

1. INPATIENT HOSPITAL SERVICES: All hospitalizations must be physician-prescribed. The maximum hospital length of stay for any single admission is three days except for
  - a. Psychiatric admissions authorized by the division's utilization review contractor, and
  - b. Maternal and newborn hospital stays related to childbirth which are limited to 48 hours of inpatient stay for a normal vaginal delivery and 96 hours of inpatient stay for a cesarean delivery.

Hospitals must secure a continued stay authorization from the division, or its designee, for patients to exceed the three day maximum length of stay.

Selected surgical procedures and medical diagnoses require- preadmission certification from the division or its designee. Organ transplants must be prior authorized by the division or its designee. Coverage for organ transplants is limited to kidney, corneal, skin, bone, and bone marrow transplants for adults and children under 21; liver transplants for adults and children under 21 with biliary atresia or other form of end-stage liver disease; and heart transplants for children under 21. Coverage for transplants also extends to coverage for outpatient immunosuppressive therapy. Organ transplants and requisite related medical care will be covered at an available transplant center either within the state or at a transplant center located outside the state that has been authorized by the division.

2. a. OUTPATIENT HOSPITAL SERVICES: "Outpatient hospital services" excludes services not generally furnished by most hospitals in the state, such as outpatient psychiatric and substance abuse treatment services.
3. LABORATORY AND RADIOLOGY SERVICES: Laboratory and radiology services must be medically necessary and ordered by a physician. Medically necessary diagnostic mammograms are covered. Laboratory tests are performed by a laboratory certified in accordance with the Clinical Laboratory Improvement Amendments (CLIA), at 42 CFR 493. Other laboratory and radiology services are furnished in an office or similar facility other than a hospital outpatient department or clinic and meet the State's provider qualifications. All medically necessary lab and radiology services are furnished without limitations. Selected laboratory and radiology services, however, require prior authorization.
4. a. NURSING FACILITY: Placement in a nursing facility providing a skilled level of nursing care requires prior authorization by the department.

b. EPSDT ENHANCED SERVICES:

1) Private Duty Nursing

Medicaid recipients under twenty-one (21) years of age may receive medically necessary private duty nursing services in accordance with 42 § CFR 440.80.

Private-duty nursing services are provided in a family setting, to Medicaid recipients under twenty-one (21) years of age experiencing a life-threatening illness and requiring more individual and continuous care than is available from a visiting nurse or is routinely provided by the nursing staff of a hospital, a skilled nursing facility or an intermediate care facility.

Private-duty nursing services are provided with the intent to prevent admission to, or promote early discharge from, an acute care or long-term care facility. Services must be provided in accordance with a plan of care approved by the recipients attending physician, and include,

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assessment; administration of treatment related to technological dependence, and; monitoring and maintaining parameters, machinery, and interventions.

Private-duty nursing does not include housekeeping, laundry, shopping, meal preparation, or transportation.

## 2) Podiatry

Medicaid recipients under twenty-one (21) years of age may receive medically necessary podiatry services in accordance with the provisions of 42 § CFR 440.60(a).

Podiatry services are provided to a Medicaid recipient who has been found to need medical services relating to specific conditions of the ankle or foot, when a physician has prescribed the treatment; and the treatment provided is within the scope of practice of the enrolled and licensed treating podiatrist. Nutrition Services

## 3) Nutrition Services

Medicaid recipients under twenty-one (21) years of age determined to be at high risk nutritionally may receive nutrition services including, one initial assessment in a calendar year and up to twelve (12) hours of nutritional counseling and follow-up care after the initial assessment in a calendar year.

Nutrition services are delivered in accordance with 42 § CFR 440.60(a) upon a determination that the Medicaid recipient is at high risk nutritionally by a physician, an advanced nurse practitioner, or another licensed or certified health care practitioner. Requests exceeding the original twelve (12) hours of service in a calendar year can be prior authorized by the State Medicaid Agency if the additional hours are medically necessary.

## 4) Chiropractic Services

Medicaid recipients under twenty-one (21) years of age who have a demonstrated medical need, receive chiropractic services in accordance with 42 § CFR 440.60. Chiropractic services are provided by a chiropractor holding an active state license and meeting the requirements of 42 CFR 405.232(b).

Covered chiropractic services are identified in the CPT Fee Schedule for Chiropractic Services table adopted by reference in regulation. The Alaska Medicaid Program allows manual manipulation to correct a subluxation of the spine, and x-rays necessary for diagnosis, if the subluxation of the spine resulted in a neuromusculoskeletal condition for which manual manipulation is the appropriate treatment. If there is no x-ray to support that a subluxation exists, the recipient's record must contain complete documentation of the examination results justifying manual manipulation for the subluxation of the spine.

## 5) Dental Services

Dental services for children are covered as specified in federal statute governing EPSDT when provided by a licensed dentist, including an orthodontist, or a certified dental health aide supervised by a dentist.

The Alaska Medicaid Program allows diagnostic examination and radiographs as needed for routine and emergency dental care; preventive care; restorative care; endodontics; periodontics; prosthodontics; oral surgery; anesthesia and sedation; professional; and office visits if an antibiotic is prescribed or administered without any further billable treatment that day.

The Alaska Medicaid Program allows for limited, interceptive, and comprehensive orthodontic treatment. Except for a recipient with a cleft palate, the recipient must display hygiene adequate to begin and successfully complete treatment. The recipient must be caries-free during the six months prior to treatment.

