.
 - Medicaid will use the average cost, trended for any expected inflation, as the reimbursement rate for the succeeding year.
 - If the cost report indicates any underpayment or overpayment for services during the reporting year, Medicaid will make a lump sum adjustment.
 - New rates are effective January 1 of each year.

Actual reimbursement is based on the rate in effect on the date of service. Only those services that qualify for reimbursement are covered under this program.

105.2.3 Requirements for Recipient Intake, Treatment Planning, and Service Documentation

An intake evaluation must be performed for each recipient considered for initial entry into organized programs or course of covered services. Individuals who are transferred between programs within an agency do not require a new intake at the time of transfer.

To determine a recipient's need for rehabilitative services, providers must perform an intake evaluation based on assessment of the following information:

- Family history
- Educational history
- Relevant medical background
- Employment/vocational history
- Psychological/psychiatric treatment history
- Military service history
- Legal history
- Alcohol/drug use history
- Mental status examination
- A description of the significant problems that the recipient is experiencing

Providers use the standardized substance abuse psychosocial assessment as the intake instrument for substance abuse recipients.

Added new section

Eligible Provider Type -- DMH Mental Illness

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth recipient visit or within ten working days after admission into a day treatment program, substance abuse intensive outpatient program, or residential program. The treatment plan must include the following:

- Represents a person-centered, recovery-oriented treatment planning process through which consumers are assisted to articulate their vision and hope for how their lives will be changed for the better within three to five years (long term recovery vision), to identify short-term outcomes that will assist in achieving the recovery goal (treatment goals), and to specify services and supports including referrals to outside agencies necessary to overcome barriers to achieving the outcomes (necessary services and supports)
- Identifies needed safety interventions based on history of harm to self or others
- Uses a strengths-based approach to treatment planning by identifying consumer and environmental positive attributes that can be used to support achievement of goals and objectives
- Identifies psychiatric, psychological, environmental, and skills deficits that are barriers to achieving desired outcomes

- Identifies treatment and supports that are needed to address barriers to achieving desired therapeutic goal

Revised section

Eligible Provider Type – DMH Substance Abuse/DHR/DYS/DHR Adult Protective Services

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth recipient visit or within ten working days after admission into a day treatment program, substance abuse intensive outpatient program, or residential program. The treatment plan must include the following:

- Identification of the clinical issues that will be the focus of treatment
- Specific services necessary to meet the recipient's needs
- Referrals as appropriate for needed services not provided directly by the agency
- Identification of expected outcomes toward which the recipient and therapist will be working to impact upon the specific clinical issues

Unless clinically contraindicated, the recipient will sign/mark the treatment plan to document the consumer's/recipient's participation in developing and/or revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent/foster parent/legal guardian must sign the treatment plan.

All State Agencies: The treatment plan must be approved in writing by any one of the following:

- Physician
- Physician Assistant
- Certified Registered Nurse Practitioner (CRNP)
- Rehabilitative Services Professional (licensed only)
- Service Supervisor
- Senior Social Work Supervisor

Service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of intake evaluation, crisis intervention and resolution, mental health care coordination, behavioral health placement assessment, and treatment plan review. Changes in the treatment plan must be approved as described above.

The preferred course of treatment for persons with co-occurring disorders (MI/SA) is integrated services where both mental illness and substance abuse clinical issues are addressed in the same treatment setting, whether that setting primarily provides mental illness or substance abuse treatment. In cases where integrated services are not possible, a dually diagnosed recipient may receive mental illness and substance abuse services simultaneously from one or more certified providers. In cases where mental illness and substance abuse services are provided independently, the daily caps specific to each service are cumulative for the day and are not interactive.

In all cases, the diagnosis and treatment plan should reflect both disorders and the interventions needed for both.

After completion of the initial treatment plan, staff must review the recipient's treatment plan once every three months to determine the recipient's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. Providers must document this review in the recipient's clinical record by noting on the treatment plan that it has been reviewed and updated or continued without change. Staff, as specified above, must perform this review.

Treatment plan reviews are not covered in cases where only an intake or diagnostic assessment is provided with no further treatment. One treatment plan review is covered following a three-month interval of no services delivered. Any subsequent reviews with no intervening treatment are disallowed.

