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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.

Direct services may be provided in the client'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 client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

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

105.1 Enrollment

HP 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.

1. A provider must be certified as a 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
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 and Mental Retardation (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.
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 client'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.

105.1.1 Minimum Qualifications for Rehabilitative Services Mental Illness Professional Staff

Rehabilitative Services Mental Illness Professional Staff qualifications are as follows:

- 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 psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A certified social worker licensed under Alabama law
- 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 who has completed a master's degree in psychiatric nursing
- 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 areas that require equivalent clinical course work 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 post graduate clinical experience as described in DMH standards
- Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service descriptions
- A pharmacist licensed under Alabama law may provide medication monitoring

105.1.2 Minimum Qualifications for Rehabilitative Services Substance Abuse Professional Staff

Rehabilitative Services Substance Abuse Professional Staff qualifications are as follows:

- Clinical screening and assessments of a substance abuse client must be performed by a person with at least two years of substance abuse treatment experience who meets any one or more of the following qualifications:
  - Licensed as a physician, psychologist, certified social worker, or counselor
  - Possesses a master's degree in a clinical area

- Treatment planning and counseling of substance abuse clients must be performed by any one or more of the following qualified professionals:
  - A person with a master's degree in a clinical area with a clinical practicum
  - A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting
  - A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience. A bachelor's level individual with less than two (2) years of direct care substance abuse experience must receive at a minimum two hours per month of documented case-development supervision from a qualified master's level clinician. Upon the individual obtaining two years of direct care substance abuse experience the case-development supervision would no longer be required and the individual would only need to receive two hours per month of ongoing documented supervision.
  - A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary process for certification. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

— Services must be provided by practitioners consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law

— Services rendered to persons with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above, unless an exception is specifically noted and defined in the service descriptions

105.1.3 Minimum Qualifications for DHR/DYS/DCA Child & Adolescent Services, DHR Adult Protective Services Professional Staff

DHR/ DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional Staff qualifications are as follows:

— 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 psychologist licensed under Alabama law

— A professional counselor licensed under Alabama law

— A marriage and family therapist licensed under Alabama law

— A social worker licensed under Alabama law

— 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 who has completed a master's degree in psychiatric nursing

- 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 areas that require equivalent clinical course work 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 professional experience supervised by a master's level or above clinician with two years of post graduate professional experience
- Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service descriptions
- A pharmacist licensed under Alabama law may provide medication monitoring

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.

Treatment eligibility is limited to individuals with a diagnosis within the range of 290-316, 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 - Clinical Modification (ICD-CM). Medicaid does not cover the V codes for adult treatment services; however, it does cover intake evaluation and diagnostic assessment even if the resulting diagnosis is a V code. For treatment services provided to children under 21, or those adults receiving DHR protective services, the only V code Medicaid covers for reimbursement is unspecified psychosocial circumstance.

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 client's treatment needs. Medicaid does not cover services for non-Medicaid eligible family members independent of meeting the client's treatment needs.

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

- Intake Evaluation
- Physician/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
- Rehabilitative Day Program
- Mental Illness Child and Adolescent Day Treatment
- Treatment Plan Review
- Mental Health Consultation
- Adult Substance Abuse Intensive Outpatient Services
- Child and Adolescent Substance Abuse Intensive Outpatient Services
- In-home Intervention
- Pre-hospitalization Screening
- Basic Living Skills
- Family Support
- Assertive Community Treatment (ACT)
- Program for Assertive Community Treatment (PACT)
- Methadone Treatment

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.