(6) Emergency Hospital Services

Emergency hospital services, as defined in 42 CFR 440.170(e), are covered for recipients under age 21.

(7) Behavior Analysis Services

In accordance with 1905(a)(6), Alaska covers the services of a Licensed Behavior Analyst pursuant to their scope of practice within the state.

In accordance with 1905(a)(6), Alaska covers the services of a Licensed Assistant Board Certified Behavior Analysts (BCBA) pursuant to their scope of practice within the state.

In accordance with 1905(a)(6), Alaska covers the services of a Behavior Technician working under the supervision of a Licensed Behavior Analyst pursuant their scope of practice within the state. The Licensed Behavior Analyst bills for all Behavior Technician services furnished.

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4. c. FAMILY PLANNING SERVICES: Fertility services not covered.
  5. a. PHYSICIAN SERVICES: Physicians services are provided in accordance with regulations at 42 CFR 440.50. A surgical procedure that could be considered experimental, investigative, or cosmetic is not covered, unless that procedure is medically necessary in the course of treatment for injury or illness and has been prior authorized by the medical review section of the division or its designee. A licensed physician provides services directly and supervises direct services provided by physician assistants, advanced nurse practitioners, certified registered nurse anesthetists, certified behavioral health aides I, II, and III, certified behavioral health practitioners, certified community health aides I, II, III, or IV, and certified community health practitioners.
  6. b. OPTOMETRIST SERVICES: Vision services are provided to recipients experiencing significant difficulties or complaints related to vision or if an attending ophthalmologist or optometrist finds health reasons for a vision examination. A second vision exam in a 12-month period must be prior authorized by the division or its designee.
  6. d.1 DIRECT ENTRY MIDWIFE SERVICES: Direct entry midwife services are those services for the management of prenatal, intrapartum and postpartum care that a direct entry midwife is authorized to provide under the scope of practice of her state license.
  6. d.2 TOBACCO CESSATION: Tobacco cessation is provided as face-to-face counseling by a qualified pharmacist to a recipient with a prescription for such service. All counseling encounters must follow general Medicaid documentation requirements for the service provided. Qualified pharmacists are those who have attended at least one continuing education course on Tobacco Cessation in accordance with federal public health guidelines found in the United States Department of Health and Human Services Public Health Services Quick Reference Guide for Clinicians: Treating Tobacco Use and Dependence. Such treatment may include discussing challenges to and strategies for success, behavior triggers, alcohol use, relapse and coordination with prescriber to ensure the correct therapy is employed.
  6. d.3 Qualified pharmacists providing administration of preventive vaccines, as authorized under "Other Licensed Practitioners" at 42 CFR 440.60, will be paid an administration fee for administering vaccines to recipients age 19 years old and above. Qualified pharmacists may administer all medically necessary vaccines, either by injection or intranasally, as authorized by the State within the scope of their practice.
  6. d.4 In accordance with § 42 CFR 440.60(a), the following licensed providers acting within their scope of practice as defined by state law: Licensed Psychologists, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists.
  7. a-d. HOME HEALTH SERVICES: Home health services are offered in accordance with 42 CFR 440.70. Home health services must be ordered by the attending physician and must be prior authorized by the State Medicaid Agency or its designee.
    - c. Equipment and appliances that require prior authorization by the State Medicaid Agency or its designee are listed in the provider manual.
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9. **CLINIC SERVICES:**

**Community Behavioral Health Center –**

A. **Definition of services** - The Medicaid agency or designee will reimburse a community behavioral health center for the provision of approved services for the treatment of diagnosable mental health disorders provided to Medicaid eligible beneficiaries.

**B. Prior authorization and limitations**

The following services do not need prior authorization if provided within the following service limits:

- i. Any combination of individual, group, and family therapy not to exceed 10 hours per state fiscal year.
- ii. Psychiatric assessment not to exceed four per recipient per state fiscal year.
- iii. Psychological testing not to exceed six hours per recipient per state fiscal year.
- iv. Pharmacologic management not to exceed one visit per week during the first four weeks of treatment and thereafter not to exceed one visit per month.
- v. If an individual is not already receiving services, one integrated mental health and substance use intake assessment or a combination of one mental health intake assessment and one substance use intake assessment.
- vi. If an individual is subject to a current behavioral health treatment plan, one integrated mental health and substance use intake assessment or a combination of one mental health intake assessment and one substance use intake assessment every six months.
- vii. Short-term crisis intervention services not to exceed 22 hours per state fiscal year.

If an organization anticipates exceeding the service limits, it is required to submit a prior authorization request to the State Medicaid Agency or its designee, documenting the medical necessity for the additional services.

**Mental Health Physician Clinic–**

A. **Definition of services** – The Medicaid agency or designee will reimburse a mental health physicians clinic for the provision of approved services for the treatment of diagnosable mental health disorders provided to Medicaid eligible beneficiaries.

**B. Prior authorization and limitations**

The following services do not need prior authorization if provided within the following service limits:

- i. Any combination of individual, group, and family therapy not to exceed 10 hours per state fiscal year.
- ii. Psychiatric assessment not to exceed four per recipient per state fiscal year.
- iii. Psychological testing not to exceed six hours per recipient per state fiscal year.
- iv. Pharmacologic management not to exceed one visit per week during the first four weeks of treatment and thereafter not to exceed one visit per month.