Documentation in the recipient's record for each session, service, or activity for which Medicaid reimbursement is requested must comply with any applicable certification or licensure standards and must include the following, at a minimum:

- The identification of the specific services rendered
- The date and the amount of time that the services were rendered (to include the time started and the time ended)
 - For Mental Health Care Coordination, Diagnostic Testing, Behavioral Health Placement Assessment, Basic Living Skills, and Crisis Intervention which can be provided in multiple, non-continuous times during the same day, it is permissible to aggregate the billable hours that are delivered at different times during the day and to write one note that covers all the different times showing one beginning and ending time covering the time span from start to finish with that consumer and service for that day.
 - Partial Hospitalization, Adult Intensive Day Treatment, Rehabilitative Day Program, Child and Adolescent Day Treatment, Assertive Community Treatment, Program for Assertive Community Treatment, and In-Home Intervention which are billed either hourly up to a daily maximum or per diem will show the time the service is started for the day and ended for the day.
- The signature of the staff person who rendered the services
- The identification of the setting in which the services were rendered
- A written assessment of the recipient's progress, or lack thereof, related to each of the identified clinical issues discussed

All entries must be legible and complete, and must be signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must sign his or her entry.

Documentation of Medicaid recipients' signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the recipient's signature and the date of service. The recipient's signature is only required one time per day that services are provided. Treatment plan review, mental health care coordination, behavioral health placement

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assessment, crisis intervention, family support, ACT, PACT, and any non-face-to-face services that can be provided by telephone do not require recipient signatures.

ACT and PACT services are billed as a bundled service on a daily rate even though the recipient might not be seen or contacted by the team each day. Documentation of the required staffing and any service provided to or on behalf of a recipient must be included in the recipient's medical record.

When clinical records are audited, Medicaid will apply the list of required documentation to justify payment. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.

Additional Information

Documentation

Documentation should not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes should not be **preprinted** or predated with the exception that a group therapy note may have a general section that identifies the participants (i.e. the number of participants, etc.), the topic, and a general description of the session which is copied for each participant. However, each participant must also have individualized documentation relative to his/her specific interaction in the group and how it relates to their treatment plan.
- The progress note should match the goals on the plan and the plan should match the needs of the recipient. The interventions should be appropriate to meet the goals. There should be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan should not be signed or dated prior to the plan meeting date.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time/date entry stamp.
 - If utilizing a computer entry system, there must be a written policy for documentation method in case of computer failure/power outage.

Corrections

- White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

105.2.4 *Requirements for Supervision/Monitoring and Complaint Procedure for Unlicensed Providers* ***Supervision/Monitoring***

In order to regulate the quality of services performed by unlicensed allied mental health providers, all behavioral health services rendered by non-licensed individuals are required to be authorized by and performed under the supervision of a qualified supervisor as determined by the participating state agency (DMH/DHR/DYS).

Each participating state agency (DMH/DHR/DYS) must abide by their policy/guidelines that have been developed outlining supervision of unlicensed allied mental health providers who provide individual, group, or family counseling or who provide any form of diagnostic testing.

NOTE:

The permitting of unlicensed allied mental health professionals to provide services does not authorize as party to hold themselves out as a licensed professional or as titled professional for which a license is required.

Complaints

Complaints received to the Alabama Medicaid Agency against unlicensed providers will be forwarded to the appropriate state agency (employing the unlicensed provider) for investigation. Each participating state agency (DMH/DHR/DYS) must abide by their policy/guidelines that have been developed outlining complaint investigation procedure and submit a report of findings and actions taken (if any) to the Alabama Medicaid Agency. The Alabama Medicaid Agency may also conduct an investigation in reference to received complaint.

105.3 Prior Authorization and Referral Requirements

Rehabilitative services procedure codes generally do not require prior authorization. (PA), except for circumstances when a Rehab Option provider determines that it is medically necessary to provide treatment services that goes beyond the indicated service limits for a recipient eligible under EPSDT (under age 21). Medical necessity will be established from the recipient's condition at the time of the request, not the diagnosis alone. PA requests for such EPSDT service limits must be submitted to the Medicaid Medical Quality Review contractor within the designated timeframe for services requested utilizing the process as outlined at: www.medicaid.alabama.gov. To receive approval for a PA request, you must submit a complete request using the approved submission form(s) found at www.medicaid.alabama.gov. Form(s) must be legible, include physician's signature and must provide clinical documentation to support the requested EPSDT coverage request. It is the responsibility of the Rehabilitation Option service provider to obtain authorization prior to rendering the service. Direct all inquiries and requests relating to prior authorization for recipients eligible for EPSDT (under age 21) to the fiscal agent Provider Assistance Center at 1-800-688-7989.

This process applies to DMH (MI/SA) and DYS rehabilitative services providers only. DHR providers will continue with the EPSDT process that is currently in place.

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines. Rehabilitative services do not require a Patient 1st referral.

