



State of Alaska

DHSS / Division of Behavioral Health

Integrated Behavioral Health Regulations Frequently Asked Questions

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Version XXII

Introduction

The “Integrated Behavioral Health Regulations Frequently Asked Questions” is intended to function as a short-term guide to assist Provider’s during the initial implementation period of the new regulations. It contains Dept. answers to Provider questions posed at the weekly Technical Assistance Teleconferences. The questions as they appear currently in the document are framed as accurately as possible using the Provider’s own words.

Much of the information contained in this document will be used to formulate official Regulation Clarifications that will then appear in the new Provider Manual: “The Alaska Medical Assistance Program Policies and Claims Billing Procedures for Community Behavioral Health Services”. This Manual will be released on December 1, 2011.

Much of the remainder of the information from this document will be condensed and used to help formulate standardized Frequently Asked Questions (FAQ) that will then appear in a separate document which will be archived on the DHSS/ Behavioral Health website. This new FAQ document will be added to from time to time.

DISCLAIMER: The Behavioral Health Services Integrated regulations set forth rules that govern the State of Alaska behavioral health service delivery system. This set of Administrative Code is designed to establish the minimum requirements for eligible providers in Alaska. However, providers may also be obligated to comply with Federal regulations or other standards that apply to their business operations and the provision of care to consumers. The Department cannot reasonably inform providers of all other requirements outside State jurisdiction that may bear on their operations, or explain how to conduct their business in relation to these requirements.

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	21	IX	38	Deleted
	22	XII	9	Added
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	5	VI	38	Added
	6	VI	39	Added
	7	VI	40	Added
	8	VI	41	Added
	9	VIII	17	Added
	10	VIII	18	Added
	11	IX	72	Added
	12	IX	73	Added
	13	IX	74	Added
	14	IX	75	Added
	15	IX	76	Added
	16	X	33	Added
	17	X	34	Added
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	12	IX	71	Added
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	3	VI	33	Added
	4	XI	4	Added
	5	IX	63	Added
6/4/2012	1	IV	7	Added
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	3	V	47	Added
	4	VI	32	Added
	5	VIII	15	Added
	6	VIII	16	Added
	7	IX	24	Deleted
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	9	IX	62	Added
	10	X	31	Added
	11	X	32	Added
4/19/2012	1	III	5	Added
	2	VI	29	Added
	3	VI	30	Added
	4	VI	31	Added
	5	IX	15	Updated
	6	IX	59	Added
	7	IX	60	Added
	8	IX	61	Added
	9	X	30	Added
	10	XI	3	Added
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	6	IX	56	Added
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	10	IX	54	Added
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	12	XI	2	Added
	13	XII	8	Added
	14	XIV	1	Added
	15	XIV	2	Added
	1/06/2012	1	V	47
2		IX	51	Updated
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12/30/2011	1	V	1	Updated
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	4	VI	22	Added
	5	IX	45	Added
	6	IX	46	Added
	7	IX	47	Added
	8	IX	48	Added
	9	IX	49	Added
	10	IX	50	Added
	11	IX	51	Added
12/6/2011	1	V	42	Added
	2	V	43	Added
	3	V	44	Added
	4	VI	21	Added
	5	IX	40	Added
	6	IX	41	Added
	7	IX	42	Added
	8	IX	43	Added
	9	IX	44	Added
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11/16/2011	1	V	19	Updated
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	6	IX	37	Added
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	3	V	40	Added
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	7	IX	29	Added
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11/09/2011	1	VI	16	Added
	2	IX	24	Added
	3	IX	26	Added
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	5	IX	28	Added
	6	X	21	Added
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11/04/2011	1	Introduction	NA	Updated
	2	VI	12	Added
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10/28/2011	1	V	37	Added
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10/3/2011	1	1A	1	Added
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9/27/2011	1	III	3	Added
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	6	IX	4	Updated
	7	IX	6	Added
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I. Acronyms and Abbreviations

ACS	Affiliated Computer Services; Department’s Fiscal Agent for the Medicaid Program
ADA	Americans with Disabilities Act 1990 / ADA Amendments Act of 2008 (Public Law 110-325)
AKAIMS	Alaska Automated Information Management System
ANP	Advanced Nurse Practitioner
API	Alaska Psychiatric Institute (DHSS/ Behavioral Health)
ASAM PPC-2R	American Society of Addiction Medicine, Patient Placement Criteria for the Treatment of Substance-Related Disorders (2nd Edition - Revised)
ASAP	Alcohol Safety Action Program (DHSS/ Behavioral Health, Prevention & Early Intervention Section)
AST	Alaska Screening Tool
BH	Behavioral Health
BHA	Behavioral Health Aid (A professional position within Alaska Tribal Healthcare Organizations)
CARF	Commission on Accreditation of Rehabilitation Facilities
CBHS Provider	Community behavioral health services provider
COA	Council on Accreditation
CPR	Cardio-Pulmonary Resuscitation
CPT CODES	American Medical Association, Current Procedural Terminology Codes
CSR	Client Status Review
Dept.	Alaska Department of Health & Social Services
Detox	Detoxification Services
DHSS	Alaska Department of Health & Social Services
DHSS/BH	Dept. of Health & Social Services, Division of Behavioral Health
DJJ	Dept. of Health & Social Services, Division of Juvenile Justice
DOC	Alaska Department of Corrections
DSM	American Psychiatric Association’s, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
EMDR	Eye Movement Desensitization and Reprocessing
ER	Emergency Room
FAQ	Frequently Asked Questions
FASD	Fetal Alcohol Spectrum Disorders

GAF	Global Assessment Functioning; Axis 5 of the Multi-Axial Diagnostic system adopted in the DSM (see above)
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)
IOP	Intensive Outpatient Services
ISA	Individualized Service Agreement
ISD	Individual Skills Development
LMFT	Licensed Marriage & Family Therapist
LPA	Licensed Psychological Associate
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
Meds.	Medications; typically psychotropic
MH	Mental Health
MOA	Memorandum of Agreement
OP	Out Patient
P&P	Policy & Procedure
PA	Physicians Assistant
Psych.	Psychological
RADACT	Regional Alcohol and Drug Abuse Counselor Training Program
Rehab	Rehabilitation
Regs.	Regulations
RN	Registered Nurse
RSS	Recipient Support Services
Rx	Prescription
SA or SU	Substance Abuse or Substance Use
SAMHSA	Federal Department of Health Services, Substance Abuse Mental Health Services Administration
SBIRT	Screening, Brief Intervention, Referral & Treatment (or Referral to Treatment)
SED	Severe Emotional Disturbance (or Severely Emotionally Disturbed)
SMI	Serious Mental Illness
TFC	Therapeutic Foster Care
Tx	Treatment
UA	Urinalysis

IA. Delayed Implementation: Implications for the period of 10/1/2011-11/30/2011

In a 9/29/2011 Guidance Document, the Division notified providers that the implementation date of 10/1/2011 for the new integrated regulations has been delayed until 12/1/2011. This letter is entitled “provider letter 9.29.11” and is located at the following URL: <http://dhss.alaska.gov/dbh/Pages/Resources/Regulations.aspx>. The following are listed questions and issues that will impact providers in the delay of implementation. These will be updated, as additional issues are identified.

1. Does the delay in implementation mean that the new regulations are not in effect?
 - The new regulations go into effect October 1, 2011, and the old regulations are repealed.
2. Does this impact an agency’s ability to deliver and bill the new service codes?
 - Yes. New service codes defined in the new regulations cannot be billed until 12/1/2011.
 - Agencies are to continue delivering services, document and bill, using the existing service codes, until 11/30/2011.
3. What billing number does an agency use during the period of 10/1/2011-12/1/2011?
 - Agencies are to continue using their existing billing number.
 - Agencies will receive communication on their future billing number, for billing of services from 12/1/2011 forward.
4. Does the delay of implementation impact the new Program Approval process for community based providers?
 - No. The new Program Approval procedure is now in effect.
 - Agencies will be receiving, via certified mail, a Department Approval Certificate based on the information submitted to the Department on the *Request for Department Approval Form*.
 - No site reviews specific to the new Program Approval process will be conducted during the period of delayed implementation.
5. What is the Divisions expectation that an agency is compliant with the new regulations, specific to documentation and service requirements?
 - During 10/1/2011-12/1/2011, each agency is to transition their respective service delivery practice from the old regulations to the new integrated regulations. This includes requirements for the professional behavioral health assessments, behavioral health treatment plans and the clinical record, and all additional requirements for alcohol and drug detoxification and residential substance use treatment services. On 12/1/2011, all providers listed in 7 AAC 70.010. and 7 AAC 135.030, are expected to be in full compliance of all new integrated behavioral health regulations.

- Specific to transition issues related to treatment plan reviews, please reference the Guidance Document dated August 29, 2011, located at the following URL: <http://dhss.alaska.gov/dbh/Pages/Resources/Regulations.aspx>
6. What guidance can providers obtain about Service Authorizations/Prior Authorizations, including RSS, during the delayed implementation period of 10/1/2011 – 11/30/2011.
 - You may continue to bill using existing service authorizations which are approved for dates of service through November 30. You must request updates to authorizations that expired on 9/30/11.
 - New PA/service authorizations should be sent in on the “old” form for period 10/1/11 – 11/30/11. RSS requests should be sent directly to DBH. All other requests are sent to ACS.
 7. Does this delay in implementation impact service limits?
 - Yes. Service limits will “reset” on 12/1/2011, as opposed to, or instead of 10/1/2011.
 8. Because providers may only charge services to the old billing codes during the delayed implementation period, are they also required to follow the pre-existing regulations and Manual requirements for those services, or must they comply with the new regulations?
 - The old regulations have been repealed and are no longer in effect.
 - The Provider Billing Manual, 2005 is no longer in effect.
 - The Division of Healthcare Services however, has maintained the capability for Providers to deliver and bill the old mental health and substance use services during the Delayed Implementation period between October 1, 2011 and November 30, 2011.
 - Providers may reference the definitions of the old services during the Delayed Implementation.
 - The new Community Behavioral Health Services & Medicaid regulations are in effect and, with the exception of services delivery and billing, all Providers are expected to transition to full compliance of the new regulations by December 1, 2011.
 9. Since only previous service codes can be billed during the Delayed Implementation period, why was the November 30 end date established, vs. a December 30 end date that would in effect complete the 2011 calendar year?
 - The Division of Healthcare Services requires time to convert to new billing codes without compromising other project time-lines that over-lap December and January.
 10. Will ACS automatically extend out to 11/30 those PA’s that ended on 9/30?
 - No. Providers will need to re-apply for PA’s with a new end date of 11/30.

11. Can ACS accept PA requests for old / ending services on the new request form?
 - No. The new request form is currently under review and revision. It is recommended that agencies use the old form.
12. Do we need to wait until Dec. 1 to begin billing for direct monitoring of services by the Directing Clinician as a component of case management?
 - Yes. During the Delayed Implementation period (Oct. 1 – Nov. 30) only old services may be billed utilizing the old service codes. Billing for any of the new Medicaid funded behavioral health services begins Dec. 1, 2011.