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- v. If an individual is not already receiving services - one integrated mental health and substance use intake assessment or a combination of one mental health intake assessment and one substance use intake assessment.
  - vi. If an individual is subject to a current behavioral health treatment plan – one integrated mental health and substance use intake assessment or one mental health intake assessment every six months.
  - vii. Short-term crisis intervention services not to exceed 22 hours per state fiscal year.

If an organization anticipates exceeding the service limits, it is required to submit a prior authorization request to the State Medicaid Agency or its designee, documenting the medical necessity for the additional services.

#### **Ambulatory Surgery Center**

- A. **Definition of services:** Ambulatory surgical center (ASC) means any distinct entity operating exclusively for providing surgical services to patients not requiring hospitalization, and in which the expected duration of services would not exceed 24 hours following an admission. (42 CFR 416.2)
- B. **Providers and qualifications:** Ambulatory surgical centers must comply with all current federal (42 CFR 416.25 – 416.54) and state enrollment requirements, have a system to transfer patients requiring emergency admittance or overnight care to a licensed, Medicaid-enrolled facility following any surgical procedure performed, and have a department approved utilization review plan.
- C. **Prior authorization and limitations:** Services requiring prior authorization are noted on the current ASC fee schedule

#### **End Stage Renal Disease Clinics**

- A. **Definition of services:** End stage renal disease services include comprehensive outpatient dialysis and related services including labs and drugs, home dialysis training and support services, or both.
- B. **Providers and qualifications:** The end stage renal disease provider must comply with all current federal (42 CFR 494.1 – 494.20) and state enrollment requirements, and be enrolled as a Medicare provider.
- C. **Prior authorization and limitations:** The facility may bill a maximum of one peritoneal dialysis treatment per day, and a maximum of three hemodialysis treatments per week. Treatment limits may be exceeded upon a determination of medical necessity.

10. **DENTAL SERVICES:** See attached Sheet to Attachment 3.1-A, page 3a

11. **PHYSICAL THERAPY AND RELATED SERVICES:** See Attachment 3.1-A, page 24a-24c

#### **12. PRESCRIBED DRUGS:**

- a. Covered outpatient drugs are drugs:
  - i. dispensed only upon a prescription; and
  - ii. for which the United States Food and Drug Administration (FDA) requires a national drug code (NDC) number; and
  - iii. Alaska covers outpatient drugs in accordance with Section 1902(a)(54) and 1927 of the Social Security Act.

- b. a compounded prescription if at least one ingredient is a covered outpatient drug as defined in (a) above and the recipient's drug therapy needs cannot be met by commercially available dosage strengths or forms of the therapy; the claim for a compounded prescription is submitted using the national drug code (NDC) number and quantity for each covered outpatient drug in the compound; not more than 25 covered outpatient drugs are reimbursed in any compound.

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Methods and Standards for  
Establishing Payment Rates: Other Types of Care

10. Dental Services

Dental services for recipients age 21 or older are limited to emergency treatment for the relief of pain and acute infection and the following prior authorized additional services up to an annual limit of \$1150 per Medicaid recipient:

- 1) routine diagnostic examination and radiographs;
- 2) preventive care,
- 3) restorative care,
- 4) certain endodontic services,
- 5) periodontics,
- 6) prosthodontics,
- 7) oral surgery,
- 8) professional consultation.

The following services are excluded:

- (1) panoramic radiograph more than once per year;
- (2) final restorations in amalgam or resin for more than five surfaces;
- (3) dental sealants;
- (4) restoration of etched enamel or deep grooves without dentin involvement;
- (5) inlays, overlays or three-fourth crowns;
- (6) endodontic apical surgery or retrograde fillings;
- (7) periodontal surgery;
- (8) implant and implant-related dental services;
- (9) orthodontic services.

12b. Dentures

Recipients age 21 and older are limited to dentures up to an annual limit of \$1150 per recipient. When upper and lower dentures are necessary and the annual limit is not adequate to cover the cost of the dental claim, twice the annual limit may be authorized by the Department. When authorizing twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year. The recipient is not allowed a new or additional annual limit for the succeeding year beyond that already paid for the dentures.

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**DEC 16 2011**

- (2) Drugs not otherwise specifically excluded from payment may be covered only after prior authorization has been obtained by the Division. These drugs may be further limited on the minimum and maximum quantities per prescription or on the number of refills to discourage waste and address instances of fraud or abuse by individuals. The Division will ensure a response to each prior authorization request is provided within 24 hours. In emergency situations, at least a 72-hour supply of the covered outpatient prescription may be dispensed.
- (3) A pharmacy shall maintain documentation of receipt of prescribed drugs by recipients. The documentation may be kept as a signature log showing which prescription numbers are received or as mailing labels if prescribed drugs are mailed to the recipient.
- (4) A provider that dispenses drugs in unit doses to a recipient in a nursing home or other long term care facility shall return unused medications to the pharmacy and the claim shall be adjusted.

