

## 110 Rehabilitative Services (ASD) – DMH

Rehabilitative Autism Services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with Autism Spectrum Disorder (ASD). These services are provided to recipients based on medical necessity guidelines as defined in Chapter 7, Understanding Your Rights and Responsibilities as a Provider.

Direct services can be provided in any home or community setting (except 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 based on medical necessity. Although limits are provided for guidance, the limitation(s) noted can be exceeded based on the individual recipient needs. While it is recognized that involvement of the family in the treatment of individuals with ASD 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 refers to a recipient's collateral defined as a family member, legal guardian or significant other.

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

For those providers seeking to render ABA Therapy services, please refer to Chapter 37 Therapy (Occupational, Physical, Speech and ABA).

Intensive Care Coordination is an integral part of Autism Services. See Chapter 106 addressing Targeted Case Management for Autism Spectrum Disorder (Target 3 or 10).

### 110.1 Enrollment

The Alabama Department of Mental Health (ADMH) enrolls Rehabilitative Autism Services providers and issues provider contracts to applicants who meet the licensure and/or credentialing requirements of ADMH and the State of Alabama, the Code of Federal Regulations (CFR), and the *Alabama Medicaid Agency Administrative Code*.

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-validate periodically with the Alabama Medicaid program (through ADMH). Providers will be notified when they are scheduled to re-validate. Failure to re-validate 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-validate, providers will have to submit a new application for enrollment.

### **National Provider Identifier, Type, and Specialty**

A provider who has a contractual agreement with ADMH as an Autism 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 reimbursement for Autism Services-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 Rehabilitative Autism Services are:

- Rehabilitative Autism Services - DMH (114)

### **Enrollment Policy for Rehabilitative Services Providers**

Autism Services providers must complete the Autism Services applications and submit to ADMH, along with proof of licensure/certification, transcript, and work experience.

To participate in the Alabama Medicaid Program, Rehabilitative Autism Services providers must meet the following requirements. Service providers must demonstrate that they meet the criteria in either (1) or (2), and (3) below.

1. A provider must have demonstrated the capacity to provide access to the following services through direct provision:
  - Must submit an application to and receive approval by ADMH to provide Rehabilitative Autism Services for children under age 21 under the Medicaid Rehabilitative Option program if they have demonstrated capacity to provide medically necessary services, either directly or through contract.
2. 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.
3. A provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to services delivered in a flexible manner to best meet their needs.

#### **110.1.1 *Minimum Qualifications for Rehabilitative Autism Service Professional Staff***

Providers are qualified personnel who provide services within home or community, and who provide services guided by an Individualized Service Plan (ISP). Providers must meet recognized standards under Autism Services and include the following disciplines, at a minimum:

- Physician

- Psychologists
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Licensed Social Workers
- Behavior Therapists (BCBA, BCBA-D, Psychologist)
- Behavior Support Monitors (RBT, BCaBA, Behavior Therapist, SLP, LPC)
- Speech Pathologists
- Occupational Therapists
- Physical Therapists
- Registered Nurses
- Child/Youth Peer Support Specialists
- Family Peer Support Specialists
- Therapeutic Mentors

A Professional Autism Services Specialist (PASS) I is defined as the following:

- An individual licensed in the State of Alabama as a
  - Physician
  - Clinical Psychologist
  - Professional Counselor
  - Marriage and Family Therapist
  - Graduate Level Social Worker
  - Registered Nurse

OR

- An individual who has a Master's Degree or above from a nationally or regionally accredited university or college in psychology, counseling, social work, or other behavioral health area with requisite course work equivalent to that degree in counseling, psychology, or social work.

A Professional Autism Services Specialist (PASS) II is defined as the following:

- Individual who has a Bachelor of Arts or Bachelor of Science in a human services related field from an accredited college or university with a minimum of one-year experience working with individuals with disabilities, families and/or service coordination

A Certified Autism Support Specialist (CASS) is defined as the following:

- A person with an Associate's degree or high school diploma or GED supervised by a Professional Autism Services Specialist I.
- A Parent Autism Peer Support Specialist provider who is parenting or has parented a child with ASD 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 an Autism Parent Peer Support Provider training program approved by state. A Parent Autism Peer Support Specialist must be supervised by a Professional Autism Services Specialist I.
- A Youth Autism Peer Support Specialist must be 18 years of age or older and serves children and youth ages 0-21 and uses his/her life experience with ASD and specialized training to promote resiliency. Youth Autism Peer Support service can be provided in an individual, family, or group setting by a Certified Child/Youth Autism

Peer Support Specialist. A Child/Youth Peer Support Specialist must be supervised by PASS I. This individual has satisfactorily completed a Youth Autism Peer Support Provider training program approved by the state.