II. Integrating Services: Dual Diagnosis Capable or Dual Diagnosis Enhanced

III. Program Approval and Accreditation

1. Can providers receive a copy of the department approval scoring sheet and clinical records score sheet?
 - Upon the completion of the Provider Approval Review, the Division will provide the findings and results to each agency.
2. Will the program approval clinical records review include claims review?
 - The department approval process could include claims review along with a clinical records review.
3. What is the expected lead-time of the notice to the Provider that the Dept. will conduct the Program Approval and how will the Provider be contacted?
 - DBH will contact a provider approximately eight to twelve weeks prior to the expiration of their current Department Approval. Providers will receive a letter via certified mail and email notifying them of the Division's intent to conduct an evaluation for the purpose of renewing a provider's Department Approval to operate.
4. We are interested in getting information via webinar on how you plan to help small agencies reach accreditation. We are an agency of 5 employees (3 clinicians, admin director, and receptionist) and are being asked to be nationally accredited. How is the state going to help us accomplish this? We are private for profit.
 - The Dept. continues to provide technical assistance upon request by any Provider, and will consider the possibility of future technical assistance webinars.
 - Accreditation organizations also offer technical assistance to Providers choosing to seek accreditation through their respective company.
5. CARF came out with new standards this year and an update to the standards is that a physical exam for detoxification is not necessary upon readmission if it was done within the last 30 days. Does the State concur?

- No, per regulation the State does not concur. Our regulations state, per 7 AAC 70.110., that at admission, and during the course of active treatment as needed, a medical evaluation will be conducted while a patient is in a detoxification facility. Our regulations do not offer the flexibility to waive requirements for patients that are readmitted within a certain timeframe. Each admission is considered a new admission. In this instance, detoxification facilities will need to follow State regulation even though CARF has a different standard.
6. Should a provider include in their application for Dept. Approval all the addresses of apartment buildings owned by the agency and used as supported housing for recipients?
- For the Dept. Approval application, Providers only need to include the physical locations and addresses of their clinic(s). Addresses for apartment buildings are not required.

IV. Recipient Definitions, Eligibility and Rights

1. Clients diagnosed with Substance Use Disorder (SUD) only, (because SUD is in the DSM-IV) should qualify as a “mental health disorder” and be eligible for psychotherapy and clinic services? But the Medicaid State plan limits coverage for SUD to rehab services only.
 - The Medicaid State Plan defines Substance Use therapies as rehabilitation services provided to the recipients in need of substance abuse services. However, Medicaid recipients are eligible for the full array of Medicaid services including clinic and rehabilitation services if they are documented as medically necessary and clinically appropriate.
2. Can the Dept. confirm that “in custody of DJJ” means “physical custody”, and that providers may deliver services to children on probation, etc.?
 - Medicaid cannot be billed while a person (adult or child) is incarcerated within a facility, or in the physical custody of law enforcement.
 - Providers are encouraged to contact the Division of Juvenile Justice to obtain confirmation that any recipient involved with their agency is eligible to receive Medicaid funded services.
3. Can a recipient under age 18, eligible for treatment, sign their own treatment plan and receive services if their parent or legal guardian refuse to sign?
 - There are no State regulations, other than those concerning reproductive health, that address a minor’s right to be treated without parental consent.
 - There are various State statutes and case law and Federal laws that relate to minors. Providers are encouraged to seek appropriate legal counsel for these issues.
4. If an appointed legal guardian (OPA) for an adult does not sign a treatment plan for the recipient, can services still be delivered? What if the recipient signs despite having a legal guardian?

- The question is difficult to answer without additional contextual information. However, the fact that OPA has been assigned to help manage the affairs of an adult conveys some concern about the adult’s competence to direct their own treatment.
 - Providers are encouraged to seek legal consultation and to confer with the Office of Public Advocacy regarding this issue.
 - Regulation requires that the recipient OR the recipient’s representative sign the treatment plan.
5. Under Definitions, page 30 – New Behavioral Health Services Integrated Regulations is a definition of “child experiencing a severe emotional disturbance”
- A. Lists clear criteria related to functionality, diagnosis and GAF, the paragraph ends with the word “or” which leads to another option –
- B. (Describes that the child) “exhibits specific mental, emotional, or behavioral disorders that
- i. Place the individual at imminent risk for out-of-home placement
 - ii. Place the individual at imminent risk for being placed in the custody of the department....
 - iii. Have resulted in the individual being placed in the protective custody of the department.....”

It appears there is a choice between criteria A and criteria B. My question is that B does not clearly define a diagnosis or GAF, does this mean that a child experiencing a V code (example: parent child problem) or an adjustment disorder with a GAF higher than 50% can qualify as SED if at risk of out of home placement?

- A diagnosis using a V code or an adjustment disorder is not sufficient alone to meet the criteria as defined in B. above. Providers must verify and document the “specific” mental, emotional or behavioral conditions of the child that are directly causing them to be at risk of out of home placement.
6. Is there an allowance in the regulations permitting providers to serve 18-21 year old clients as adults? If so, this doesn't appear to be included in the manual.
- Yes, there are allowances in regulations whereby providers are permitted to serve 18-21 year old clients who meet the definition of a child experiencing a severe emotional disturbance to be served as adults experiencing a serious mental illness according to 7 AAC 70.050 (4) and 7 AAC 135.020 (d). The manual currently does and will continue to contain the following regulation definitions as follows:
 - [7 AAC 70.990 (10) and 7 AAC 160.990 (b) (88)] for “a child experiencing a severe emotional disturbance” which state "an individual under 21 years of age who..."

- [7 AAC 70.990 (2) and 7 AAC 160.990 (b) (85)] for “an adult experiencing a serious mental illness” which state "an individual 21 years of age or older who..."
 - The manual will be updated to reflect the leeway reflected in 7 AAC 70.50 and 7 AAC 135.020 which allow providers to provide Comprehensive Community Support Services (under 7 AAC 135.200) in place of Therapeutic Behavioral Health Services (in 7 AAC 135.220) if a child experiencing a severe emotional disturbance is at least 18 years of age and except for age, falls within the definition of an adult experiencing a serious mental illness.
7. Could you please provide me with the regulation citation for this requirement? I can find it in several areas but am having difficulty locating it in regulations that pertain to behavioral health.
FAQs 4/19/12 pg 14
IV. Recipient Definitions, Eligibility and Rights
2. Can the Dept. confirm that “in custody of DJJ” means “physical custody”, and that providers may deliver services to children on probation, etc.? Medicaid cannot be billed while a person (adult or child) is incarcerated within a facility, or in the physical custody of law enforcement.
- Please refer to FAQs Section IV., Question No. # 2, and to Section 1, Part A, page 13 of the [billing] manual: "Alaska Medical Assistance Program Policies and Claims Billing Procedures for Community Behavioral Health Services".
8. May a CBHS Provider bill Medicaid for behavioral health services provided to a child with the primary diagnosis of Autism?
- Yes, as long as the child meets the designated criteria noted in Regulation for a child experiencing either an emotional disturbance, or a severe emotional disturbance, or a substance use disorder.
9. May a Medicaid eligible child with the primary diagnosis of Autism receive behavioral health services?
- Yes, diagnosis alone does not determine recipient eligibility. A Medicaid eligible child may receive behavioral health services if she/he meets the regulatory criteria for a child experiencing an emotional disturbance, or a severe emotional disturbance, or a substance use disorder, or a short term crisis.
 - All services provided to recipients must be medically necessary and clinically appropriate, and the provider must document this justification in the clinical record.

V. Medicaid Billing and Enrollment Issues

1. In the FAQ’s, Version X, Page 14, Question No. # 1 states that Short Term Crisis Intervention may be provided telephonically, but it cannot be billed as a Medicaid service. However, in the Provider Policy & Billing Manual in the Service Detail

Sheet for this service, in the section for Additional Information it states: “The assessment portion of Crisis Intervention may be provided telephonically only when the service cannot otherwise be performed face-to-face.” Can you please clarify the Dept’s position on this issue?

- A Policy Clarification related to the old regulations was readopted October 1, 2011 when the new Regulations went into effect. As stated in the Program Policies and Claims Billing Procedures Manual, Providers may conduct the assessment portion of ST Crisis Intervention telephonically if this service could not otherwise be provided face-to-face. Providers must document why the service was not conducted in person.
2. What services can be provided via telephone?
 - The only services that can be provided via telephone with the appropriate documentation is:
 - Case Management services provided in accordance with 7 AAC 135.180, for authority to provide telephonically see 7 AAC 135.010(d)(3);
 - Peer support services provided in accordance with 7 AAC 135.210, for authority to provide telephonically see 7 AAC 135.210(b)(1); and
 - Family Psychotherapy services provided in accordance with 135.150, for authority to provide telephonically see 7 AAC 135.150(c).
 3. Recipients in Outpatient SU programs are no longer eligible to have UA’s? Providers use UA’s even in outpatient settings to monitor sobriety. Can a regulation clarification be done to re-include the billing code for 80100 for recipients in Outpatient?
 - The Urinalysis lab code 80100 is not a billable code for Medicaid at this time. Coverage of this code as a separate billable service may be considered in the future regulation updates.
 4. Are there regulations or other requirements govern the provision and billing of respite care?
 - There are no regulations governing the provision or billing of respite care. There are requirements for respite care billing within the FASD waiver.
 5. Can the one hour per week per recipient of Case Management billed by the directing clinician for the purpose of monitoring the provision of service delivery be provided via video tape of the service delivery?
 - All billable Medicaid services must be provided face-to-face, including the provision of interactive telemedicine, to the recipient with the exceptions listed in the answer to Section V, question #2.
 6. Can the one hour per week per recipient of case mgmt billed by the directing clinician for the purpose of monitoring the provision of service be billed and payable in addition to the Detox and/or residential daily rate services?

- Yes, Case Management services can be provided on the same day as Residential Substance use Treatment and Detoxification. Please see regulations 135.280(d)(4) and 135.190(b)(3) for authority.
7. What billable services may be used to assist a recipient with supported employment?
 - 7 AAC 135.200-Comprehensive Community Support for Adults and 7 AAC 135.220-Therapeutic Behavioral Health Services for Children.
 8. High intensity residential substance abuse providers must provide 20 hours of services per week. Is that based upon a five day work week or seven day week?
 - The Division interprets “20 hours of services per week” as occurring within a period of 7 days.
 9. Can the Directing Clinician still bill 1hour of Case Management (which is a rehab service) for monitoring of the provision of service to an “emotionally disturbed” / ED consumer?
 - Case Management is not an available service to an ED consumer. Case Management is a rehabilitation service. In order to bill this service to Medicaid, the recipient must meet eligibility as SED, SMI or SUD.
 10. What is the relationship between the requirements for FASD Waiver and the requirements set out in Ch. 70 & Ch. 135 for the clinical record?
 - The FASD Waiver Medicaid regulations apply to youth receiving waiver services. Providers must adhere to Waiver regulations in addition to 7 AAC 70, 7 AAC 135, and 7 AAC 105.230.
 11. Can a Residential Behavioral Rehabilitation Services Provider deliver services at admission if the Treatment Team has been unable to meet to develop a treatment plan? (This situation seems to apply to either a child who is currently not otherwise receiving services, OR perhaps a child that is referred for RBRS whose Treatment Team was not consulted or was unable to meet prior to admit.)