Intake Evaluation (90791-HE 90791-HF)

HE = Mental Illness HF = Substance Abuse

Definition

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

Key service functions include the following:

- A clinical interview with the client and/or family members, legal guardian, or significant other
- Screening for needed medical, psychiatric, or neurological assessment, as well as other specialized evaluations
- A brief mental status evaluation
- Review of the client'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 Staff - Mental Illness Services

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

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A 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
- 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 areas that require equivalent clinical course work, 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 as described in DMH standards

Eligible Staff - Substance Abuse Services

Clinical evaluation and assessments of a substance abuse client may be performed by a person with at least two years of substance abuse treatment experience who possesses any one or more of the following qualifications:

- Licensed as a psychologist, social worker, or professional counselor
- Has a master's degree in a clinical area that included a clinical practicum

Eligible Staff - DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Clinical evaluation and assessments of a child and adolescent services/adult protective services client may be performed by a person who possesses any one or more of the following qualifications:

- A physician licensed under Alabama law to practice medicine or osteopathy
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A 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
- 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 areas that require equivalent clinical course work, and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as part of the requirements for the degree
  - Has six months of post master's level professional experience supervised by a master's level or above clinician with two years of postgraduate professional experience
- An individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager 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, Youth Services Counselor II, Youth Services Case Manager or above.

Billing Unit:	Episode
Maximum Units:	One per year
Billing Restrictions:	May not be billed in combination with Treatment Plan Review (H0032), Child and Adolescent In-Home Intervention (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 client and staff member, that affords an adequate therapeutic environment and that protects the client's rights to privacy and confidentiality.

Additional Information

An intake evaluation must be performed for each client considered for initial entry into a treatment program. This requirement applies to any organized program or course of covered services that a client 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 client'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 client 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 client 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 client's needs.
- Include referrals as appropriate for needed services not provided directly by the agency.
- Identify expected processes/outcomes toward which the client and therapist will be working to impact upon the specific clinical issues.
- Be approved in writing by a licensed psychologist, 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.

— 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 consultation, pre-hospitalization screening, 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 Client Intake, Treatment Planning, and Service Documentation section.

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

Definition

Contact between a client, another service agency provider, or independent practitioner and a licensed physician, physician assistant, or certified nurse practitioner occurring in an individual, group, or family setting for the purpose of medical/psychiatric development of a medication regimen, the provision of therapeutic services, or the provision of case consultation.

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 Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

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.

Billing Unit:	15 minutes
Maximum Units:	6 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Substance Abuse Intensive Outpatient Services (H0015), Child and Adolescent Substance Abuse Intensive Outpatient Services (H0015-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 client and staff member, that affords an adequate therapeutic environment, and that protects the client'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.

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:

- 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 client 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 client'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 client 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.

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 modifiers **GT** (via interactive audio and video telecommunications system) or **GQ** via asynchronous (store & forward) telecommunications system).

Added: In addition to modifier HE or HF, all

Deleted: ~~All~~

Diagnostic Testing done by physician or psychologist (96101-HE 96101-HF)

Definition

Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and the psychologist or psychiatrist and interpretation of the test results.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure code 96101 -Diagnostic testing may only be performed by:

- A psychiatrist licensed under Alabama law

OR

— A psychologist licensed under Alabama law

Billing Unit:	One hour
Maximum Units:	5 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 client and staff member, that affords an adequate therapeutic environment, and that protects the client'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.

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.

Diagnostic Testing done by technician (96102-HE 96102-HF)

Definition

Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and the technician and interpreted by a qualified health care professional.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure code 96102 -Diagnostic testing may be performed by: a person who possesses any one or more of the following qualifications:

- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 areas that require equivalent clinical course work 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.

Billing Unit:	One hour
Maximum Units:	5 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 client and staff member, that affords an adequate therapeutic environment, and that protects the client'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.

Diagnostic Testing administered by a computer (96103-HE 96103-HF)

Definition

Administration of standardized objective and/or projective tests (eg, MMPI) of an intellectual, personality, or related nature by a computer and interpreted by a qualified health care professional.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Diagnostic testing-procedure code 96103 must be administered by a computer and interpreted by a qualified health care professional.

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 client and staff member, that affords an adequate therapeutic environment, and that protects the client'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 by a rehabilitative services or child and adolescent services/adult protective services professional or a registered nurse with the client, family, legal guardian, and/or significant others to ameliorate a client's maladaptive emotional/behavioral reaction. Service is designed to resolve the crisis and develop symptomatic relief, increase knowledge of where to turn for help at a time of further difficulty, and facilitate return to pre-crisis routine functioning.