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TN No: 11-007 Approval Date: NOV 30 2012 Effective Date: September 7, 2011  
Supersedes: NA

Description of Service Limitations

- (3) The following drugs are not covered:
- (a) drugs that are prohibited from receiving federal Medicaid matching funds under 42 CFR 441.25, as amended October 1, 1981;
  - (b) drugs, except for birth control drugs and drugs listed in 12. a. (a)(1)(c) of this attachment if dispensed in an unopened container, for which more than a 30-day supply is ordered per prescription and
  - (c) brand name multi-source drugs when a therapeutically equivalent generic drug is on the market unless the prescriber writes on the prescription "The brand-name medically necessary drug" or "allergic to the inert ingredients of the generic drug." The information may be submitted electronically or telephonically. Telephonic information must be documented by the prescriber in the recipient's record.
- (4) The state will be negotiating supplemental rebates in addition to, and separate from, Federal rebates authorized in Title XIX. The following supplemental rebate policies are in compliance with the requirements of Section 1927 of the Act:
- a. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data.
  - b. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.
  - c. CMS has authorized the State of Alaska to enter into the Michigan multi-state pooling agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on February 28, 2008 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on September 16, 2013 has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.
  - d. Supplemental rebates received by the State under these agreements in excess of those required under the national drug rebate agreements are shared with the federal government on the same percentage basis as applied under the national rebate agreements.
  - e. All drugs covered by the supplemental rebate program, regardless of any prior authorization requirement, comply with provisions of the national drug rebate program.
  - f. For drug classes under review by the Pharmacy and Therapeutics (P&T) Committee, a manufacturer's payment of supplemental rebate(s) may result in its product being covered without documentation of medical necessity if it meets therapeutic equivalency criteria and is recommended by the committee.

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Supersedes TN No 07-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Alaska

MEDICAID PROGRAM: REQUIREMENTS RELATING TO  
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

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Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

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TN No. N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency ———— Alaska ————

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR  
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1927(d)(2) and 1935(d)(2)	1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit Part D.
	X <b>The following excluded drugs are covered:</b>
	X (a) agents when used for anorexia, weight loss, weight gain – limited to Megace Oral Suspension
	<input type="checkbox"/> (b) agents when used to promote fertility
	X (c) agents when used for cosmetic purposes or hair growth – limited to all cosmetic drugs
	<input type="checkbox"/> (d) agents when used for the symptomatic relief cough and colds
	X (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride – limited to prescription Vitamins (oral vitamins, folic acid, Vitamin A, Vitamin Vitamin D, and analogs, Vitamin B complex when
	Medically necessary)
	X (f) non-prescription drugs – limited to laxatives and bismuth preparation, Vaginal antifungal creams and suppositories, Nonoxyl 9 contraceptives, Bacitracin topical ointment, loratadine, omeprazole

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**MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY**

Citation(s)	Provision(s)
1927 42 CFR 447.201 42 CFR 440	X (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific categories below)
	X (h) barbiturates <b><u>(Except for dual eligible individuals effective January 1, 2013 when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications)</u></b>
	X (i) benzodiazepines <b><u>(Except for dual eligible individuals effective January 1, 2013 as Part D will cover all indications)</u></b>
	X (j) smoking cessation (except for dual-eligibles beginning January 1, 2006.)
	(The Medicaid agency lists specific category of drugs below)
	(k) Drugs for weight gain (Anabolic Steroids); Megace Oral Suspension
	(l) All cosmetic drugs are covered except hair growth drugs, which are not covered
	(m) Prescription vitamins: oral vitamins, folic acid, Vitamin A, Vitamin K, Vitamin D, and analogs, Vitamin B Complex when medically necessary.
	(n) Prescription drugs: laxatives and bismuth preparations, vaginal antifungal creams and suppositories, Nonoxyl 9 contraceptives, Bacitracin Topical Ointment, Tobacco cessation drugs, loratadine, omeprazole.

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Supersedes: TN No: 11-007

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**Description of Service Limitations**

- 12a. All medically necessary vaccines , including those for influenza, are covered for Alaska Medicaid recipients age 19 and over, per ACIP guidelines available at <http://www.cdc.gov/vaccines/recs/acip/default.htm>.
- 13c. Qualified enrolled licensed Medicaid providers practicing within their scope of practice to administer all medically necessary vaccines to adults age 19 and over and children under age 19.

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**JUL 21 2010**

**Description of Service Limitations**

- 12 c. Prosthetic devices are provided upon a physician's order.
- 12 d. Eyeglasses are provided to recipients in response to an initial or change of prescription, or as a replacement of a lost or destroyed pair of glasses. Tinted lenses are not covered unless medically necessary. Contact lenses are not covered except for specific medical conditions. Tinted lenses and contact lenses must be prior authorized. Eyeglasses are purchased for recipients under a competitively bid contract.
13. **DIAGNOSTIC, SCREENING, PREVENTIVE, REHABILITATIVE SERVICES:**
- a. Mammography coverage is limited to diagnostic mammograms necessary to detect breast cancer.
- b. i. Screening mammograms are covered at the age and frequency schedule of the American Cancer Society, as provided in state statute.
- ii. Behavioral Health Screening is used to determine the likelihood that a mental health condition, emotional disorder, brain injury, or substance abuse disorder is present and to determine the need for further referral, assessment or treatment. Any willing and qualified mental health provider may deliver this service.
- d. Rehabilitative Services are limited to the following.

**(1) Mental Health Rehabilitative Services**

Mental Health rehabilitative services are provided to recipients to remediate and ameliorate debilitating effects of behavioral health disorders for the maximum reduction of the each disabling condition. These services help the recipient develop appropriate skills and to improve overall functioning.

The state assures that any willing and qualified provider can deliver these services. Participants who reside in institutions for mental diseases (IMDs), nursing facilities and/or acute care facilities are not eligible to receive these services. Further, any willing and qualified provider may deliver these services and the participants do not have to be in a particular setting to receive services.