The Division response considers that this question can be interpreted and applied in two scenarios. See below:

- A Residential Behavioral Rehabilitation services Provider should follow the process outlined in the Residential Behavioral Rehabilitation Services Provider Handbook, adopted by regulation in 7 AAC 135.800.
- A CBHS provider providing Daily Residential Behavioral Rehabilitation services needs to have a treatment plan in place prior to delivering billable services. The treatment plan must be signed by the directing clinician, recipient or their legal representative, and based on the input of the treatment team. All members of the behavioral health treatment team shall attend meetings in person or by telephone and be involved in team decisions unless the clinical record documents:
 - that participation by the recipient or other individual involved with the care of the recipient is detrimental to the recipient's well-being;

- family members, school district employees, or government agency employees refuse to or are unable to participate after the provider's responsible efforts to encourage participation; or
 - weather, illness, or other circumstances beyond the member's control prohibits that member from participating.
12. Can services billed by physician use either physician billing number or CBHS billing number?
- Yes, physicians use either their own physician billing number or the CBHS billing number.
13. Can case management be provided internally within an agency and billed to Medicaid?
- No. A previous Policy Clarification that will be carried forward explains that an agency may not bill for case management services conducted within and for their own agency.
14. Can providers currently provide “Family Psychotherapy without recipient present” and bill the old “Family Psychotherapy” service code?
- No. Family psychotherapy, w/o recipient present is a new service which cannot be billed until the delayed implementation period ends 11/30/11. Services billed during the delayed implementation period must be delivered according to the existing service description.
15. May providers serve recipients that only receive medication management?
- Yes. Providers will still be required to meet all the clinical record documentation requirements for these recipients.
16. Can providers conduct and bill for a client status review as often as needed, or more than once within the 90-135 day treatment period?
- As determined by the Dept., Providers may only bill for a client status review once every 90-135 days.
17. If therapist receives phone call from family members of client to discuss issues related to client, can that telephone contact be billable under Psychotherapy, Family w/o patient present (code 90846) if it lasts 30minutes?
- No. The service as described does not meet the definition of Family psychotherapy.
18. Please clarify definition of Multifamily Group billing code (90849). Can family w/out client be billed under client? Does this code mean that a group consisting of family members (w/out client?) from multiple client families can be billed under each client for that group session? Or does it mean multiple clients within same family, they are participating in a family session, and that the provider can bill each client in family for that family session under this code?

- Providers that want to deliver Multi-family group psychotherapy should reference the service code description that appears in the American Medical Association’s Current Procedural Terminology manual.
 - The Dept. is prohibited from reproducing that information in any publication.
19. Historically we have billed Medicaid H0015 or H2035 (depending on Level of care) for an outpatient substance abuse intervention. That same intervention crosswalks back to 90806 if the patient has private insurance. Medicaid has allowed lower credentialed staff to provide substance abuse interventions and considered them rehabilitation services. Private insurance does pay for substance abuse counseling as a professional service but rarely pays for rehabilitation services (For example, the T1012 codes which crosswalks back to “other psyc service”, or any of the mental health skill development codes). Private insurance also requires master level licensed staff. We are currently providing a group called Seeking Safety; it is a nationally recognized best practice appropriate for clients with substance use disorders, mental health problems, or co-occurring issues. We must bill the same codes for all participants regardless of diagnosis.
- Aside from the Provider’s description of their billing practice, there is no question posed here.
 - All services delivered and billed to Medicaid must be provided by qualified staff, and documented accurately in the clinical record according to the service description noted in regulation.
20. Can Case Management and Therapeutic behavioral services be provided in a treatment foster home as long as it is not provided by the Treatment Foster Parent?
- Case Management may be provided in a treatment foster home, by a case manager who is not the foster parent.
 - Therapeutic behavioral health services cannot be provided in a treatment foster home because the service as defined in regulation is the same as Daily behavioral rehabilitation services which is billed by the foster parent. The same service cannot be billed on the same day in the same setting.
21. Can a second rehabilitation service be provided on the same day in a separate setting for a recipient who is also receiving Daily rehabilitation services (H0018)? (i.e. A recipient residing in therapeutic foster care receives Therapeutic behavioral health services (H2019) at school, and also Daily rehab. services at home.)
- Yes, as long as the staff rendering the service is not the Foster parent, and Therapeutic behavioral health services for children are not provided in the Foster home (see Answer to question No. # 6 above).
22. Is there a rehabilitation service available that replaces T1006 – Alc. & Drug Abuse Services, Family counseling?
- No.
 - The new service: Comprehensive Community Support Services covers all the elements of individual and group counseling.

- Medicaid eligible recipients may receive the clinic service: Family Psychotherapy if it is medically necessary and clinically appropriate, and provided by qualified staff (i.e. Mental Health Professional Clinician).
23. Can a CBHS Provider bill Short Term Crisis Intervention or Stabilization for a Medicaid eligible recipient who does not have an open clinical record with the Provider, and/or may not continue any other service treatment with the Provider?
- Yes, as long as the recipient is eligible to receive Medicaid behavioral health services and the service is provided by qualified staff and as described in regulation.
24. Can the Directing Clinician simultaneously monitor the provision of group to more than one of their recipients and bill case management for each recipient for the same amount of time spent during the same time frame? (i.e. D.C. bills for recipient A, B, & C for 30 minutes each of CM for time spent on the same day monitoring group counseling between 2pm – 2:30pm.)
- No. Case Management is a service provided to, or for, an individual recipient and cannot be billed as a group service.
 - In this case, the Directing Clinician could only bill case management for the specific time spent separately monitoring the delivery of group services for one recipient at a time (i.e. the DC could bill 15 minutes of CM for monitoring of recipient A between 2pm – 2:15pm, and 15 minutes of CM for monitoring of recipient B between 2:15pm – 2:30pm).
 - A separate individualized progress note is required for each recipient’s clinical record that fulfills the requirements for this service as list in regulation - 7 AAC 135.180(a)(3).
25. Will clients with only substance abuse dx now be eligible for billing under the 90806 or 90847 codes if the service is provided by a master’s licensed clinician?
- Yes. Medicaid recipients are eligible for the full array of Medicaid funded clinic and rehabilitation services if they meet eligibility requirements and the services are documented as medically necessary and clinically appropriate, and are delivered by qualified staff.
26. Would MTP be coded as an Individual Counseling session (H0004)?
- The Dept. assumes that the acronym MTP refers to ‘Master Treatment Plan’, which is a designation that is not referenced in the new Community Behavioral Health Services & Medicaid regulations.
 - The development of a treatment plan itself is not a Medicaid billable service.
 - The service: Individual Counseling (H0004), is ending 11/30/11.
 - All elements of H0004 are included in the new service: Comprehensive Community Support Services; individual (H2015).
 - Any service that is provided and billed to Medicaid must first appear in a recipient’s treatment plan.

- The treatment plan is a living document that is expected to change over time. Providers should reflect the problems, goals, and related treatment services as they are known at any point in time to meet recipient needs. Additional information is updated to the treatment plan as recipients participate in active treatment and problems and needs continue to be identified.
27. The MEDICAID BILLING NUMBER ISSUE: Addy Kelly of Salvation Army requests to separately keep each of the DA Medicaid billing numbers for Clitheroe and for Booth.
- Each Provider agency will receive a single Medicaid billing number.
 - AKAIMS has the capacity to maintain separate data for programs within a Provider agency.
28. I am not clear on the in-school interventions. It appears what we do with supporting kids in school with behavioral problems falls most cleanly under Day Treatment but this service category states that the service must be provided as group treatment, but can be done in a classroom but with the academic teacher their. Can you clarify if we can provide one on one support in school to help kids be successful when behavioral issues threaten their participation in that setting?
- Day treatment services for children must be provided as group treatment.
 - Both Therapeutic behavioral health services for children, and Recipient Support Services, may be provided to individuals in a school setting, and billed to Medicaid, as long as the service is provided as active treatment according to the service description noted in regulation.
29. Does Family Skill Development go away as previously described and then intended to be captured under Case Management?
- Individual, group and family skill development services will cease to be Medicaid billable services on 11/30/11.
 - However, all the elements of each of these services are included in the new service Therapeutic behavioral health services for children.
 - Case Management is a distinctly different service with its own description and requirements.
30. If the daily rate for Daily behavioral rehabilitation services is NOT being billed by a Foster parent, can the Foster parent, or other provider in the home, then bill for Therapeutic behavioral health services?
- Yes.
31. May Case management be billed for a case manager to accompany a recipient to a psychiatric interview conducted by the agency's own psychiatrist, or by any independent psychiatrist off-site?
- No.

- Case management may be provided to coordinate the provision of an assessment, or to provide linkage between the recipient and other needed services (7 AAC 135.180(a)(1) & (2)).
32. The language in 7 AAC 135.110(a)(1)(A) states that a provider may bill for one BH Assessment, but 7 AAC 135.040(b)(6) states that [based on a current behavioral health treatment plan] a provider may bill for a combination of one MH Assessment and one SU Assessment. May a provider bill for both types of assessments for the same recipient upon intake?
- Yes, if two separate and distinct assessments are conducted by different staff.
 - If the same staff member conducts both the MH and the SU intake assessment, the proper assessment to be billed would be the Integrated behavioral health intake assessment.
33. For clients who are Medicaid eligible, can our agency directly charge the client for no-show appointments?
- There are no Medicaid covered services for “*No-Shows*”; all Medicaid reimbursable services must be delivered directly to a recipient as active treatment.
 - Providers may establish their own policy to bill Medicaid recipients independently for *No-Shows* as long as ALL recipients seen by the Provider agency are also subject to the same policy and billed at the same rate.
34. What other services may be billed when providing either Crisis-intervention or Crisis-stabilization?
- A CBHS Provider may provide as a Crisis-intervention service any “medically necessary, and clinically appropriate behavioral health clinic or rehabilitation service or intervention in accordance with 7 AAC 135.010 that is included in the crisis plan”. – 7 AAC 135.160(b)
 - A CBHS Provider may provide “as part of the short-term Crisis-stabilization plan, any medically necessary, clinically appropriate behavioral health rehabilitation service necessary to return the recipient to the ...level of functioning before...the crisis occurred”. – 7 AAC 135.170(b)
35. Psychological Testing Clarification.
- New regulations specify up to six hours of billable psychological testing services available for our Medicaid clients. Prior there was not a specific limit identified. Can you clarify how this number was derived? Are there specific tests that Medicaid identified as billable/not billable due to this restricted time allotment for the psychologists? There has been an expressed concern that this six hours allotted will prevent them from completing recommended tests due to additional time required to complete.
 - If additional testing is recommended by the psychologist that will not be able to be completed within the six hours granted, are they allowed to submit a request for more? If so, how would that process work?

- Or, if additional testing is warranted/recommended, do we refer out of our clinic to neuropsychologists in the community for the additional 12 hours of testing for specific tests that are not covered under our psychologists? What tests would those be that are different from what our clinical psychologists do?
 - The annual service limit of six hours for psychological testing and evaluation services was carried over to the new integrated regulations from 7 AAC 43.727(a)(3), which is now repealed.
 - The Medical Assistance Program (Medicaid) does not identify or limit the specific tests that may be utilized for psychological testing and evaluation.
 - Providers may request an extension of the service limits for Psychological testing and evaluation based upon individual recipient need. Providers submit the Service Authorization request through the usual process using the new form.
 - Referral for Neuropsychological testing should be considered for recipients who demonstrate cognitive deficits or skills impairment that may be the result of brain injury or specific neurological illness that has affected brain structure or neural pathways.
 - Providers should consult local psychologists and/or neuropsychologists for information regarding the types of tests utilized in assessing recipients.
36. Are we able to bill Medicaid for one hour of psychotherapy if a recipient is seen for more than 45 minutes but less than 60?
- Yes. The American Medical Association Current Procedural Terminology (CPT), adopted by reference in 7 AAC 160.990, allows billing for procedural code 90806, (Individual psychotherapy), or procedural code 90812 (Individual psychotherapy – interactive), if the service is provided 45 to 50 minutes face-to-face with the patient.
 - The Dept. considers billing against these codes as counting as 1 hour toward the annual service limits for a recipient.
37. Can case management be billed for a Case Manager assisting agency sponsored Foster parents in the foster home?
- No. Providers may not bill Medicaid for case management services delivered internally to their own agency.
 - Case management services may be provided to Foster parents who are not sponsored by the case manager's agency.
38. Can we bill the AST and CSR if an assessment is never completed (i.e.; referral withdrawn, placed with other provider, etc.)?
- Yes, both the AST and the initial CSR may be billed if a Provider determines that a concurrent assessment is unnecessary or cannot be conducted within their agency.