Key service functions include the following:

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

Eligible Staff - Mental Illness Services

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

- A physician licensed under Alabama law to practice medicine or osteopathy or a certified registered nurse practitioner (CRNP) practicing within the scope approved by the Alabama Board of Nursing
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law
- 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 areas that require equivalent clinical course work 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
- An individual who has completed an approved case management training course

Eligible Staff - DHR/DYS/DCA Child and Adolescent Services, 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 Youth Services Counselor II, Youth Services Case Manager, 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, Youth Services Counselor II, Youth Services Case Manager, 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)

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Location

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

Additional information

If the client is unable to sign a receipt for service or if the service is rendered by phone, the documentation in the client's record should so indicate. The V 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

A treatment plan focused intervention between a client and a rehabilitative services or child and adolescent services/adult protective services professional. Treatment is designed to maximize strengths and to reduce behavioral problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational and/or community adjustment.

Key service functions include the following:

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

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

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

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A 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
- 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 areas that require equivalent clinical course work 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 - Substance Abuse Services

- Clinical screening and assessment of a substance abuse client must be performed by a person with at least two years of substance abuse treatment experience who meets any one or more of the following qualifications:

  Licensed as a physician, psychologist, certified social worker, or counselor;

  Possesses a master's degree in a clinical area.

- Treatment planning and counseling of substance abuse clients must be performed by any one or more of the following qualified professionals:

A person with a master's degree in a clinical area with a clinical practicum;

A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting;

A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience: A bachelor's level individual with less than two (2) years of direct care substance abuse experience must receive at a minimum two hours per month of documented case-development supervision from a qualified master's level clinician. Upon the individual obtaining two years of direct care substance abuse experience the case-development supervision would no longer be required and the individual would only need to receive two hours per month of ongoing documented supervision;

A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary process for certification. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

- Services must be provided by practitioners consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law.
- Services rendered to clients with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above, unless an exception is specifically noted and defined in the service descriptions.

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 client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

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

Effective for Date of Services 01-01-2013 and thereafter:
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

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 treatment plan focused intervention involving a client, his or her family unit, and/or significant others, and a rehabilitative services, substance abuse, or child and adolescent services/adult protective services professional. Treatment is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational, and/or community adjustment.

Key service functions include the following:

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

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

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

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A 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
- 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 areas that require equivalent clinical course work 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 - Substance Abuse Services

Services may be provided by a person with at least one year of substance abuse treatment experience who meets any one or more of the following qualifications:

- A person licensed as a psychologist, certified social worker, or professional counselor
- A person with a master's degree in a clinical area
- A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience

— A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary accreditation process. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

Billing Unit:	30 minutes
Maximum Units:	3 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 client and staff member, that affords an adequate therapeutic environment, and that protects the client'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 V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Group Counseling (90853-HE, 90853-HF)

Definition

A treatment plan focused intervention involving a group of clients, and a rehabilitative services, substance abuse, or child and adolescent services/adult protective services professional. Treatment utilizes interactions of group members to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational, and/or community adjustment.

Key service functions include the following:

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

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

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

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A 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
- 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 areas that require equivalent clinical course work 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 - Substance Abuse Services

Group counseling for substance abuse services clients may be performed by a person with at least one year of substance abuse treatment experience who meets any one or more of the following qualifications:

- A person licensed as a psychologist, certified social worker, or professional counselor
- A person with a master's degree in a clinical area
- A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience
- A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience based, voluntary accreditation process. Such certification

must have mutual reciprocity with surrounding states and be nationally recognized

Billing Unit:	30 minutes
Maximum Units:	3 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 client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

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

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

Definition

Administration of oral or injectable medications as directed by a physician.