## 110.2 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 of F84.0, F84.1, F84.5, and F84.9, assigned by a licensed physician or a licensed psychologist as listed in the most current International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM).

### 110.2.1 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 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.

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

- Behavior Support
- In Home Therapy (Mental Health Support)
- Mental Health Care Coordination
- Peer Support
- Psychoeducational Services
- Therapeutic Mentoring

Added: (Mental Health Support)

Intensive Care Coordination is an integral part of Autism Services. All providers must participate in the development of the Individualized Service Plan (ISP). All services must be provided as outlined on the ISP. Refer to Chapter 106 addressing Targeted Case Management for Autism Spectrum Disorder (Target 3 or 10).

The ISP teams are usually comprised of the child/youth, Intensive Care Coordinator, parents/family members, and other service providers as they relate to the identified needs of the child/youth. The team will establish a written ISP. The ISP team then implements this plan.

An ISP is required for each child/youth and ICC personnel is responsible for assisting eligible children/youth in gaining access to needed medical, social, therapeutic, educational, and other services and is responsible for initiating and guiding those service interventions.

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

The following is a description of each ASD service. Please see ASD Services Grid for Billing Unit, Daily Maximum Units, and Billing Restrictions.

The following procedure codes apply when filing claims for ASD Rehabilitative Services. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four procedure code modifiers.

Claims without procedure codes or with invalid codes will be denied. Only the procedure codes listed in this section are covered under this program.

<b>HCPCS Code</b>	<b>Description</b>	<b>Daily Max</b>	<b>Annual Max Units</b>
H2019	Behavior Support	16	4160
T1027	In Home Therapy (Mental Health Support)	8	832
H0046	Mental Health Care Coordination	24	312
H0038	Peer Support – Family Individual Group	20	2080
		20	2080
H0038	Peer Support – Youth Individual Group	20	2080
		20	2080
H2027	Psychoeducational Services Individual Group	8	416
		8	416
H2014	Therapeutic Mentoring Individual Group	8	416
		8	416

Added: (Mental Health Support)

## **Behavior Support (H2019)**

Positive behavior support therapy and monitoring is designed to address challenging behaviors in the home and community for children and youth with ASD or ASD with co-occurring IDD. A behavioral therapist writes and monitors a behavioral management plan that includes specific behavioral objectives and interventions that are designed to diminish, extinguish, or improve specific behaviors related to the child's or youth's behavioral health condition. The behavioral therapist supervises and coordinates the interventions and trains others who works with the family to implement the plan in the home and in the community.

### *Eligible Provider Type:*

Behavior Support services may be performed by a person who possesses any one or more of the following qualifications:

#### **Behavior Therapist:**

- A Professional Autism Services Specialist I (PASS I) who is
  - Licensed and Board Certified Behavior Analyst (BCBA, BCBA-D, LBA) OR Licensed Psychologist, AND
  - Possesses at least two years full-time working experience in providing services to individuals with ASD, one year of which must be post-graduate work.

#### **Behavior Support Monitor:**

- PASS I who qualifies as at least one of the following:
  - Licensed and Board Certified Assistant Behavior Analyst (BCaBA, LABA)
  - Registered Behavior Technician
  - Licensed Professional Counselor (LPC)
  - Licensed Speech Pathologist (SLP)
  - Licensed Occupational Therapist (OT)
  - Licensed Clinical Social Worker (LCSW)

#### **AND**

- Possesses at least two years full-time working experience in providing services to individuals with ASD, one year of which must be post-graduate work.
- **A Professional Autism Services Specialist II (PASS II)** who qualifies as at least one of the following:
  - A Bachelor degree in a relevant human services field and the appropriate training in implementing behavioral interventions, including: Licensed & Board Certified Assistant Behavior Analyst (BCaBA, LABA), Registered Behavior Technician (RBT)  
AND
  - Minimum one-year of supervised experience in performing ASD services after obtaining the degree.
- **A Certified Autism Support Specialist (CASS)** who qualifies as:
  - High-school diploma or GED, and
  - Registered Behavior Technician Certification, and
  - Minimum two years' experience working with children/adolescents/transition-age youth, and adequate ongoing supervision.