39. Can we bill a CSR and AST without the youth present as we get many referrals and complete assessments for youth out of area and out of state?
- Providers cannot bill for an AST and a CSR unless it is completed with the person present.
 - Providers may conduct these services via tele-medicine with out-of-state recipients.
40. Can the AST and CSR be billed for a BRS recipient?
- Yes.
41. Is it possible to bill family therapy without the client present and children's therapeutic behavioral health service, individual at the same time?
- Yes, if both services are included in the treatment plan they may be provided by different staff during the same clock hour.
42. Will the department continue third Party Liability (TPL) Avoidance for mental health rehabilitation services that are non-covered by Medicare and other health plans?
- The department has reinstated TPL Avoidance for mental health rehabilitation services as follows:
 - MEDICARE – service codes that are highlighted in pink within the Health Care Procedure Coding System (CHPCS) book and indicated as “Non-covered by Medicare”.
 - PRIVATE INSTURANCE – Services that are not specifically identified as detoxification or residential substance use disorder treatment services.
43. May a Provider bill for case management conducted with foster parents in support of a child placement if the Provider does not have a contract with the foster home?
- Yes, as long as the Provider does not have an existing contract with the foster home for any current or previous placements.
 - If the foster home has a current placement and contract with the Provider then the provision of case management would be an internal service to the agency and may not be billed to Medicaid.
44. What Diagnosis Codes can be used for billing AST, CSR (and Crisis Stabilization) services by staff that is not qualified to diagnose? These services are performed before an assessment is done by professional staff who can diagnose.
- Currently, Behavioral health providers may bill non-specific V-Codes, including:
 - V 40.2 Other mental problems
 - V 40.3 Other behavioral problems
 - V 79.1 Special Screening for Alcoholism

- The use of these codes should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for a visit that is captured in another code should be used.
 - DBH business practice that any claim submitted with a V-Code will require a manual review.
45. For clients transported from Seward who the provider takes by automobile into Anchorage for health care appointments, can CCCS, TBHS, or RSS be billed for time spent with client during car ride if patient needs extra support to keep them safe/stable?
- Medicaid does not reimburse for transportation services. All services must be medically necessary and clinically appropriate, and delivered as active treatment as noted in the recipient's treatment plan, and documented in a progress note. All services must be delivered by qualified staff according to the service requirements established in regulation. Providers need to identify recipient need based upon a professional behavioral health assessment, and determine what service(s) will adequately assist the recipient to meet treatment goals.
46. Parenting w/Love & Limits (PLL) is a scripted, evidence-based program which requires strict adherence to the PLL model. At some points in the program, adults and youth "break out" and the adults meet with a masters-level clinician while the youth meet with a case manager. In both cases, the content and process of these "break-out" sessions is scripted. The problem is: How to bill for 2 different services delivered at the same time? Codes: 90849 + H2019-HQ (multi-family sessions) and 90846 + H2019-HQ or H2019.
- The Regulations do not address specific evidence based practices. All behavioral health services must meet the descriptive criteria noted in regulation, and must be provided directly to the recipient by rendering staff that are qualified to deliver the service. Any service provided to a recipient by a CBHS Provider must meet this criterion in order to bill for services. In regards to PLL, the following services could be provided concurrently: 90846 - Family Psychotherapy (without patient present) and H2019/H2019HQ - Therapeutic BH Services for Children. However, 90849 - Psychotherapy, Multi-family Group could NOT be provided concurrently with H2019/H2019HQ because the child must be present for both services.
47. We are questioning the codes to be used for the billing of the initial screening AST & CSR when no dx is available. FAQ's allowed us the following (ref to P 24, #44, version XIV)
- V40.2 other mental problems
 - V40.3 other behavioral problems
 - V79.1 special screening for alcoholism

According to conversations our office had with DBH and HCS we have been told the V40.3 code is not a viable ICD9 code for billing. We were instructed to use V40.31

or V40.39 instead. It is my understanding these were the only options that were being allowed. According to ICD9Data.com these codes can be defined as follows:

V40.31 wandering in disease classified elsewhere

V40.39 other specified behavioral problem

For the purposes of screening we are asking about using V40.9 which is defined as 'unspecified mental or behavioral problem'. Our reasoning for this is that the problem has not yet been diagnosed; therefore, it is not specified. Also, we treat many who are involved with alcohol and drugs as well as having mental health issues.

- The codes that may be used to bill for an AST and initial CSR when a diagnosis is not available has been amended as follows:
 - V40.2 other mental problems
 - V79.1 special screening for alcoholism
 - V40.39 other specified behavioral problem
 - V40.9 unspecified mental or behavioral problem

48. We frequently provide Therapeutic BH Services (Family w/ patient present) and as our notes come in, I have a few questions as to how we can make them easier on staff. For example, is it possible for staff who are providing this service to clients who are siblings at the same time - can they bill at the same time?

- No, a provider must separately account for the time spent delivering this service for each sibling based upon the problems and goals noted in their respective treatment plans.

49. If a client is referred to a group with a roster of 4 other people, and is the only one to show for group session, but participates with the counselor for the expected length of the group session, is the service billed as group (H2015-HQ) or individual (H2015)?

- The correct billing for this service as described would be Comprehensive Community Support Services (H2015). Though the agency's intent was to conduct a group session, there was only one recipient in attendance who spent individual time with the counselor, which is clearly an individually focused service.
- The session would still need to address the problems and goals specified in the recipient's treatment plan.

50. If an Intern completes a psychological evaluation, which is then co-signed by a licensed clinical psychologist, is that service billable to Medicaid as psychological testing & evaluation?

- No. All Medicaid billable services must be delivered directly to the recipient by a qualified rendering provider.

51. Can we bill Case Management for generating service authorizations since it includes clinical review and data gathering, and ensures funding for services?

- No. Completing a service authorization is a billing procedure and cannot be billed as a treatment service.
52. Is it the Division's intent to require the provision of direct clinical services by the physician under agreement with the agency for the purpose of providing general direction and direct clinical services?
- No. Physicians under agreement with a provider for the purpose of assuring general direction and direct clinical services are under no obligation to provide services, but have the option of delivering services as needed in collaboration with the provider.
53. May a Provider bill Medicaid for services delivered to an adult recipient on 'conditional release' from API or other IMD [pursuant to 42 CFR 435.1009(3)(4)]?
- Per 42 CFR 435.1009 (c), an individual on conditional release or convalescent leave from an IMD is not considered to be a patient of that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receives outpatient treatment, the patient is on conditional release. The Medicaid payment exclusion only applies to individuals who are patients in an IMD. Therefore, providers may bill Medicaid for individuals who are on conditional release or convalescent leave from an IMD if they are otherwise eligible for Medicaid.
54. If a client is seen for crisis and a Crisis Intervention plan is created with therapy services as one of the service interventions identified as medically necessary, are those therapy sessions part of the 10 hours per fiscal year that clients receive for psychotherapy, OR are those therapy sessions part of the 22 hours of Short-term Crisis Intervention?
- Providers may optionally bill the psychotherapy as part of the S.T. Crisis Intervention (S9484), or as a separate service utilizing one of the psychotherapy codes (e.g. 90804, or 90846, etc.).
 - If the psychotherapy is billed under S9484 the service duration is drawn from the 22 hours/FY service limit for S.T. Crisis Intervention.
 - If the psychotherapy is billed under any one of the psychotherapy service codes the duration is drawn from the combined 10 hours/FY service limit for psychotherapy.
55. If two different agencies are setting up a telemedicine session, who may bill for the Telemedicine Facilitation (Q3014), and how does a provider bill for Telemedicine Facilitation when the session is set up between different programs / facilities of the same agency?
- Facilitation of Telemedicine (Q3014) may only be billed to the Medicaid program by Dept. approved Community Behavioral Health Services provider agencies.

- If two different CBHS providers establish and maintain electronic connectivity for a telemedicine session both agencies may bill Medicaid for the facilitation service.
 - If a single CBHS provider establishes and maintains electronic connectivity for a telemedicine session between two of its own agency facilities or programs, the provider may only bill Medicaid for one facilitation service.
56. Can Case Management (T1016) be billed for a case manager accompanying a recipient to a physician's appointment?
- No. Please see FAQ's: Section V, Question No. #31.
57. Can Comprehensive Community Support Services (H2015) or Peer Support Services (H0038) be billed for coaching a recipient during a physician's appointment?
- Either service may be provided and billed to Medicaid if the recipient problem related to the described situation has been assessed and is noted on the recipient's treatment plan along with the corresponding service, goal and active intervention.
58. Can a provider which has a grant for SED Child services, and a program approval for rehabilitation services bill for Comprehensive Community Support Services if they have determined that a child between 18 – 21y/o is best served as an adult?
- Yes, however, the provider must note the change on the recipient's treatment plan, and update the assessment accordingly.
 - Please see FAQ's, Section VI., Question No. # 43 for further information.
59. May a provider bill psychotherapy conducted in a Therapeutic Foster Home?
- Yes, as long as the recipient qualifies to receive rehabilitation services.
 - Please see FAQ's, Section V., Question No. # 43 for further information.
60. May a provider bill for Peer Support Services when accompanying a recipient or recipient family member at a Treatment Team meeting?
- No. According to regulation [7 AAC 135.180(b)] only the Case Manager is able to bill for the time setting-up, traveling to or from, and attending a Treatment Team meeting.
 - Attempting to bill for Peer Support Services at a Treatment Team meeting would constitute inappropriately billing for two behavioral health services provided simultaneously in the same clock hour to the same recipient.
61. May a provider bill for both Peer Support, Individual (H0038) and Peer Support, Family (H0038-HR) for a meeting with a child, who is accompanied by their peer support staff, and the parent, who is accompanied by their own peer support staff?
- No. The meeting between parent and child would be conducted as a family service, and only one rendering provider may bill for their time delivering that service.

62. May a provider that has a grant for Rural Peer Support Services bill for peer support when the peer support staff responds to a psychiatric emergency with a Mental Health Professional Clinician?
- Providers with a Rural Peer Support Services grant, which may call for Peer Support staff and a MHP Clinician to respond in tandem to psychiatric emergencies, must pay for the Peer Support staff through grant funds.
 - If the MHP Clinician determines after conducting a Short-term crisis intervention assessment and developing a crisis plan that Peer Support Services are indicated to assist the recipient to resolve the crisis, the provider may then bill Medicaid for any Peer Support Services delivered subsequently to the crisis assessment and plan.
63. Does Medicaid cover EMDR (eye movement desensitization and reprocessing), and what should be used as the CPT Code?
- The list of behavioral health services that can be provided and paid for through the Medicaid program may be found in the “Alaska Medical Assistance Program Policies and Claims Billing Procedures for Community Behavioral Health Services”.
 - EMDR is considered to be a therapeutic technique that potentially could be used as an intervention in the course of a recipient’s treatment.
64. May a physician bill under their physician’s Medicaid billing number for services provided for a [High Intensity] Residential SUD Treatment Services provider, or should those services be billed under the residential provider’s billing number?
- A physician working for a Residential substance use treatment services provider can only bill for services using their personal Medicaid billing number if the services they render are separate and distinct from those services that are required to be delivered for residential substance use treatment. [7 AAC 70.120; 7 AAC 135.280].