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

Medication administration for child and adolescent services/adult protective services clients 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

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 client and staff member, that affords an adequate therapeutic environment, and that protects the client'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. Medicaid covers this service under substance abuse for methadone clients only. 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 client and a rehabilitative services, or child and adolescent services/adult protective services professional, pharmacist, RN, or LPN for the purpose of reviewing the overt physiological effects of psychotropic medications; monitoring compliance with dosage instructions; instructing the client and/or caregivers of expected effects of psychotropic medications; assessing the client's need to see the physician; and recommending changes in the psychotropic medication regimen.

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

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

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A 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 pharmacist licensed under Alabama law
- 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 areas that require equivalent clinical course work 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

- Registered nurse licensed under Alabama law
- Licensed Practical Nurse 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).

Location

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

Additional Information

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

Partial Hospitalization Program (H0035)

Definition

A physically separate and distinct organizational unit that provides intensive, structured, active, clinical treatment with the goal of acute symptom remission, immediate hospital avoidance, 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 client need:

- Initial screening to evaluate the appropriateness of the client'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.)
- Activity therapy closely related to the presenting problems that necessitated admission (e.g., aerobics, maintaining a recovery diary, creative expression (art, poetry, drama) pertaining to the recovery process)
- Medication administration
- Medication monitoring
- Family education closely related to the presenting problems, such as diagnosis, symptoms, medication, coping skills, etc.
- Patient education closely related to the presenting problems, such as diagnosis, symptoms, medication, etc., rather than academic training

Eligible Staff – Mental Illness Services

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

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 client is attending/actively enrolled in Partial Hospitalization whether or not the restricted services occur on the same day as Partial Hospitalization.

Location

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

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.

Adult Intensive Day Treatment (H2012)

Definition

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, with the goals of community living skills acquisition/enhancement, increased level of functioning, and enhanced community integration. Intensive Day Treatment shall constitute active, intermediate level treatment that specifically address the client's impairments, deficits, and clinical needs.

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

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program
- Individual, group, and family counseling
- Activity/recreational therapy (e.g., sports, leisure activities, hobbies, crafts, music, socialization, field trips)
- 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
- Client education closely related to presenting problems, such as diagnosis, symptoms, medication, etc. rather than academic training

Eligible Staff – Mental Illness Services

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

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 client is attending/actively enrolled in Intensive Day Treatment whether or not the restricted services occur on the same day as Intensive Day Treatment.

Location

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

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 clients to become productive participants 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 clients participating in the program.

Key service functions include the following:

1. Initial screening to evaluate the appropriateness of the client's participation in the program
2. Development of an individualized program plan

— Structured work oriented activities (e.g., learning and practicing good work habits and/or developing skills to help consumer prepare for specific jobs appropriate to their level of ability)

— Educational skills (e.g., Adult Basic Education, GED, computer skills, support and assistance with returning to school)

— Employment assistance (services designed to help client attain and sustain volunteer work, part-time employment, or a full-time job)

— Sheltered employment opportunities (e.g., thrift store, garden center, or sheltered workshop)

— Goal-oriented groups (e.g., groups designed to help clients identify, discuss, achieve and/or maintain personal life goals, such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family, etc.)

— One-to-one goal-oriented sessions (e.g., one-to-one services designed to help a client identify, discuss, achieve and/or maintain personal life goals, such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family, etc.)

— Skill building (e.g., skills training sessions focused on learning, improving, and maintaining daily living skills, such as grocery shopping, use of public transportation, social skills, budgeting, laundry, and housekeeping, to help clients develop and maintain skills they need to achieve and/or sustain personal life goals

— Utilization of community resources

Eligible Staff – Mental Illness

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

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 Intensive Day Treatment (H2012).

Location

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

Child and Adolescent Mental Illness Day Treatment (H2012-HA)

Definition

A combination of goal-oriented rehabilitative services designed to improve the ability of a client to function as normally as possible in his or her 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 client's participation in the program
- Development of an individualized program plan
- Individual, group and family counseling
- Education for the client's parents or guardians regarding emotional and cognitive development and needs
- Services that enhance personal care skills
- Services that enhance family, social, and community living skills
- Services that enhance the use of leisure and play time

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

The program must be staffed and have a program coordinator as required by the applicable certifying/licensing authority.