Key service functions include the following:

- Discrete Trial Training- PASS I, PASS II, CASS
- Incidental Teaching- PASS I, PASS II, CASS
- Pivotal Response Training- PASS I, PASS II, CASS
- Verbal Behavior Intervention- PASS I, PASS II, CASS
- Functional Communication Training- PASS I, PASS II, CASS
- Coping Skills Training- PASS I, PASS II, CASS
- Assessment- PASS I, PASS II
- Reduction of Environmental Barriers to Learning- PASS I, PASS II, CASS
- Maladaptive Behavior Reduction- PASS I, PASS II, CASS
- Functional Behavior Assessment- PASS I, PASS II
- Functional Analysis- PASS I
- Crisis Intervention- PASS I, PASS II
- Social Skills Therapy- PASS I, PASS II, CASS
- Basic Living Skills- PASS I, PASS II, CASS
- Psycho-educational Services- PASS I, PASS II, CASS
- Sensory Integration- PASS I, PASS II, CASS
- Development of Individual Program Plan- PASS I
- Progress Reporting- PASS I
- Transition Planning- PASS I
- Family Training- PASS I, PASS II, CASS
- Augmentative Communication Training- PASS I, PASS II, CASS

Billing Unit: 15 minutes

Maximum Units: 16 units/day; 4,160 units/year (1040 hours annually)

Billing Restrictions: 97151 Behavior Identification Assessment, 97152 Observational F/U assessment, 0362T Exposure Behavioral F/U assessment, 97153 Adaptive Behavior Treatment, 97154 Group Adaptive Behavior Treatment, 97158 Social Skills Group, 0373T Exposure Adaptive Behavior Treatment, 97155 Adaptive Behavior Modification, 97156 Family Adaptive Behavior Treatment Guidance, 97157 Multiple Family, Group Treatment Guidance

Added: (Mental Health Support)

**In Home Therapy (T1027) (Mental Health Support)*****Definition***

A structured, consistent, strength-based therapeutic relationship between a licensed clinician and a child or youth with ASD or ASD and co-occurring IDD and his or her family for the purpose of treating the child's or youth's behavioral health needs. In-Home Therapy services are provided under a multidisciplinary team model. In Home Therapy 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.

***Eligible Provider Type:***

In Home Therapy services may be performed by a person who possesses any one or more of the following qualifications:

- Professional Autism Services Specialist I (PASS I): (i) An individual licensed in the State of Alabama as a (1) Professional Counselor, Graduate Level Social Worker, Registered Nurse, Marriage and Family Therapist, Clinical Psychologist, Physician; or (ii) An individual who (1) Has a Master's Degree or above from a nationally or regionally accredited university or college in psychology, counseling, social work, or other behavioral health area with requisite course work equivalent to that degree in counseling, psychology, or social work.
- Professional Autism Services Specialist II (PASS II) – An individual who has a Bachelor of Arts or Bachelor of Science in a human service related field from an accredited college or university with a minimum of one-year experience working with individuals with disabilities, families and/or service coordination

Key service functions include the following:

- Psychoeducational Services- PASS I, PASS II
- Individual counseling/therapy- PASS I, PASS II
- Family counseling/therapy- PASS I, PASS II
- Group counseling/therapy- PASS I, PASS II
- Coping Skills Training- PASS I, PASS II
- Assessment- PASS I
- Therapeutic Treatment- PASS I, PASS II
- Crisis Intervention- PASS I, PASS II
- Basic Living Skills- PASS I, PASS II
- Social Skills Therapy- PASS I, PASS II
- Treatment Plan Review- PASS I
- Progress Reporting- PASS I
- Development of Individual Program Plan- PASS I
- Transition Planning- PASS I

Billing Unit: 15 minutes

Maximum Units: 8 units/day; 832 units/year (208 hours annually) 4hrs/week



**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:***

- PASS I
- PASS II
- CASS

Billing Unit: 15 minutes

Maximum Units: 24 per day, 312 per year

***Additional Information***

Acceptable service provision that qualify as Mental Health Care Coordination includes but is not limited to: Telephone or face to face consultation with a contract provider, doctor, therapist, school teacher, school counselor and/or other professional that is working with the child external to your agency regarding the treatment needs of the child.