VI. BH Services: Definitions, Service Limits and Authorization

1. Is there a nosological category or definition for SED adults?
 - The definition of an adult experiencing a Serious Mental Illness (SMI) is inclusive of an adult experiencing a Severe Emotional Disturbance (SED). See regulation 7 AAC 70.990(2) for the definition of SMI.
2. Does the four per year allowable Psychiatric Assessment – Interview (90801) just apply to the licensed therapist (directing clinician) services, or does it include four total for the client by all agency providers, which may include the psychiatrist, directing therapist, psychologist?
 - A psychiatric assessment (90801) must be conducted by a licensed: physician, physician’s assistant, or advanced nurse practitioner (7 AAC 135.110(e)(1)), which is limited to four assessments per State fiscal year.

- Any qualified staff of a MHP Clinic may conduct a mental health intake assessment (H0031), which is limited to one assessment every six months (7 AAC 135.110(a)(2)(A)).
 - Any qualified staff of a MHP Clinic may conduct psychological testing and evaluation (96101), which is limited to six hours each State fiscal year (7 AAC 135.110(g)).
3. How can the “progress toward achieving the individualized objectives in the treatment plan” be adequately assessed for a methadone client at admission” (The service: T1007 – Treatment plan review for methadone recipient, is limited to one per admission, and cannot be extended.)
 - Providers are allowed to conduct and bill for service code T1007 at any time during the course of treatment as indicated, as long as the service is provided only once per recipient, per admission to the program.
 - Providers are also expected to conduct [and bill for] the administration of the AST and the initial CSR, and subsequent CSR’s every 90 – 135 days of active treatment.
 4. When do the services limits reset?
 - All Medicaid service limits reset on December 1, 2011 and will expire [again] on June 30, 2012.
 5. With services now based on the State fiscal year, and the fact that ACS does not accept PA’s for multiple years, should the agency file one PA on Oct. 1, and then a new one on Jan. 1?
 - During the delayed implementation period all PA’s with an end date of 11/30/11 or earlier will be accepted by the Dept.
 - Providers may need to submit PA’s to cover the period between October 1, 2011 and November 30, 2011.
 - All PA’s will terminate on November 30, 2011.
 - Providers will then routinely submit Service Authorizations (i.e. PA’s) for no longer than 90 – 135 days, or the date of the recipient’s next scheduled client status review, whichever is shorter.
 6. Does the code H0015 - Alcohol and Drug intensive outpatient, get used for ALL services to IOP clients or only Group and Individual counseling sessions?
 - The service: Alcohol and Drug, intensive outpatient (H0015) is ending 11/30/11.
 - The term ‘intensive outpatient’ is not referenced within the Community Behavioral Health Services & Medicaid regulations.
 - The new service: Comprehensive Community Support Services includes all elements of (H0015).

7. Is H0005 [Alc. & Drug Services – Group Counseling] and H0004 [Individual Counseling?] staying the same for the relevant service?
 - No. Alcohol and drug services, group counseling (H0005) and individual counseling (H0004) are services that will end 11/30/11.
 - All elements of these two services are included in the new service, Comprehensive Community Support Services; individual (H2015) and group (H2015HQ).
8. When a recipient is discharged from treatment, can the CSR provided at discharge be administered and billed if the previous CSR was completed less than 90-135 from discharge?
 - Yes. The 90 – 135 day requirement between administrations of a client status review/CSR does not apply in this case.
 - The client status review/CSR administered at discharge should be completed with the recipient present as close to the end of treatment as possible regardless of the date of the previous CSR.
9. What date establishes the 90 – 135 day requirement for conducting a subsequent CSR?
 - Regulations require that a client status review/CSR be conducted concurrent with a behavioral health assessment.
 - If a Provider conducts and bills for a behavioral health assessment, the date the next (i.e. second) client status review/CSR is due is 90-135 days from the date of the assessment.
10. If, or when, a recipient no longer qualifies for rehabilitation services can case management still be used for discharge planning?
 - Case management services may be provided to a recipient, as described in their treatment plan, while the recipient is engaged in active treatment with the Provider, including discharge planning.
 - Behavioral health services may not be delivered and billed unless those services are provided under an individualized treatment plan that meets the requirements of 7 AAC 135.130.
 - Treatment plans remain current based on upon the periodic client status review conducted under 7 AAC 135.100(c).
11. Can Short-term crisis intervention or crisis stabilization be provided to a recipient who is NOT presently receiving services from the Provider?
 - Yes.
 - Short-term crisis intervention may be provided to any eligible recipient since the service is provided by a Mental Health Professional Clinician who is qualified to determine if the recipient is experiencing an emotional disturbance, a severe emotional disturbance, or a serious mental illness.

- Short-term crisis stabilization in this case may only be provided to a recipient experiencing a substance use disorder, unless the recipient is previously known to be either SED or SMI as determined by a Mental Health Professional Clinician.
 - Short-term crisis stabilization is a rehabilitation service that may only be provided to a recipient who is experiencing a substance use disorder, or who is SED or SMI.
 - Short-term crisis stabilization may be provided by either a Substance Use Disorder Counselor or Behavioral Health Clinical Associate.
 - Both a SUD Counselor and a BHC Associate by definition are qualified to determine if a recipient is experiencing a substance use disorder.
 - However, neither a SUD Counselor nor a BHC Associate is qualified to determine if a recipient is SED or SMI.
 - Therefore the only recipient eligible to receive this rehabilitation service, who is not currently receiving services from the Provider and their condition is not otherwise previously known, is a recipient experiencing a substance use disorder.
12. Can a residential substance use treatment Provider conduct and bill for a client status review at intake and again at discharge if the recipient is only in care for 45 days or less?
- Yes. A client status review, utilizing the CSR form, must be conducted at intake (concurrent with a behavioral health assessment) and again at discharge from treatment regardless of the elapsed time between intake and discharge.
13. Are Prior Authorizations required to exceed limits on substance abuse treatment services?
- Yes, if the treatment is provided as out-patient through the delivery of Comprehensive community support services for adults or Therapeutic behavioral health services for children.
 - Residential substance use treatment services, or Detoxification services, paid through Medicaid as a day rate, has no service limit.
14. Can you explain the discrepancy between the restriction against billing for case management services provided internally to an agency, and the allowance for a Directing Clinician to bill for 1hr. /Wk./recipient of case management?
- Exceptions to requirements appear in a number of places within the regulations.
 - The ability for a Provider to bill 1 hour per week per recipient by the Directing Clinician for the monitoring, by direct observation, the delivery of services is one of those exceptions.

15. Substance use disorder clients especially demonstrate rapid change in their social and behavioral status. How often may a Provider conduct and bill for a client status review?
- The client status review, by regulation may only be conducted and billed to Medicaid once every 90 – 135 days.
 - However, Providers may conduct reviews of recipient's status and response to treatment as often as clinically indicated.
16. The service codes for Individual Psychotherapy, 90804 and 90810 (30 minutes), and 90806 and 90812 (60 minutes) appear to be the same. Can you explain the difference?
- The Individual Psychotherapy service codes 90810 (30 minutes) and 90812 (60 minutes) are for children only and are interactive, using play equipment, physical devices, or a language interpreter or other mechanism of non-verbal communication.
 - The Individual Psychotherapy service codes 90804 (30 minutes) and 90806 (60 minutes) are for all recipients.
17. Please clarify if a diagnosis code will be required for SBIRT billing, and if brief interventions can be provided by phone or VTC.
- SBIRT is a screening service that does not require an intake assessment or behavioral health treatment plan, and does not require a DSM diagnosis.
 - All components of SBIRT must be provided in-person with the recipient. SBIRT cannot be provided via telephone, but may be provided via tele-medicine (VTC) as long as the recipient is present.
18. Would you please confirm that only a substance use intake assessment is required for detox?
- That is correct. The regulations only require that a substance use intake assessment be conducted at intake and during the course of active treatment as needed for all levels of alcohol and drug detoxification services.
19. Can a provider still deliver a service after filing a Service Authorization (request for extension of service limits) which has not yet been approved?
- Yes, however the provider accepts the risk that they will not receive reimbursement if the Service Authorization is subsequently denied.
20. We are concerned that we may not be able to fulfill the [daily rate] service requirements for residential substance use treatment during week-end hours if recipients miss scheduled activities due to illness, etc. What advice does the Dept. have for these situations?
- To bill Medicaid for a daily rate reimbursement Providers must provide, and document in a progress note, some form of active treatment each day the recipient is in treatment.

- The active treatment may be offered as any of the following:
 - Teaching of life skills to restore or improve functioning
 - Counseling focused on functional improvement, recovery and relapse prevention
 - Encouraging & coaching
 - The fact that a recipient may miss one or more scheduled week-end activities may not preclude the possibility of them participating in other active treatment activities with Provider staff.
21. Is a treatment team required for emotionally disturbed youth as well as youth experiencing a severe emotional disturbance?
- Yes, all youth who receive Medicaid funded behavioral health services must have a treatment team.
22. Must a skills trainer who is providing support to clients in their regular classroom also hold group meetings outside of the classroom at least twice a week with those same clients, for the purposes listed in the regs? Can a Provider still provide and bill for these groups if not all clients attend?
- Yes, if a staff member of a CBHS Provider is providing Therapeutic behavioral health services for children [7 AAC 135.220] in a classroom setting they must also hold group sessions twice a week outside the regular academic class. The Provider may bill for these services even though not all recipients are able to attend every session.
 - Depending upon the recipient's assessed needs Providers could alternatively provide Recipient Support Services [7 AAC 135.230], or Day treatment services for children [7 AAC 135.250] in a school setting.
 - For Providers to deliver these services within a school setting the service must be medically necessary and clinically appropriate and must be provided as active treatment and meet all the requirements noted in regulation.
23. Can the AST, CSR, and Assessments be conducted over the telephone (not face-to-face; not via telemedicine) for patients who live outside Anchorage seeking Residential SU Treatment (done in order to make placement decisions using ASAM before patient travels)? If these services can't be billed to Medicaid because they are conducted telephonically, what is the down-stream impact regarding the ability to fund using grant dollars and/or bill Medicaid for subsequent services provided after patient arrives but based on an assessment conducted by telephone?
- The question is concerned about the use of telephonic assessments to support compliance with regulatory requirements governing clinical records. Specifically, the question related to the use of non-Medicaid reimbursable intake assessments which are conducted telephonically to support residential placements.

- Medicaid regulations require a behavioral health assessment to be conducted upon admission to services (7 AAC 135.110) concurrent with a client status review which must be completed with the recipient present (7 AAC 135.00). Services provided accordingly would be reimbursable by Medicaid if the service was provided to an eligible recipient.
- The Community Behavioral Health regulations (7 AAC 70.100) require all approved Community Behavioral Health clinics to maintain clinical records that are in compliance with Medicaid standards. Therefore, all services provided must adhere to Medicaid requirements whether or not a specified service is billed to Medicaid or provided to a Medicaid recipient.
- While the regulations require assessments to be provided in-person (or via telemedicine), Medicaid regulations (7 AAC 135.100) also allow assessments to be updated as new information becomes available. Therefore, if assessments are updated with new information obtained in-person upon admission to a treatment program and the clinical record is appropriately signed and dated, the clinical record would be in compliance with Medicaid standards. In these cases, while the assessment itself would not be billable, services included in a treatment plan and based on the assessment would be in compliance with Medicaid standards and therefore billable.
- Please note that if the telephone interview is preliminary to the assessment which is conducted with a face-to-face interview of the person on admission then the assessment is billable.

24. A scenario was presented: a CBHC has a client currently receiving treatment at API and preparing to receive the client upon their discharge from API. Can an agency bill off of another agency's (in this care API) treatment plan?

- NO.