Services are client-centered and focused on the remediation of specific dysfunctions and disabilities as set out in the treatment plan, and may be provided

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**JUN 10 2010**

**Description of Service Limitations**

individually or in groups that could include family members. Treatment is always focused on the Medicaid-eligible recipient; not the family.

(a)The following mental health rehabilitative services are available for children under 21 years of age with an appropriate mental health diagnosis resulting from an EPSDT screen or a mental health assessment. Pursuant to EPSDT, no limitations on services are imposed for individuals under 21 years of age if determined to be medically necessary and prior authorized by Alaska Medicaid. Services may be provided to seriously mentally ill and severely emotionally disturbed adults.

**i. Assessments:** A systematic evaluation of a recipient upon admission to services and periodically during the course of treatment, to assess and document substance abuse and/or mental health disorders, including assessing mental status, social and medical history, presenting problems, related symptoms, and service needs of the recipient for the purpose of establishing a diagnosis and developing an individualized treatment and/or rehabilitation plan. The service includes **functional assessments** which assess the functioning levels in the life domains necessary for independent living. Assessments are provided by a Master's level clinician or above.

**ii. Therapy and Treatment** includes treatment, therapeutic interventions, and rehabilitative services designed to alleviate behavioral health disorders (mental, emotional and/or substance abuse related) and encourage growth and development while helping to prevent relapse of such conditions. Also includes planning, delivery and monitoring of a dynamic set of services that target specific behaviors identified in the assessment and treatment plan designed to improve functioning and enhance quality of life. Services are designed to improve the functioning level of the recipient through supporting or strengthening the behavioral, emotional, or intellectual skills necessary to live, learn or work in the community.

Services include

**Therapeutic behavioral services** include teaching of life skills designed to restore the recipient's functioning and support community living; counseling focused on functional improvement, recovery and relapse prevention; encouraging and coaching. Therapeutic behavioral services are provided by all willing and qualified mental health providers.

**Psychosocial Rehabilitation Recipient Support** services are recognized as medically necessary through a professional behavioral health assessment that documents the recipient's history of high risk behavior or the rationale for heightened vigilance; and recommends the frequency and location where the service should be provided. These services are identified in the recipient's treatment and rehabilitation plan along with target symptoms; and how provider is

### **Description of Service Limitations**

expected to resolve high risk behavior. Psychosocial rehabilitation recipient support does not include the daily supervisory activities that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a severely emotionally disturbed child; or a seriously mentally ill adult. Services are limited to a maximum of four hours per day per recipient, without prior authorization. Psychosocial rehabilitation recipient support services are provided by all willing and qualified mental health providers.

**Day treatment services** teach self management skills to improve the recipient's behavioral functioning; provides counseling and coaching focused on overall functional improvement. Services are provided in accordance with the recipient's individualized treatment plan. Day treatment services are provided by all willing and qualified mental health providers.

**iii.Medications Administration** includes oral medication administration with direct observation, monitoring the individual's response to medication, assessment and documentation of medication compliance, and evaluation and documentation of medication effectiveness and any side effects. Medication administration must be provided by licensed medical personnel.

### **Specific Provider Qualifications for Providers of Rehabilitative Services**

Except for medication administration, preceding services may be provided by:

- an individual with a master's degree or more advanced degree in psychology, social work, counseling, child guidance, or nursing with specialization or experience in mental health who, if employed by a mental health physician clinic, is licensed to practice in the state in which the service is provided; or
- a marital and family therapist who meets licensure requirements in Alaska or in a state with requirements substantially similar to Alaska requirements where services are provided, and who works in the individual's field of expertise; or
- a professional counselor who is meets licensure requirements in Alaska or in a state with requirements substantially similar to Alaska requirements where services are provided, and who works in the individual's field of expertise; or
- mental health clinical associate who is an individual who may have less than a master's degree in psychology, social work, counseling, or a related field with specialization or experience in working with chronically mentally ill adults or severely emotionally disturbed children and works within the scope of the individual's training and experience, and works under the direction of a mental health professional clinician, physician, or psychiatrist operating within the scope of their practice

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**Description of Service Limitations**

(2) Alcohol and Substance Abuse Rehabilitation Services:

(i) **Service Descriptions and Provider Qualifications for Alcohol and Substance Abuse Assessment, Detoxification, Therapeutic Behavioral, Psychosocial Support and Brief Intervention:**

Each service listed in the following section may be provided by one or more of the following, for both children and adults who are found in a treatment plan to need substance abuse services. Pursuant to EPSDT, no limitations on services are imposed for individuals under 21 years of age if determined to be medically necessary and prior authorized by Alaska Medicaid:

- 1) psychologists, psychological associates, clinical social workers, marriage and family therapists, professional counselors, psychiatric nurses, or certified nursing assistants who are licensed and practicing within the scope of their experience and authority ; OR
  - 2) a paraprofessional substance abuse counselor. Paraprofessional substance abuse counselors meet the requirements of a mental health clinical associate who is an individual who may have less than a master's degree in psychology, social work, counseling, or a related field with specialization or experience in working in the field of substance abuse and behavioral health and who works within the scope of their training and experience, and who works under the direction of a licensed health care professional operating within the scope of their practice.
- (a) **Assessments:** A systematic evaluation of a recipient upon admission to services and periodically during the course of treatment, to assess and document substance abuse and/or mental health disorders, including assessing mental status, social and medical history, presenting problems, related symptoms, and service needs of the recipient for the purpose of establishing a diagnosis and developing an individualized treatment and/or rehabilitation plan.
- (b) **Alcohol and Drug Detoxification** Services are delivered face-to-face and include an initial nursing assessment, physiological stabilization, diagnosis, treatment and on-going assessment and monitoring of the recipient's withdrawal symptoms.
- (c) **Therapeutic behavioral services** teach life skills designed to restore the recipient's functioning and support community living; counseling focused on functional improvement, recovery and relapse prevention; encouraging and coaching
- (d) **Psychosocial Rehabilitation Recipient Support** services are recognized as medically necessary through a professional behavioral health assessment that documents the recipient's history of high risk behavior or the rationale for heightened