Inappropriate tasks include: Scheduling/Rescheduling/Canceling appointments, sharing clinical information within your agency/organization, reading reports or case summaries, writing progress notes or reports, receiving information not pertaining to the treatment needs of the child.

## **Peer Support (Youth:H0038-HA or HA;HQ Group; Family: H0038-HC or HC:HQ Group)**

### ***Definition***

Peer Support services provides structured, scheduled activities that promote socialization, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists. 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 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:***

Family Peer Support services may be performed by a person who possesses the following qualifications:

- A **Parent Autism Peer Support Specialist** provider who is parenting or has parented a child with ASD and can articulate the understanding of his/her 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 Autism Peer Support Provider training program approved by the state. A Parent Autism Peer Support Specialist must be supervised by a Professional Autism Services Specialist I.

Youth Peer Support services may be performed by a person who possesses the following qualifications:

- A **Youth Autism Peer Support Specialist** must be 18 years of age or older and serves children and youth ages 0-21 and uses his/her life experience with ASD and specialized training to promote resiliency. Youth Autism Peer Support service can be provided in an individual, family, or group setting by a Certified Child/Youth Autism Peer Support Specialist. A Child/Youth Peer Support Specialist must be supervised by PASS I. This individual has satisfactorily completed a Youth Autism Peer Support Provider training program approved by the state.

Key service functions include the following:

- Mentoring, advocacy, development of coping/problem solving skills
- Promotion of socialization and development of natural supports
- Engagement of community services

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.

**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 disorder
- Expected symptoms
- Ways in which the family member can support individuals with the disorder

***Eligible Provider Type:***

- PASS I
- PASS II
- CASS

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

## **Therapeutic Mentoring (H2014– Individual; H2014-HQ – Group)**

### **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 PASS I 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.

Key service functions include the following:

- Basic Living Skills
- Social Skills Training
- Coping Skills Training
- Assessment
- Plan Review
- Progress Reporting
- Transition Planning

### *Eligible Provider Type*

- PASS I
- PASS II
- CASS

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

### 110.2.2 Reimbursement

The Medicaid reimbursement for each service provided by an Autism Rehabilitative Services provider is based on the following criteria and does not exceed the lowest of the following amounts:

- The fee schedule established by Medicaid as the maximum allowable amount
- 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.

### 110.2.3 Requirements for Recipient Intake, Treatment Planning, and Service Documentation

Once a recipient is determined eligible for Rehabilitative Autism Services, the Intensive Care Coordinator will refer the client to appropriate Rehabilitative Autism Services.

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)
- 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 providing the service. 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. Any non-face-to-face services that can be provided by telephone do not require recipient signatures.

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

- Corrections must be made legally and properly by drawing a line through the entry and making sure that the inaccurate information is still legible. Write “error” by the incorrect entry and initial. Do not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout, or writing over an entry. 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.

**110.2.4 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 ADMH. ADMH must abide by their policy/guidelines that have been developed outlining supervision of unlicensed allied mental health providers who provide ASD Rehabilitative Services.

NOTE: The permitting of unlicensed allied mental health professionals to provide services does not authorize a 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 Alabama Department of Mental Health – Office of Autism Services for investigation. DMH 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.

**110.2.5 Requirements for Telemedicine Billing**

Effective (**date TBD**) the end of the public health emergency transition period please follow the guidelines below. Until further notice continue to bill the currently approved codes (as posted on the Alabama Medicaid Agency website with the ‘02’ and ‘CR’ modifiers---your State Agency provider will notify you when to begin utilizing the codes, modifier and processes below).

The following codes **only** are approved for the use of telehealth billing. Please follow the guidelines outlined below.

H2014
H2014 - HQ
H2019
H2027
H2027 – HQ
H0038 – HA
H0038 – HA:HQ
H0038 – HC
H0038 – HC:HQ
T1027

All services (including those rendered via teleconference with a direct service or consultation recipient) must be rendered by an approved Medicaid treatment provider (operating within their scope of practice) as outlined in Section 110.1.1.