25. When a patient has made significant treatment progress, they become eligible for "take home" doses as allowed by federal regulations. What is the correct way to bill for these? For example, when a patient has earned 2 take-home privileges, the nurse administers one methadone dose to the patient to take on-site and then she administers two doses for the patient to take home for the next two days. It only makes sense to bill for each dose, considering the high cost of administering methadone (salaries, security, overhead, insurance). Do we bill 3 units for the day the patient comes in (one billing line)? Or one unit per line for each of the three doses on the date they are administered (3 lines – one for each unit given on that day)?

- The on-site administration of methadone is a billable service by definition [7 AAC 145.580(27), and 135.990(17)].
- The provision of medications for a recipient to self-administer at home is not a billable service. Medication administration services require the active administration of injectable or oral medication directly by qualified staff in-person to a recipient.

26. Can the Dept. provide clarification on the meaning of the terms "services" and "interventions". Are services individual psychotherapy, family therapy, etc. and interventions defined as motivational interviewing?
- The definition for "services" appears in 7 AAC 160.990(78): "service" means a medical evaluation or procedure, drug, medical supply, item, equipment, transportation, or other benefit related to an individual's health or delivery of health care;. Regulation does not define the term "interventions", but the term commonly refers to those activities that are conducted by a rendering provider to deliver a service to a recipient.
27. What is the minimum amount of time required for the patient to be present in order to bill family psychotherapy with the patient present? What is the maximum time the patient can be present to bill family psychotherapy without the patient present?
- Bill 90846 – Family psychotherapy without the patient present if the patient is not present during any part of the session.
 - Bill 90847 – Family psychotherapy with the patient present, if the patient is present during any part of the session.
28. Please clarify if an ED (emotionally disturbed) client eligible for clinic services may have service limits extended for those services they are eligible for that are documented as medically necessary in the clinical record."
- The service limits for any/all services may be extended only through the service authorization process whereby the provider completes and submits a Request for Service Authorization to exceed the limits using the form provided in the manual and on the website. Provider records need to include documentation of the necessity for any/all services.
29. Regarding Residential Substance Use Disorder Treatment's daily rate, how can the day in care be billed when the patient is sick in bed all day long?
- According to 7 AAC 135.280 (b) "To qualify for payment for providing substance use treatment services, a [CBHS] provider must provide the following active treatment each day the recipient is in treatment
 - (1) teaching of life skills designed to restore or improve the recipient's overall functioning relative to their substance use disorder;
 - (2) counseling focused on functional improvement, recovery, and relapse prevention;
 - (3) encouraging and coaching.
 - According to 7 AAC 70.120
 - (c) Residential substance use treatment servicesmust include the following component services...(1) through (14)
 - (d) All residential substance use treatment services must be medically necessary, clinically appropriate, and provided in accordance with [ASAM] and [DSM]
 - (f), (g), and (h) include minimum numbers of hours per week of treatment

must be delivered based on the level of intensity of treatment (clinically managed low, medium or high intensity).

- If the patient is sick in bed all day long and is too sick to be able to participate in active treatment whereby "the individual who renders the services actively engages the recipient and provides pre-planned specific interventions, supports, or other actions that assist the recipient in achieving the goals in the behavioral health treatment plan" [7 AAC 70.990 (1)], then the daily rate cannot be billed. The rates paid for residential substance use treatment are for active treatment and do not include the cost of the patient's room and board.

30. With respect to the Service Definition Description for Recipient Support Services (RSS), can RSS be used to supervise and monitor the safety of a client who is determined to be at significant risk of harm FROM others due to their severe mental illness? There are adult clients, who, because of their mental illness, are at risk of chronically or episodically to be victimized by others.

- No, RSS is to provide structure, supervision, and monitoring necessary to either maintain clients who are meet eligibility for this and other rehabilitation services within the community or to prevent harm to the recipient or others.
- Given the situation described, the provider may identify the client's risk of harm by others as a problem for which the client may receive other interventions (such as comprehensive community support services) to assist and strengthen the clients ability to handle situations where others may pose a threat and skills the client should employ when encountering threats of harm by others. One such skill would include assisting the client to contact the appropriate law enforcement officials who are the appropriate community members to intervene when the public feel their safety has been threatened.
- Active treatment and do not include the cost of the patient's room and board.

31. The community behavioral health services provider where I work has a separate contract to provide services under an employee assistance program (EAP) whereby people may come here for minimal treatment of episodic, non-severe behavioral health issues. Most folks can be seen and treated with 6 or fewer sessions. Do we have to provide these people with an AST, CSR, and Assessment even though the people are not covered by the Medicaid program, nor is their treatment being funded through state grants?

- At a minimum, all community behavioral health services providers must meet the Title 7 AAC Chapter 70 standards for treatment of all clientele. In addition to conducting the AST, an assessment is the standard of care for entry into any behavioral health treatment, therefore, this standard must be met for all clients.

32. If we have a client who is currently at Rainforest Recovery Center and our clinician goes there and provides a therapy session, can we bill or not bill for the service even though RRC is/may be billing for a "daily rate" to Medicaid?

- According to 7 AAC 135.280(d)(5) any needed behavioral health clinic service may be billed and delivered on the same day as residential substance abuse services.
33. The Crisis Recovery Center requests clarification on whether or not the regulations allow Crisis Recovery center to bill both clinic and rehabilitation services for clients in crisis who have either Adjustment Disorder or Substance Use disorders. Clients with these diagnoses do not meet the DSM criteria for an Axis I diagnosis of Serious Mental Illness or Emotional Disturbance.
- Yes, any clinic or rehabilitation service ordered in the short-term crisis intervention plan to address the crisis, may be provided to any eligible Medicaid recipient per 7 AAC 135.160(b).
34. Which Service Authorization form must the provider retain in the clinical record?
- 7 AAC 135.040(d)(1) requires that only the request must be documented in the clinical record according to Medicaid documentation standards.
 - Providers may choose to also include the division response.
35. If we have several programs, all with different treatment plans and a customer who happens to utilize two or more of these programs, would we be able to have a Service Authorization for each program/treatment plan or does that one customer have to have one service authorization for all services provided under that MH number?
- Providers that have multiple programs and one Medicaid billing number must submit only a single service authorization request for all services intended to be provided to a recipient, regardless of which program delivers those services.
36. The Crisis Recovery Center requests clarification on whether or not the regulations allow Crisis Recovery center to bill both clinic and rehabilitation services for clients in crisis who have either Adjustment Disorder or Substance Use disorders. Clients with these diagnoses do not meet the DSM criteria for an Axis I diagnosis of Serious Mental Illness or Emotional Disturbance.
- CRC may bill both clinic and rehabilitation services for clients in crisis. These services may be delivered as either:
 - Short-term crisis intervention services, which is a Medicaid clinic service, and must be delivered by a mental health professional clinician; or
 - Short-term crisis stabilization services, which is a Medicaid rehabilitation service that may be delivered by a substance use disorder counselor or a behavioral health clinical associate.
 - The service description in 7 AAC 135.160 for Short-term crisis intervention services allows for both clinic and rehabilitation services to be provided to a recipient who is in crisis.
 - The service description in 7 AAC 135.170 allows for any rehabilitation service to be provided to a recipient who is in crisis.

- The recipient eligibility requirements in 7 AAC 70.050 allow for a Community behavioral health services provider, who receives money from the state (i.e. grant), to provide services to an individual who is experiencing a short-term crisis.
 - The recipient eligibility requirements in 7 AAC 135.020 allow a Community behavioral health services provider to provide:
 - Medicaid clinic services to an adult experiencing an emotional disturbance; and,
 - Medicaid rehabilitation services to an individual experiencing a substance use disorder.
37. If a recipient in Medium or High Intensity residential program misses treatment due to illness or early discharge and does not complete the required 20hrs / week of therapeutic rehabilitation services, can the provider bill the daily rate for the days of the week that the recipient participated fully in the program?
- Providers operating a medium or high intensity residential substance use treatment program may bill the daily rate as long as they meet all the requirements noted in regulation for these services [7 AAC 70.120 and 7 AAC 135.280].
 - The 20 hours per week of therapeutic rehabilitation services are intended to be a minimal program requirement which is provided for all residents to participate in as available (vs. a specific treatment requirement calculated hourly for each recipient).
38. If a new service is determined to be medically necessary for a recipient receiving S.T. Crisis Intervention after the Crisis Intervention Plan was developed, can that new service be added to the existing Plan, or is there another means of documenting the need for the service?
- A new service may be added to a S.T. Crisis Intervention or S.T. Crisis Stabilization Plan at any time the recipient is receiving services for a crisis.
39. Can a provider (Daybreak) serve an 18y/o client as an adult, and bill Medicaid for the services?
- Yes. 7 AAC 135.020(d) allows providers to deliver comprehensive community support services in place of therapeutic behavioral health services for a person at least 18 years of age and under 21 years of age if they fall within the definition of an adult experiencing a serious mental illness.
40. How is the 20 hours / week of clinical and therapeutic rehabilitative services calculated for medium / high intensity residential substance use treatment, especially for those recipients that are periodically unable to participate in treatment every day of the week?
- Please see answer in Section VI to question No. # 37.

41. If a recipient receives SBIRT, including a brief intervention, can counselor schedule another meeting for another brief intervention?
- No. If a recipient requires continued intervention following a SBIRT screening, they should be referred for on-going treatment.
42. If a client is in crisis and a Crisis Intervention plan is created with psychotherapy services as one of the service interventions identified as medically necessary – are those therapy sessions part of the 10 hours per fiscal year that clients receive OR are those therapy sessions part of the 22 hours of S.T. Crisis Intervention?
- S.T. Crisis Intervention includes individual or family psychotherapy [7 AAC 135.160(c)].
 - Providers may bill all crisis related services noted in the crisis treatment plan toward the 22hrs / FY, OR they may bill these services separately.
 - However, if the services are billed separately, the normal service limits listed in 7 AAC 135.040 apply; providers may request authorization to exceed these service limits if needed.
43. For a child experiencing SED who qualifies to receive CCSS “in lieu of” TBHS, can a provider deliver that service for a single event or repeatedly within the dates of the treatment plan and client status review?
- A provider by regulation [7 AAC 70.050(4)] may continuously provide behavioral health services for adults, for any person between 18 - 21 years of age who except for age falls within the definition of an adult experiencing a serious mental illness.
 - All services provided to recipients must be medically necessary and clinically appropriate, and the provider must document this justification in the clinical record.
 - Once a recipient between the ages of 18 – 21 has been assessed as meeting the criteria for an adult experiencing a serious mental illness, a provider would be obligated to update the assessment and treatment plan to justify that the recipient no longer meets this criteria, but instead meets the criteria of a child experiencing a severe emotional disturbance.
44. May a provider conduct S.T. Crisis Intervention for someone in the emergency room of a hospital and bill Medicaid?
- Providers may conduct S.T. Crisis intervention services for a new or current recipient in a hospital emergency room and bill Medicaid if the recipient has not been admitted to the hospital [7 AAC 135.160(h)].
 - If the recipient was admitted to the hospital, they must have been discharged prior to the Provider conducting S.T. Crisis intervention services.
 - Providers with a Psychiatric Emergency Services grant may provide crisis services in a hospital emergency room as allowed by grant. The expenses for these services are paid through grant funds.

45. May a Provider deliver clinic services in the community settings designated for rehabilitation services for those recipients who qualify for rehabilitation services?
- In effect, recipients that qualify for rehabilitation services may receive ANY medically necessary and clinically appropriate behavioral health service as delivered on the premises of the CBHS provider, the recipient's home, the recipient's school, or any other appropriate community setting.
46. Can you provide an example of when RSS may be provided to the same recipient at the same time by two rendering providers?
- The requirements for RSS are clearly defined in 7 AAC 135.230.
 - Providers have the responsibility to assess the level of need for each recipient and determine the most effective intervention to meet that need.