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**Description of Service Limitations**

vigilance; and recommends the frequency and location where the service should be provided. These services are identified in the recipient's treatment and rehabilitation plan along with target symptoms; and how provider is expected to resolve high risk behavior.

- (e) **Brief intervention** services involve motivational discussion focused on raising the recipient's awareness of their substance use, the potential harmful effects of the substance use, and encouraging positive change.

- (ii) **Service Descriptions and Provider Qualifications for Medication and Medical Services**

Each service listed in the following section must be provided by medical personnel acting within the scope of their license, for both children and adults who are found in a treatment plan to need substance abuse services. Service providers include physicians, physician assistants, nurse practitioners, registered nurses, licensed practical nurses, and certified nurse aides. Pursuant to EPSDT, no limitations on services are imposed for individuals under 21 years of age if determined to be medically necessary and prior authorized by Alaska Medicaid.

- (f) **Medication Administration** includes the administration, by medical personnel, of injectable or oral medications with direct observation, monitoring the individual's response to medication, assessment and documentation of medication compliance, and evaluation and documentation of medication effectiveness and any side effects.
- (g) **Medical Services** related to the treatment of substance disorders including intake physicals, pharmacological management, monitoring, medical decision-making, and methadone administration.

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**Description of Service Limitations**

intellectual skills necessary to return to independent functioning, to a maximum of 10 hours per week;

- (G) Medical Services directly related to substance abuse, as prescribed or otherwise medically necessary; methadone maintenance is limited to one dose per day; and
- (H) Detoxification Services, to a maximum of five 24-hour days in any 30-day period unless prior-authorized.

Providers must be approved by the Division of Alcoholism and Drug Abuse. Care Coordination services (Supplement 1 to Attachment 3.1-A) are limited to 4 hours in any 6-month period, with each service contact consisting of at least 20 but not more than 30 minutes. (Children found by an EPSDT screen to need services in excess of the limits above, with prior-authorization, may receive additional service.)

(3) Behavior Rehabilitation Services

Behavior Rehabilitation Services are provided to children/youth to remediate debilitating psycho-social, emotional and behavioral disorders. The services provide early intervention, stabilization and development of appropriate coping skills upon the recommendation of a licensed practitioner of the healing arts within the scope of their practice within the law. Prior authorization of services is required.

(A) Service Description

Behavior Rehabilitation Services may be provided in a variety of settings and consist of interventions to help children/youth acquire essential coping skills. Specific services include milieu therapy, crisis intervention, crisis counseling, regular scheduled counseling and skills training. The purpose of this service is to remediate specific dysfunctions, which have been explicitly identified in an individualized written treatment plan that is regularly reviewed and updated. Client centered treatment services may be provided individually or in groups and may include the child's/youth's biological, adoptive or foster family. Treatment is focused upon the needs of the child/youth; not the family unit. These services may be in conjunction with or in support of any other professional treatment services the child/youth may be receiving as required by the diagnosed condition.

The services will include crisis intervention and counseling on a 24-hour basis to stabilize the child's behavior until resolution of the problem is

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**Description of Service Limitations**

reached, or until the child or youth can be assessed and treated by a qualified Mental Health Professional or licensed Medical Practitioner.

Regular scheduled counseling and therapy is provided to remediate specific dysfunctions, which have been explicitly identified in the treatment plan.

Skill training is provided to assist the child/youth in the development of appropriate responses to social and emotional behaviors, peer and family relationships, self-care, conflict resolution, aggression reduction, anger control, and to reduce or eliminate impulse and conduct disorders.

Milieu therapy refers to those activities performed with children and youth to normalize their psycho-social development and promote the safety of the child or youth and stabilize their environment. The child or youth is monitored in structured activities, which may be developmental, recreational, academic, rehabilitative, or a variety of productive work activities. As the child or youth is monitored, planned interventions are provided to remediate the identified dysfunctional or maladaptive behaviors and promote their replacement with more developmentally appropriate responses.

**(B) Population to be Served**

The population served will be EPSDT eligible children/youth who have primary mental, emotional and behavioral disorders and/or developmental disabilities that prevent them from functioning at developmentally appropriate levels in their home, school, or community. They exhibit such symptoms as severe personality disorder, organic disorder, or other mental disorder with persistent nonpsychotic or psychotic symptoms; drug and alcohol abuse, anti-social behaviors that require close supervision and intervention and structure; or sexual behavior problems that severely or chronically impair their ability to function in typical family, work, school, or other community roles. Children/youth may be victims of severe family conflict, behavioral disturbances often resulting from psychiatric disorders of the parents, or may be medically compromised and developmentally disabled children/youth whose needs are not already met by another program.

**Description of Service Limitations**

- (C) **Provider Qualifications:** Providers of these services must be approved by the Division of Family and Youth Services.