105.4 Cost Sharing (Copayment)

Copayment does not apply to rehabilitative services.

105.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Rehabilitative services providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

105.5.1 Time Limit for Filing Claims

Medicaid requires all claims for rehabilitative services to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions for more information regarding timely filing limits and exceptions.

105.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-10 diagnosis codes, within the range of F0150-F99 must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. The Z code unspecified psychosocial circumstance is covered only for children and adolescents or adults receiving DHR protective services. Claims filed for pregnant women (SOBRA) must include V222 (pregnant state, incidental) as well as the appropriate MI/SA diagnosis code.

105.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Use the modifiers to distinguish mental illness/substance abuse, adult/child and adolescent, individual/group services.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible DMH MI-SA/DHR/DYS staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.-This may represent a different session or patient encounter, not ordinarily encountered or performed on the same

day by the same eligible DMH MI-SA/DHR/DYS staff. *However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly. It is the responsibility of the provider to check the site quarterly for any billing related updates.

105.5.4 Place of Service Codes

The following place of service codes apply when filing claims for rehabilitative services:

POS Code	Description
03	School
11	Office
12	Home
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
33	Custodial Care Facility

<i>POS Code</i>	<i>Description</i>
34	Hospice
52	Psychiatric Facility Partial Hospitalization
53	Community Rehabilitative Services Center
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
99	Other Unlisted Facility

105.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5., Required Attachments, for more information on attachments.

105.5.6 Billing Instructions for Medical-related Services

Instructions for Claims with Dates of Service August 1, 2000 and Thereafter

1. Bill Medicare on a UB-04.
2. Services covered by Medicare should be automatically crossed over to Medicaid as a UB-04 outpatient crossover. If for some reason the claim never crosses over or the claim is denied after crossing over, send an Institutional Medicaid/Medicare-related claim form to Medicaid using the same information as it was sent to Medicare. Indicate coinsurance, deductible, and allowed amounts as applied by Medicare.
3. If Medicare does not pay on any part of the services, bill the amount due for the services on a CMS-1500 claim form using procedure codes listed in the provider manual. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically. For paper claims, enter "key TPL input code M" in block 19 of the CMS-1500 form.

105.5.7 Billing Instructions for Medicare-Related Services

A. Partial Hospitalization Program – Medicare covers such services as education training, group therapy, activity therapy, etc. These services are billed to Medicare on a UB-04 claim using procedure codes (e.g. G0177, G0176, 90853, 90816, 90818, 90791, etc.).

1. Services **covered** by Medicare should be filed with Medicaid on a **Medical Medicaid/Medicare-related crossover claim form**, either electronically or on paper. Bundle all Medicare paid services together and use H0035-HE procedure code/modifier. Indicate the total coinsurance, deductible, allowed, and paid amounts as applied by Medicare.
2. Services **not covered** by Medicare should be filed with Medicaid as a straight Medicaid claim on a CMS-1500 claim form using the procedure codes listed in the provider manual since Medicaid covers these services. These claims must be submitted with an override code in order for Medicaid to consider payment and not

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reject the claim for Medicare coverage. For paper claims, enter “key TPL input code M” in block 19 of the CMS-1500 form. For an electronic override, submit a delay reason code of ‘11’. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically.

B. Service covered by Medicare rendered by Medicare enrolled provider (e.g., LCSW):

1. For the recipient with Medicaid/Medicare (non-QMB), the LCSW is covered by Medicare; but not Medicaid. After the payment has been received by Medicare; file Medicaid on **Medical Medicaid/Medicare-related crossover claim form** with the provider (clinic’s) NPI and the clinic’s secondary provider number. Do not file these claims using any of the LCSW’s provider number.
2. For the recipient with QMB coverage, the LCSW is covered by Medicare and Medicaid. These claims will crossover from Medicare and Medicaid will process with the enrolled LCSW’s provider number if billed appropriately to Medicare.

C. Medicaid Covered Service either not covered by Medicare or rendered by provider not allowed to enroll in Medicare:

1. For services not covered by Medicare or for services rendered by a provider not enrolled in Medicare, claims should be filed with Medicaid as a straight Medicaid claim on a CMS-1500 claim form using the procedure codes listed in the provider manual since Medicaid covers these services. These claims must be submitted with an override code in order for Medicaid to consider payment and not reject the claim for Medicare coverage. For paper claims, enter “key TPL input code M” in block 19 of the CMS-1500 form. For an electronic override, submit a delay reason code of ‘11’. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically.

105.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Sterilization/Hysterectomy/Abortion Requirements	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
ASC Procedures List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N