VII. Screening and the AST

1. Where in the regulations does it state: the AST is not required for clients seen initially for crisis intervention/crisis stabilization?
 - The regulations do not speak to this issue. Clarification that the AST is not required for individuals within detoxification and psychiatric emergency services is defined in the Performance Measures System Policy.
2. AST informs the choice of assessment; our agency always does Integrated MH/SU assessment regardless. What if AST reveals NO Substance Use Disorder but provider chooses Integrated Assessment anyway?
 - The purpose of the AST is to determine the likelihood that a client has a behavioral health disorder. The purpose is not to establish the presence or specific type of such a disorder, but to identify potential need and to inform the assessment process.
 - If an AST indicates no Substance Use Disorder, and if an agency has qualified staff, an Integrated Assessment is expected to be completed.
 - The expectation is that co-occurring conditions are the expectation and not the exception. The intent of the regulations is to expand co-occurring capability throughout the treatment system.
3. When was the AST first required, and what do providers do when it is discovered that the AST is missing from the clinical records of recipients who have been in treatment for many years prior to the new regulations?
 - The AST was first required by grant condition for Community Mental Health Clinics in 2003 and subsequently for Alcohol and Drug Treatment Providers in 2005.
 - The regulatory requirement for completing the AST for each new and returning recipient went into effect October 1, 2011 but was not implemented until December 1, 2011.

- Providers are not required to administer the AST to any recipient currently receiving active treatment who did not previously complete an AST.
 - For any new or returning recipient since December 1, 2011 who did not complete an AST, providers should note that fact somewhere in the clinical record and indicate the reason if known.
 - Providers are not subject to any negative audit findings related to Medicaid in regards to the AST for any recipient records in existence prior to December 1, 2011.
4. Please clarify if a provider is still required to conduct a “behavioral health screening” [per 7 AAC 135.100] if the recipient has been referred “by a court or another agency” as stated in 7 AAC 135.110(a)?
- Providers are not obligated to complete a behavioral health screening using the AST for recipients referred by a court or another agency.
 - However, Providers are encouraged to utilize the AST for these recipients in order to screen for issues that may not have been evident to the referring court or agency, such as substance use, depression, TBI, trauma, etc. The AST provides information that should be further explored in a Behavioral Health Assessment.
 - Providers may bill \$35 to Medicaid for conducting a behavioral health screening utilizing the AST with qualified recipients.

VIII. Professional BH Assessments and Adaptation of the Functional Assessment

1. Is there still a requirement for an annual psychiatric assessment?
 - As of October 1, 2011, there is no requirement for an annual psychiatric assessment.
2. May Agency B conduct [another] BH Assessment on a consumer who has already received an assessment from Agency A? (Concern exists for Substance Use Treatment Providers that must contend with assessments received from private firms – including ASAP contractors – that may lack ASAM or other criteria.) The larger issue is whether each Provider may conduct their own assessment with a new / returning consumer regardless of any pre-existing assessments conducted by other Providers.
 - The regulations do not address this issue. Neither the Department, nor the Division has a policy that governs the issue. Providers are free to accept other agency assessments, and Providers may conduct their own assessments on new and returning recipients. A recipient's treatment plan is based upon recommendations from an assessment. All assessments should be updated as new information becomes available.
3. In the final version of the regulations it now indicates that the behavioral health [assessments] have to be conducted “at admission”. This is language that was not in the previous regulations version and was also not in the June 4, 2009 version issued

for public comment.....Many substance abuse providers conduct assessments prior to admission to determine the most appropriate level of care in accordance with ASAM. There is frequently a delay in services starting due to waitlist issues. Many times clients do choose not to avail themselves of services. Making the assessment the date of admission makes it difficult to track, brings up treatment planning issues etc.

- The regulations don't define "admissions", or assign timeframes to the term.
 - The Division recognizes that ASAM criteria applied by some agencies include a practice that conducts assessments prior to admission for appropriate placement. It is also recognizes that many assessments do not result in an admission to services.
 - There is no assigned intent specific to the term. As the Division works with providers in the development of an integrated system of care, identifying such issues will help refine the planning process.
4. How does Department define "psychosocial evaluation" (noted in definition of Behavioral Health Clinical Associates) – SU Intake assessment.
 - There is no definition of psychosocial evaluations in the regulations. Industry standards identify this evaluation as a documented summary of collected data about a patient's psychological, developmental, family, occupational and social background and current status as part of the initial evaluation of a patient or client in a variety of treatment settings.
 5. Are Semi Annual Mental Health Assessments by the Directing Clinician mandatory?
 - A Professional behavioral health assessment is only required upon admission, but must be updated as new information becomes available.
 6. It is our policy, supported by CARF standards, to administer integrated assessments to all new clients. Under the new regulations, are we able to continue our current practice of administering integrated assessments?
 - Yes. In fact, the Dept. also encourages that all new and returning recipients receive an integrated assessment when at all possible. Dual diagnosis is "an expectation not an exception".
 7. At the time of a treatment plan review, what information should be added to the assessment?
 - All Professional behavioral health assessments must be updated as new information becomes available (7 AAC 135.110).
 - Providers should consider updating assessments whenever information becomes available that identifies a new problem that may require a new treatment service, or whenever information becomes available related to treatment recommendations that subsequently affect the treatment plan.
 8. Our clients remain in services for a significant length of time. Currently we complete an annual assessment update which meets the requirement of updating the assessment

as new information becomes available. Are annual assessments still required before the annual treatment plan is written?

- There is no requirement in the new regulations for an annual assessment.
- A Professional behavioral health assessment must be conducted upon admission to services and during the course of active treatment as necessary and updated as new information becomes available.
- A recipient's treatment plan must remain current based upon a client status review which is conducted every 90-135 days.

9. Does the language in 7 AAC 135.110(e) mean that a psychiatric assessment is not mandatory if the recipient's condition does not indicate the need as assessed by the licensed clinician in their assessment?

- That is correct. A psychiatric assessment is not mandatory for every recipient, and should be administered based upon recipient need.
- However, one of the Professional behavioral health assessments must be conducted for each new or returning recipient upon admission to services.

10. If a behavioral health assessment indicates the need, is there still a 30 day / 1 month time requirement for psychiatric assessments to be completed?

- A Professional behavioral health assessment must be completed upon admission to services.
- The regulations do not establish a time frame for when a psychiatric assessment should be completed if recommended by a PBH assessment.
- Services may only be provided and billed to Medicaid if those services are based upon a PBH assessment and indicated in a current treatment plan.

11. Must a psychiatric assessment be updated annually?

- As of Oct. 1, 2011, there is no longer a regulation requirement for an annual psychiatric assessment.

12. What are the time frames for writing a Behavioral health assessment and treatment plan (especially for detox services)?

- The regulations are silent on the time required to complete either an assessment or a treatment plan.
- An assessment is required to provide treatment recommendations that form the basis of a subsequent behavioral health treatment plan.
- A signed treatment plan must be in the clinical record for the Dept to pay a Provider for services rendered to a recipient.
- Providers are encouraged to meet all the minimum requirements for an assessment and a treatment plan as early as possible to allow for the delivery of services.

13. Do residential treatment Providers receiving referrals from a lower level of care need to re-assess clients?
- No.
 - However, an assessment must provide treatment recommendations that form the basis of a subsequent behavioral health treatment plan, and must be updated as new information becomes available.
 - If a Provider adopts an assessment from another agency, the Provider is obligated to the information contained in the assessment.
14. Is there still a one month requirement for a completion of a psychiatric assessment?
- The Behavioral Health Services Integrated regulations do not impose a requirement on the length of time in which a psychiatric assessment should be completed once the need has been identified.
15. Clitheroe, and most other substance abuse treatment agencies, also conduct telephonic Assessments on potential clients in remote Alaska communities, where residential substance abuse treatment services are not available.

Seldom are the clients Medicaid eligible nor do they have private insurance, so usually these are not billed to a third party; instead, the client pays. In the case of DOC inmates, DOC pays for the Assessment.

The practice of conducting Substance Abuse Assessments telephonically has been going on for many years, and is the most efficient, economical way for individuals with substance abuse problems to gain access to treatment services that are not available in their community or in the prison. If this practice is no longer valid, what would be a viable alternative?

- Any CBHS Provider that delivers services statewide confronts the issue of matching recipient needs with program capabilities. However, the practice of conducting assessments telephonically does not meet the definition of a professional behavioral health assessment, and is not billable to Medicaid, and would not fulfill the documentation requirements for the clinical record. All behavioral health services provided by a CBHS Provider must meet the service criteria and staff requirements outlined in regulation. Professional behavioral health assessments must be conducted directly with a recipient, face-to-face (including via tele-behavioral health) for the information to be acceptable for the clinical record.
16. We have been receiving assessments from local agencies that conduct telephone interviews with individuals incarcerated – we have also seen telephonic assessments that are done in a “major hub” for individuals in villages. As for FNA we do not provide telephone assessments as we believe it needs to be done face to face – so that leaves us with those agencies that do telephone assessments and whether we should accept them based on the new regulations. While a telephonic assessment is not billable, they are still being provided.

- Please see Answer to Question No. # 15, above. FNA is correct that assessments conducted telephonically do not meet criteria established by regulation. In the case of these referrals, a professional behavioral health assessment should be conducted by FNA staff for each recipient.
17. Do the recommendations listed in an assessment become the “original” treatment plan, and can services be billed while a treatment plan is being developed?
- No, the recommendations listed in an assessment only “forms the basis for a treatment plan”, but cannot be used of themselves as a treatment plan.
 - Services must first be identified in a treatment plan and may only be delivered and billed to Medicaid upon the completion of that plan.
18. If the AST indicates the need for an assessment is there a specific timeframe in which the assessment must be completed?
- No. There is no requirement in regulation for when an assessment must be completed. The only stipulation is that an assessment must be completed prior to developing a treatment plan.
19. Can clinic services be recommended in a SUD assessment conducted by a substance use disorder counselor?
- Substance use disorder counselors, in keeping with their scope of practice, may only directly recommend rehabilitation services in an SUD Assessment.
 - However, a Substance use disorder counselor can recommend that the recipient participate in a Mental Health Assessment. Any needed clinic services for the recipient would then be directly recommended by the mental health professional clinician conducting the Mental Health Assessment.
20. May a SUD Counselor or BH Clinical Associate assist in gathering information for the Integrated Assessment, and relay it to the MHP Clinician conducting the assessment?
- A Mental Health Professional Clinician may use any collateral information as part of the behavioral health assessment.
 - The Integrated assessment is billed as a clinic service, and must be conducted by qualified staff as required in regulation [7 AAC 135.110(d)].