**Program Coordinator:** Responsibilities include supervision of staff, providing overall direction to the program, planning and coordinating program activities and delivery of services, and assure the safety and protection of children/youth and staff.

**Minimum Qualifications –** A bachelor's degree, preferably with major study in psychology, sociology, social work, social sciences, or a closely related field, and two years experience in the supervision and management of a residential facility for care and treatment of children/youth. Six years of experience serving children or youth in a residential setting may be substituted for the bachelor's degree.

**Social Service Staff:** Responsibilities include case management and the development of service plans; individual, group and family counseling, individual and group skills training; assist the child care staff in providing appropriate treatment to children/youth; coordinate services with other agencies; document treatment progress.

**Minimum Qualifications:** A master's degree with major study in social work or a closely related field and one year of experience in the care and treatment of children/youth, or a bachelor's degree with major study in social work, psychology, sociology or a closely related field and two years experience in the care and treatment of children/youth.

**Child Care Staff:** Responsibilities include direct supervision and control of the daily living activities of children/youth, assisting social service staff in providing individual, group and family counseling, skills training, provide therapeutic interventions to children/youth as directed by the individual treatment plans to address behavioral and emotional problems as they arise, monitor and manage the children/youth's behavior to provide a safe, structured living environment that is conducive to treatment.

**Minimum qualifications:** require that no less than 50% of the child care staff in a facility have a bachelor's degree. Combination of formal education and experience working with children/youth may be substituted for a bachelor's degree. Child-care staff are members of the treatment team and work under the direction of a qualified social service staff or a program coordinator.

**Description of Service Limitations**

(D) Other Settings for Service Delivery

Behavioral Rehabilitative Services may be provided in a foster-care or adoptive setting that is less restrictive and more normative than a residential setting. The state child placement agency determines whether behavioral rehabilitative services are necessary and appropriate in the foster-care or adoptive setting. Services are authorized through an evaluation process and results are incorporated into the child's case plan.

Foster- or adoptive-care settings are licensed under state law and approved by the state agency. State licensed social workers, psychiatric nurses, or agency-certified caseworkers provide professional supervision of behavioral rehabilitative services delivered in these settings. The state agency provides quality assurance to ensure each child receives the services appropriate for their needs. Service provider qualifications for each care setting are defined in state regulations.

TN No. 03-07 Approval Date July 11, 2003 Effective Date: April 1, 2003

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**Description of Service Limitations**

(4) School-Based Rehabilitative Services

School-based rehabilitative services are health-related services that:

1. address the physical or mental disabilities of a child,
2. are recommended by health care professionals, and
3. are identified in a child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

School-based services are delivered by providers operating within the scope of their practitioner's license and/or certification pursuant to State law and federal regulations, at 42 CFR 440.110, which specify the following qualifications for licensure:

- Physical therapists must have graduated from a school of physical therapy approved by the Council on Medical Education and Hospitals of the American Medical Association, or the American Physical Therapy Association and pass the board exam.
- Occupational therapists must have successfully completed a curriculum approved by the Committee of Allied Health Education and Accreditation of the American Medical Association or the American Occupational Therapy Association and pass the board exam.
- Speech pathologists must possess a Certificate of Clinical Competence in speech-language pathology from the American Speech-Language-Hearing Association or have completed the equivalent educational requirements and work experience necessary for it or have completed the academic program and be currently acquiring the work experience to qualify.
- Audiologists must have a master's or doctorate in audiology from an accredited educational institution and also have EITHER a Certificate of Clinical Competence in Audiology from the ASHA, or is in the process of completing the year of supervised clinical experience required for the Certificate of Clinical Competence from ASHA.

A physician or other practitioner of the healing arts operating within the scope of their practice must prescribe physical and occupational therapy services. A physician or other practitioner of the healing arts operating within the scope of their practice must refer patients for speech, hearing, and language services provided by, or under the direction of, speech pathologists or audiologists.

School-based rehabilitative services include:

1. physical and occupational therapy evaluations, and treatments,
2. speech evaluations and therapy treatments, and
3. audiological services.
4. evaluation, screening and assessment components that identify a child's need for physical, occupational, speech -language-hearing therapies when the evaluations lead to the child receiving these services within their IEP.

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**Description of Service Limitations**

14. **INSTITUTIONS FOR MENTAL DISEASES FOR AGE 65 OR OLDER:** Services in institutions for mental diseases for individuals age 65 or over are provided if placement is prior authorized by the Division of Mental Health or the Professional Review Organization on contract with the Division.
15. **INTERMEDIATE CARE FACILITY SERVICES:** Placement in a nursing facility offering an intermediate level of nursing care or in an ICF/MR require prior authorization by the Division of Medical Assistance.
16. **INPATIENT PSYCHIATRIC FACILITY SERVICES:**
- (1) Inpatient psychiatric facility services for individuals under 21 are provided if placement is prior authorized by the Division of Mental Health or PRO or the state's designee.
  - (2) Rehabilitative services, including appropriate therapies, are provided for severely emotionally disturbed children in a JCAHO-accredited residential facility.
20. **EXTENDED SERVICES TO PREGNANT WOMEN:** All state plan services are provided for pregnant women through 60 days after pregnancy ends. Nutrition services are provided by registered dietitians to high-risk pregnant women. Prior authorization is required in most cases, and visits are limited to seven per pregnancy.
24. **OTHER MEDICAL CARE:**
- a. Transportation: Non-emergency medical transportation must be authorized in advance by the medical review section of the Division of Medical Assistance or its fiscal agent. Non-emergency transportation must occur on weekdays during normal working hours. Emergency medical transportation is covered to the nearest facility offering emergency medical care. The services of an emergency air ambulance or an accompanying escort must be authorized no later than the first working day following the travel. Ground ambulance service is approved only for a one-way trip at a time.
  - d. Nursing Facility Services for Children: Nursing facility placement for patients under age 21 requires prior authorization by the Division of Medical Assistance.