If any of these services are provided via video telecommunication, it **must** be provided in the most private available setting and must be conducted through a two-way interactive audio **and** video technology system that permits two-way communication between the treatment provider and the Medicaid recipient. This service **does not** include a telephone conversation, electronic mail message, or facsimile transmission between the treatment provider, recipient, or a consultation between two treatment providers.

The origination site for treatment services can be delivered in any setting that is convenient for both the recipient/family and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality. In order for providers to qualify for Medicaid reimbursement for telehealth services, the origination site must be located in the state of Alabama.

The distant site is the location of the treatment provider providing the telehealth professional services. For physicians, telemedicine can be provided 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. For all other treatment providers, treatment services can only be provided by a treatment provider located within the state of Alabama.

### **Standards for Recipient/Provider Participation:**

Medicaid covers services provided via telehealth 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 for **physicians** 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](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](http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx)

In order for other treatment providers to participate in the telemedicine program:

- a) Treatment provider must be enrolled with Alabama Medicaid through their participating state agency, following all approved guidelines for enrollment.



- b) Treatment provider must obtain prior consent from the recipient before services are rendered; Consent form has to be approved by the participating state agency.

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.

Treatment providers of telehealth services shall implement confidentiality protocols that include, but are not limited to:

- 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.

Each treatment provider providing telehealth services 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 treatment provider shall make the protocols and guidelines available for inspection at the telehealth site, and to the Medicaid Agency upon request.

The treatment provider shall keep a complete medical record on all telehealth services provided to recipients with documentation of the use of telehealth technology documented, to include the HIPAA compliant platform, 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 telehealth 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 telehealth room in easy access for the recipient.

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

Additionally, in providing telehealth services, treatment providers shall ensure that the telecommunication technology and equipment used at the recipient site, and at the treatment provider site, is sufficient to allow the treatment provider to appropriately evaluate, diagnose, or treat the recipient for services billed to Medicaid.

Treatment providers 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 medically necessary treatments.

**Informed Consent:**

Prior to an initial telehealth service, the treatment provider 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 telehealth 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 (this applies to physicians only);
- All existing confidentiality protections apply to the telehealth treatment services provider by treatment providers;
- S/he has access to all medical information resulting from the telemedicine consultation/telehealth treatment services 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/telehealth treatment services 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/telehealth treatment services 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/telehealth treatment service if an urgent need arises, or to be informed ahead of time that this is not available.

The treatment provider 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 treatment provider or his/her designee, and understands the informed consent may apply to follow-up treatment services with the same treatment provider. The treatment provider providing the telehealth treatment 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 and documented in the medical record.

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 HA or HC, only Medicaid approved procedure codes for Telehealth billing can be billed for telemedicine services and must be billed with modifier **GT** (via

interactive audio and video telecommunications system). The telemedicine origination site and/or transmission fees is not reimbursable under the Rehabilitative Services program.

### **110.3 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.

Approval is required if number of service hours will be exceeded for a particular service. All prior approvals of additional Autism Services units require approval from the *Regional Autism Coordinator*. All requests must be received at least **10 days** prior to the anticipated date of need. All approvals for additional units are based on the individual's needs and extraordinary circumstances.

To request additional units, the provider must complete the "Request for Additional Hours" form and submit for review by Intensive Care Coordinator (ICC). The ICC will determine need and approve if appropriate. The client/family should be made aware of request. The ICC should then send to the Regional Autism Coordinator for approval of increase. The Regional Autism Coordinator will determine need and approve if appropriate. The ICC will then be responsible of updating authorization in Therap.

To access the "Request for Additional Hours" form, refer to the ADMH Autism Services website at <https://mh.alabama.gov/autism-services/>.

Rehabilitative services do not require an ACHN referral.

### **110.4 Cost Sharing (Copayment)**

Copayment does not apply to rehabilitative services.

### **110.5 Completing the Claim Form**

#### **110.5.1 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.

#### **110.5.2 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.

### 110.5.3 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 ASD services and individual/group services.

#### **Modifier 59 (Distinct Procedural Service)**

Under certain circumstances eligible DMH ASD 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 ASD 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 (<https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.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.

### 110.5.4 Place of Service Codes

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

POS Code	Description
11	Office
12	Home
99	Other Unlisted Facility

\*\*\*Must document in progress/treatment notes where the POS 99 service occurred.

### 110.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

### 110.6 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, Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5, Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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