Billing Unit:	One hour
Maximum Units:	4 per day, 1040 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). These restrictions apply while a client 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 client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Treatment Plan Review (H0032)

Definition

Review and/or revision of a client's individualized treatment plan by a qualified staff member who is not the primary therapist for the client. This review will evaluate the client's progress toward treatment objectives, the appropriateness of services being provided, and the need for a client's continued participation in treatment. This service does not include those activities or costs associated with direct interaction between a client and his or her primary therapist regarding the client's treatment plan. That interaction must be billed through an alternative service, such as individual counseling.

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

- Treatment plan review, for mental illness and child and adolescent services/adult protective services clients, may be performed by a person who possesses any one or more of the following qualifications:
  - A psychologist licensed under Alabama law
  - A social worker licensed under Alabama law
  - A registered nurse licensed under Alabama law who has completed a masters in psychiatric nursing
  - A professional counselor licensed under Alabama law
  - A marriage and family therapist licensed under Alabama law
  - For services billed through DHR, a supervisor employed by DHR as a Service Supervisor or a Senior Social Work Supervisor
  - For services billed through DHR or DYS, 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 areas, and who (a) has successfully completed a practicum as part of the requirement for the degree or (b) has six months of post-master's level or above clinical with two years of postgraduate professional experience

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

Additional Information

The client'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 client'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 diagnoses only. The V 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.

Mental Health Consultation (H0046)

Definition

Assisting other external service agency providers or independent practitioners in providing appropriate services to an identified Medicaid client by providing clinical consultation.

Key service functions include written or verbal interaction in a clinical capacity in order to assist another provider to meet the specific treatment needs of an individual client and to assure continuity of care to another setting.

Eligible Staff – Mental Illness

Mental health consultations for mental illness services clients may be performed by a person who possesses any one of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law
- 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 areas that require equivalent clinical course work 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 – DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Mental health consultations for child and adolescent services/adult protective services clients may be delivered by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager 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, Youth Services Counselor II, Youth Services Case Manager 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 client 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 V 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 client's record or the approved authorization/override form filed in the record and dated and signed by the staff member performing the work.

Adult Substance Abuse Intensive Outpatient Services (H0015)

Definition

A combination of time limited, goal oriented rehabilitative services designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle.

Key service functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Medical services including prescription of medication and medication management
- Group and family counseling
- Substance abuse education
- Pre-discharge planning
- Family therapy focusing on client and family education regarding substance abuse and community support
- Linkage to community resources

Eligible Staff – Substance Abuse Services

This program must be staffed and have a program coordinator as required in the current *Community Substance Abuse Standards Manual*.

Billing Unit:	1 hour
Maximum Units:	6 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (H0004)

Location

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

Additional Information

Up to three family members included in family counseling may be counted for reimbursable units.

Child and Adolescent Substance Abuse Intensive Outpatient Services (H0015-HA)

Definition

A structured treatment designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle. Programs that provide an academic curriculum as defined by and registered with the State Department of Education and that students attend in lieu of services provided by a local education agency cannot bill Medicaid for the time devoted to academic instruction.

Key services functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program
- Group and family counseling
- Education for the client's parents or guardians regarding substance abuse and associated problems
- Substance abuse education for client
- Medical services including the prescription of medication and medication management

Eligible Staff – Substance Abuse Services

The program must be staffed and have a program coordinator as required in the current *Community Substance Abuse Standards Manual*.

Billing Unit:	1 hour
Maximum Units:	6 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (H0004).

Location

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

Additional Information

Up to three family members included in family counseling may be counted for reimbursable units.

(Adult) In-Home Intervention (H2021)

Definition

Home based services provided by a treatment 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 client.

Key service functions include the following when provided by a tea composed of a Rehabilitative Services Professional (master's level clinician) and a Case Manager:

— Individual or family counseling

— Crisis intervention

— Mental Health Consultation

— Basic Living Skills

— Family Support

— Case Management

— Medication Monitoring

Key service functions include the following when provided by a team composed of a Registered Nurse and a Case Manager:

— Crisis Intervention

— Mental health Consultation

— Basic Living Skills

— Family Support

— Case Management

— Medication Monitoring

— Medication Administration

Eligible Staff – Mental Illness

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

— A rehabilitative services professional staff member or

— A registered nurse licensed under Alabama law and

— A person with a bachelor's degree

Each team member must successfully complete an approved case management training program.