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### Description of Service Limitations

#### f. **Personal Care Services:**

Covered services are limited to non-technical hands-on assistance with activities of daily living (ADLs), which include bathing, dressing, and grooming, problems with instrumental activities of daily living (IADLs), such as shopping and cleaning necessary to maintain the health and safety of the recipient, and other problems that require trained care. Personal care services must be provided in either the recipient's home, or other locations necessary to assist with the activities of daily living, but may not be provided in institutions. Allowable services must be defined in a service plan developed as a result of a functional assessment approved by the state-authorized Personal Care Agency (PCA) or the Alaska Department of Health and Social Services (DHSS).

Services must be provided only through a qualified PCA agency by health care paraprofessionals called Personal Care Assistants (PCAs). The PCAs must have completed a state approved PCA training program, except in cases where:

- the personal care agency has determined that the recipient or their representative is capable of specifying the training requirements for the personal care assistant and supervising them;
- the personal care agency has trained the recipient or their representative in their responsibilities; and
- the personal care assistant has successfully completed the recipient-specific training provided by the recipient or their representative.

To be a representative, an individual must be directly involved in the recipient's day-to-day care and available to assume the responsibility of managing the recipient's care, including directing the care as it occurs in the home. Legally responsible relative of the recipient are excluded from payment for personal care services

#### **Personal care services do not include:**

- (1) application of dressings involving prescription medication and aseptic techniques; invasive body procedures – including injections and insertion or removal of catheters; tracheostomy care; tube or other enteral feedings; medication administration; or care and maintenance of intravenous equipment. However, personal care assistants may perform these tasks under the following conditions:
  - the recipient of services, or their representative, is capable and willing to delegate such functions, which are within the purview of individuals and their unpaid caregivers to perform;
  - the recipient or representative is capable and willing to supervise the administration of these tasks; and
  - the personal care agency or the department has determined that the recipient or their representative is capable of delegating the tasks and perform these supervisory functions.
- (2) heavy chore services in the home, including cleaning floors and furniture not used directly by the recipient, laundry not incidental to the recipient's care, cutting firewood, and shopping for groceries and other household items not required specifically for the health and maintenance of the consumer;
- (3) any task the personal care agency, supervising nurse, or division determines, as a result of the assessment, could reasonably be performed by the consumer or a member of the consumer's household;
- (4) respite care intended primarily to relieve a member of the consumer's household, a family member, or a caregiver other than a personal care assistant from the responsibility of caring for the consumer; and
- (5) supervision, babysitting or care of any other household members, social visitation, general monitoring for equipment failure, home maintenance, or pet care, except for a certified service animal.

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**Personal care services may be provided through two different qualified Personal Care Agency (PCA) Models:**

**Agency Based Personal Care Assistance (ABPCA):** The beneficiary may choose a personal care agency in the agency-based model, which provides services through an agency that oversees, manages, and supervises the beneficiary's care. The ABPCA agency hires, schedules, develops a backup plan if the regularly scheduled personal care assistant (PCA) is unavailable, and dispatches PCAs.

**Consumer Directed Personal Care Assistance (CDPCA):** The beneficiary may choose a consumer directed personal care assistance model, which provides administrative support to the consumer who manages his or her own care by hiring, firing, and supervising his or her own PCA. The CDPCA will assess the recipient's needs every twelve months or more frequently if necessary, and must develop a backup plan with the recipient or a legal representative. The CDPCA agency must ensure that basic elements required for enrollment of each individual PCA are met.

**Provider Qualifications:** The state does not limit personal care agencies to private or non-profit.

To qualify for certification as a PCA agency, the agency must meet the applicable certification criteria set out in the department's Personal Care Assistant Agency Certification Application packet. ABPCA and CDPCA agencies must employ a Program Administrator who has attended mandatory state training. For the ABPCA agency type only, the agency must also employ a Registered Nurse.

At both CDPCA and ABPCA agencies, the personal care assistant must be at least 18 years of age, must meet all the requirements of the model as described in state regulations, including successful completion of First Aid and CPR training within the last two years, must be individually enrolled to bill Medicaid, must pass a criminal background check, must not have been denied a health care provider license or certification for a reason related to patient services, and must be able independently to assist the recipient with the specific Activity of Daily Living and services.

Additionally, to be a personal care assistant for an ABPCA, the assistant must be a licensed nurse, or CNA, or a community health aide, or have successfully completed a training approved by the State, or completed an equivalent training five years prior to applying to be employed as a PCA. Training requirements for personal care assistants working in ABPCA agencies include at least 40 hours of instruction, given by a nurse licensed by the State of Alaska, in infection control, bowel and bladder care, nutrition and food planning and preparation, physical transfers, assistance with self-administration of medication, blood pressure, temperature, respiration, developmental disabilities and physical and mental illnesses, body systems, mechanics and disorders, death and dying, use of equipment necessary to perform the tasks of a PCA, universal precautions, and affecting PCAs such as record keeping, confidentiality, reporting Medicaid fraud.

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