Billing Unit:	15 minutes
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 Consultation (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 client'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 Consultation (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

Time limited home based services provided by a treatment team in order to defuse an immediate crisis situation, stabilize the family unit, and prevent out of home placement of the child or adolescent consumer, who presents with a serious emotional disturbance and who is at risk of out of home placement.

Key service functions include the following:

— Individual Counseling

— Family Counseling

— Family Support

— Basic Living Skills

— Crisis intervention (24 hour availability)

— Medication Monitoring

— Mental Health Consultation

— Case Management Services

— Treatment Plan Review

Eligible Staff – Mental Illness

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

- A master's level mental health professional with one year of post master's experience in child and adolescent or family therapy

— A person with a bachelor's degree

— Each team member must successfully complete an approved case management training program and In-home Training Program

Billing Unit:	One day (children)
Maximum Units:	One per day, 140 per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791), Crisis Intervention (H2011), Individual Counseling (90804), Family Counseling (90846, 90847, 90849), Treatment Plan Review (H0032), Mental Health Consultation (H0046), Case Management, Family Support (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 always be together during the provision of services to children and their families. 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.
- All In-home clients must be referred to a Case Manager after the In-home team has completed the In-home Intervention.
- 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.

Pre-hospitalization Screening (H0002-HE H0002-HF)

Definition

Face-to-face contact between a rehabilitative services or child and adolescent services/adult protective services professional or a registered nurse and a client to determine 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 client's need for local or state psychiatric hospitalization
- An assessment of whether the client 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 Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Pre-hospitalization screening may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A registered nurse licensed under Alabama law
- 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 areas that require equivalent clinical course work 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.

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 client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

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

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

Definition

Psychosocial services provided on an individual or group basis to enable a client to maintain community tenure and to improve his or her capacity for independent living.

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 client
- Patient education about the nature of the illness, symptoms, and the client's role in management of the illness

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

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

- Meets the qualifications for MI, SA, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager, or above
- Is a registered nurse licensed under Alabama law

Billing Unit:	15 minutes
Maximum Units:	2080 units per year
	20 per day (individual)
	8 per day (group)
Billing Restrictions:	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 client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Family Support (H2027 – Individual; H2027-HQ – Group)

Definition

Service provided to families of rehabilitative services clients to assist them in understanding the nature of the illness of their family member and how to help the client be maintained in the community.

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 Staff – Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

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

- Meets the qualifications for MI, SA, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager, or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above
- Is a registered nurse licensed under Alabama law

Billing Unit:	15 minutes
Maximum Units:	416 units per year
	8 per day for services provided to an individual client's family
	8 per day for services provided to a group of clients' 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 client's rights to privacy and confidentiality.

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 in accordance with DMH certification standards to adults with serious mental illness who are in a high-risk period due to an exacerbation of the illness 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
- Physician assessment and treatment
- Medication administration
- Medication monitoring
- Individual, group, and/or family counseling
- Crisis intervention
- Mental health consultation
- Case management
- Family support
- 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 client moves from a team intervention to a less acute array of individually delivered services.

Eligible Staff – Mental Illness

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 client and must individually provide services to each client 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 client ratio on an ACT team where the part-time psychiatrist is not counted as one staff member or a 1:10 staff to client ratio on a PACT team.

Billing Unit:	One day
Maximum Units:	365 days per year
Billing Restrictions:	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 Consultation (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 client might not be seen or contacted by the team each day. ACT and PACT services may be billed while a client 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 client’s rights to privacy and confidentiality.

Additional Information

Documentation of the required staffings and all client contacts by ACT and PACT team members shall be included in the client's medical record. All service documentation shall follow the guidelines in Section 105.2.3. Client signatures are not required for ACT and PACT key service functions; however, services which are provided outside the ACT and PACT benefit will require client 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.

Methadone Treatment (H0020)

Definition

Methadone treatment is a periodic service designed to offer the individual an opportunity to effect constructive changes in his/her lifestyle by using Methadone in conjunction with the provision of rehabilitation and medical services. Methadone treatment is also a tool in the detoxification and rehabilitation process of narcotic-dependent individuals. For the purpose of detoxification, Methadone is used as a substitute narcotic drug. It is administered in decreasing doses for a period not to exceed 21 days. For individuals with history of psychoactive substance dependence or severe narcotic dependency prior to admission to the service, Methadone may also be used in maintenance treatment. In these cases, it may be administered or dispensed in excess of 21 days at relative stable dosage levels with the treatment goal of an eventual drug-free state.

Eligible Staff –Substance Abuse

The program must be staffed and have a Program Coordinator as required in the current *Community Substance Abuse Standards Manual* or subsequent revisions.

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 client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

Additional Information

No more than 35 clients who do not meet the requirements for Phase III under the *Community Substance Abuse Standards Manual* will be assigned to a counselor, provided that the counselor may increase the ratio to 1:50 by adding 15 clients to the caseload who have been in opiate replacement treatment and qualify for Phase III requirements under the *Community Substance Abuse Standards Manual*. Clients who receive take-home doses under the hardship waivers, but do not otherwise satisfy Phase III requirements shall not be deemed Phase III clients.

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. Utilization will be monitored through retrospective reviews.

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 Client Intake, Treatment Planning, and Service Documentation

An intake evaluation must be performed for each client 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 client'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 client is experiencing

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

Eligible Staff – Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth client visit with the primary therapist 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 client's needs
- Referrals as appropriate for needed services not provided directly by the agency
- Identification of expected outcomes toward which the client and therapist will be working to impact upon the specific clinical issues

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

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

- A psychologist licensed under Alabama law
- A social worker licensed under Alabama law
- 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 who has completed a master's in psychiatric nursing
- A professional counselor licensed under Alabama law
- 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 marriage and family therapist licensed under Alabama law
- A supervisor employed by DHR as a Service Supervisor or a Senior Social Work Supervisor
- For services billed through DHR, DYS, or DCA, 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 areas that require equivalent course work and who meets at least one of the following qualifications: (a) has successfully completed a practicum as part of the requirement for the degree or (b) has six months of post-master's level professional experience supervised by a master's level or above clinical with two years of postgraduate professional experience

Eligible Staff – Mental Illness

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth client visit with the primary therapist 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
- Is approved in writing by a licensed physician, certified nurse practitioner, licensed physician's assistant, licensed psychologist, licensed certified social worker, a licensed marriage and family therapist, a registered nurse with a master's degree in psychiatric nursing, or a licensed professional counselor.

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 consultation, pre-hospitalization screening, 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 client 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 client's treatment plan once every three months to determine the client's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. Providers must document this review in the client'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 client'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 Consultation, Diagnostic Testing, Pre-Hospital Screening, 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 client's progress, or lack thereof, related to each of the identified clinical issues discussed

All entries must be legible and complete, and must be authenticated and dated promptly 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 authenticate his or her entry. Authentication may include signatures, written initials, or computer 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 client's signature and the date of service. The client's signature is only required one time per day that services are provided. Treatment plan review, mental health consultation, pre-hospitalization screening, crisis intervention, family support, ACT, PACT, and any non-face-to-face services that can be provided by telephone do not require client signatures.

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

105.3 Prior Authorization and Referral Requirements

Rehabilitative services procedure codes generally do not require prior authorization. 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 - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes, within the range of 290-316, 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 V 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.

105.5.4 Place of Service Codes

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

POS Code	***Description***
11	Office
12	Home
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
33	Custodial Care Facility
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 5.7, 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 procedures 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 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. Licensed Certified Social Worker (LCSW) – effective for claims processed February 23, 2008, and thereafter:

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.

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	Section 5.2
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
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