IX. Clinical Record Documentation, Treatment Plans and the CSR

1. Can the Division provide clarification on documentation requirements as they relate to “start and stop” times on progress notes? Does this requirement apply to all behavioral health service codes?
- Documentation requirements of “start and stop” times for behavioral health services is limited to time-based services billed using CPT codes that specify a time requirement in the code definition. For covered behavioral health services this standard applies to the following services:
 - 90804: Psychotherapy, Individual; 30 minutes

- 90806: Psychotherapy, Individual; 60 minutes
 - 90810: Psychotherapy, Individual; 30 minutes
 - 90812: Psychotherapy, Individual; 60 minutes
 - 96101: Psychological Testing; 1 hour
 - 96118: Neuropsychological Testing; “per hour of the psychologist’s or physician’s time both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report”
 - 99408: SBIRT; “15 to 30 minutes”
2. Does OCS have to participate in a treatment team meeting if they don’t have custody but are involved with the family?
 - Yes, if they are involved with the family but don’t have custody they are still providing supervision to the family. According to 7 AAC 135.120(c)(1)(C) “a staff member of the office in the department responsible for children’s services, if the recipient is in state’s protective custody or supervision”.
 3. If the recipient of services only wants Pharmacological Management, do providers still need to meet the requirements for a clinical record?
 - The requirements for a clinical record (7 AAC 135.130) still need to be met for Pharmacological Management to be a billable service. It is important to document medical necessity within the Behavioral Health Assessment and recommend in the Treatment plan the need for Pharmacological Management services.
 4. Is there still an interim treatment plan?
 - The regulations do not speak of an “Interim treatment plan”; rather, there is expectation that the treatment plan is a living document that reflects the most current assessment information over time.
 5. If a child with a severe emotional disturbance is receiving services in the school, does a school representative need to be part of the child’s treatment team? What if the parents do not want the school involved?
 - A school representative is not a required member of a behavioral health treatment team for a recipient under the age of 18 years.
 - If it is clinically indicated, it is appropriate to work with parents to eventually accept the school as part of the team, and monitor progress to determine if services are effective.
 6. The Medicaid standard of documentation in 7 AAC 135.130 (Clinical Record) states that a provider “shall retain a record of any service provided to the recipient in accordance with 7 AAC 105.230”. How does this documentation standard apply to residential substance abuse treatment services, as this service type is reimbursed by a day rate? Can a single progress note be generated for the day?

- The Medicaid standard of documentation in 7 AAC 135.130 (Clinical Record) applies to residential substance use treatment services.
 - A single progress note may be generated per day, that documents the range of services delivered, as defined in 7 AAC 70.120 (b) – (c) (14), under the day rate for residential substance use treatment services, if the progress note documents a single service delivered by the same renderer of the service during that day, and reflects the total accumulated time.
 - A single progress note cannot reflect multiple and dissimilar services.
 - A single progress note cannot reflect the activities of more than one staff member.
 - A separate and individual progress note must be generated for those additional behavioral health services that the department will pay for on the same day as residential substance use treatment services (7 AAC 135.280 (d) (1-6):
 - Behavioral health screening under 7 AAC 135.100;
 - Completing a client status review under 7 AAC 135.100;
 - Needed professional behavioral health assessments under 7 AAC 135.110;
 - Case management services under 7 AAC 135.180;
 - Needed behavioral health clinic services under 7 AAC 135.010;
 - A medical evaluation (Eff. 10/1/2011, Register 199).
 - The residential day rate can only be billed if at least one service has been delivered for that day:
 - Clinically managed low-intensity residential substance use treatment services include five or more hours of clinical and therapeutic rehabilitative services per week.
 - Clinically managed medium-intensity residential substance use treatment services include twenty or more hours of clinical and therapeutic rehabilitative services per week.
 - Clinically managed high-intensity residential substance use treatment services include twenty or more hours of clinical and therapeutic rehabilitative services per week.
7. Can the documentation requirements for non-attendance of Treatment Team Members include the unsuccessful attempts of the agency to contact the member to inform them of the date / time of the Treatment Team meeting?
- Yes. Providers must document if a member “refuses or is unable to participate after the Provider’s responsible efforts to encourage participation”, or if a member cannot attend because of “weather, illness or other circumstances beyond the members control.” 7 AAC 135.120(d)(2) & (3)
8. In the Policy and Procedures – Clinical Records Documentation Requirements for AK Medical Assistance Behavioral health Care Providers: section on progress notes

indicates that a progress note must contain: “identification of the recipient’s diagnosis and medical need for the services.” This is an additional requirement regulations (7 AAC 135.130 Clinical Record (a) 8 (A-F) of what must be contained in a progress note.

The requirement that this is referring to is required in the regulations to be a part of the clinical record (assessment and treatment plan specifically) but these regulations do not specify the progress note. Please clarify the Divisions expectations.

- 7 AAC 105.230 (d) Requirements for provider records reads as follows: “...The clinical record must include (1) information that identifies the recipient’s diagnosis...”
- Individual progress notes are not required to include the recipient’s diagnosis.
- 7 AAC 135.130 (a) 8 (A-F) defines the requirements for individual progress notes.

9. Can an agency choose to have a treatment plan for consumers over 18 but under 21? How would this affect billing issues?

- All recipients must have a treatment plan to bill for services. The treatment team should decide which system best meets the recipient’s needs. The main differences between the adult and child system are:
 - Therapeutic Behavioral Health Services for Children allows for family interventions; Community Support Services for Adults does not
 - The treatment team requirements for children are more prescriptive
 - Case management can be utilized to coordinate treatment team meetings for youth who experience severe emotional disturbances

10. Is psychiatric services/pharmaceutical management “only” sufficient treatment for recipients of CBHS provider?

- Yes, a recipient may receive “only” psychiatric services as long as these services are determined to meet the needs of the recipient, and the clinical record requirements are met.

11. Question deleted 2.20.13 – See Provider Letter 1.18.13 GD Pharmacologic Management Services.

12. Can the Dept. intervene with ACS to improve their capacity to receive PA’s via FAX, and via posted mail?

- Within the next month, ACS will be changing their fax system. Providers will still use the same numbers but the problem with busy signals will be eliminated. The fax lines will be able to accommodate simultaneous faxes.
- The Division will continue to work internally within the Department to convey providers’ concerns about fiscal agent services.

- Providers are encouraged to call the Provider Hot-Line with issues that impact their operations.
13. Does the Dept. still intend to require a progress note for conducting the AST, the CSR, and the BH Assessment?
- No. Providers do not have to document the completion of the AST, CSR and BH Assessment in a progress note.
 - The completed AST, CSR and BH Assessment however, must appear in the clinical record in order to bill Medicaid.
14. Since there is no longer an allowance for an ‘interim’ or ‘master’ treatment plan, how do providers meet treatment plan requirements for new recipients whose problems are not initially well understood but who need immediate services (especially children referred from out-of-state)?
- The treatment plan is a living document that is expected to change over time. Providers should reflect the problems, goals, and related treatment services as they are known at any point in time to meet recipient needs. Additional information is updated to the treatment plan as recipients participate in active treatment and problems and needs continue to be identified.
15. Question deleted 2.20.13 – See Provider Letter 1.18.13 GD Pharmacologic Management Services.
16. It is our practice to include an addendum to the assessment when changes occur that only update the assessment, but not recreate it. As a non-billable document, are addendums acceptable as part of a client’s clinical record?
- Yes. Your agency is operating exactly as intended by regulation by updating the assessment via an addendum whenever new information becomes known. The addendum, or addition, to the assessment is an acceptable and expected part of a client’s clinical record.
17. Does the 1hr/Week/Recipient of case management service by the Directing Clinician have to appear in the treatment plan?
- No, if case management services are already ordered in the treatment plan.
 - Yes, if no other case management services other than those provided by the Directing Clinician are ordered in the treatment plan.
18. How does the CSR fit into the admission process for Akeela, Inc. that is required to accept assessments from other providers?
- All Providers may conduct their own assessment of a recipient “upon intake”.
 - The Client Status Review form must be completed for each new and returning recipient concurrent with a behavioral health assessment.
19. Does the discharge need a corresponding Progress note? What would this code be?

- Regulations require that a final Client Status Review (CSR) be completed for each recipient upon discharge (billed as H0046), and a copy of the CSR placed in the recipient's clinical record.
 - Documentation of discharge beyond the above requirement is to be determined by each Provider.
20. Can the Division provide clarification on the need and the required content for progress notes now required for the AST, CSR, and professional behavioral health assessments?
- The Dept. has determined that providers do NOT have to document the completion of the AST, CSR and BH Assessment in a progress note.
 - The completed AST, CSR, and BH Assessment however, must appear in the clinical record in order to bill Medicaid.
21. The code [for Alc & Drug Assessment] is H0001; should we use the same code for (H0001) for the Progress note to document that service? We would then have two H0001 for the same service and that does not make sense to us...
- See Answer to Question No. # 20 above.
22. CSR: same code for all CSR's over the course of treatment (Intake, 90-145, and discharge)? Do the CSR's need a corresponding progress note as well? What would that code be?
- See Answer to Question No. # 20 above.
23. Must the Narcotic Drug Treatment Center, Inc. complete an AST and CSR on clients that are only placed on a Wait-list, but do not receive any services except minimal assessment, orientation, urinalysis and education on HIV/AIDS, FASD & TB?
- If your agency is conducting a professional behavioral health assessment as defined in 7 AAC 135.110 then an AST and CSR must be completed concurrently with the assessment.
 - Completion of a professional behavioral health assessment, the AST, and the CSR are Medicaid billable services.
 - If your agency is only providing screening and brief intervention services to detect substance use problems, and the appropriate level of intervention, then neither the AST nor CSR is required.
 - Providers may bill Medicaid for Screening, Brief Intervention and Referral for Treatment (SBIRT).
 - 7 AAC 135.130(b) requires Providers of Medicaid behavioral health services to retain a record of any service provided to a recipient even if the recipient is not currently receiving services.
24. Does the progress note for Case management services have to meet all the requirements stated in regulation (especially 'the description of recipient's progress toward treatment goals')?

- Yes. Though at times it is awkward to document the recipient’s progress toward a treatment goal in response to the provision of case management, the requirement may be fulfilled by noting that the recipient did, or did not, benefit from the service, or acted upon the result of the service, or was able to work toward achieving a treatment goal because of the service, etc.
25. Do providers need to document in a progress note the administration of the AST, the CSR, and a BH Assessment provided to an ISA recipient?
- Yes. Each of these services need to be documented in an individual progress note to initiate the claims adjudication and reimbursement process.
 - ISA funds are not available for all non-resourced recipients, but only those recipients who have a demonstrated and documented high-risk behavior that requires services intended to prevent or divert them from moving into a higher level of care.
26. Regarding the documentation requirements for Screening, Brief Intervention & Referral for Treatment (SBIRT), should a Provider file that information as an assessment or via a progress note?
- Providers “shall document SBIRT in a progress note in accordance with 7 AAC 135.130(a)(8).” – 7 AAC 135.240(d)
 - The requirement to “identify the treatment goal the service targeted” is fulfilled by definition of the service itself found in 7 AAC 135.990(20).
 - SBIRT is a distinct and separate [billable] behavioral health service; it does not meet the requirements for, nor can it take the place of, a behavioral health assessment.
27. Question deleted 2.20.13 – See Provider Letter 1.18.13 GD Pharmacologic Management Services.
28. Can a single progress note be used to document the same service provided by the same staff person to the same recipient at different times during the same day?
- Yes, as long as the following conditions are met:
 - The service provided is NOT a time-based code
 - The staff person rendering the service notes the elapsed time and the intervention or activity that occurred for each time the service was delivered
 - The cumulative number of service units is entered into AKAIMS on the Encounter Profile screen within the yellow required box for Number of Service Units
 - Medicaid billing reflects the cumulative number of service units of all service episodes
 - A separate progress note is required under all the following conditions:
 - For ALL time-based codes

- For different rendering staff
 - For different services
 - For services provided on different days
29. Was it an oversight to not include in regulation the previous treatment plan requirements for discharge plan, goal attainment dates, and progress toward less intensive services?
- No. The intent of the Behavioral Health Services Integrated regulations is to establish minimum requirements and to reduce the administrative footprint of the Dept. on Provider operations.
 - Providers operate under standards other than just the Alaska Administrative Code. For example, accreditation standards, ASAM standards of care and other professional standards of care, as well as potential Federal requirements related to audits, etc.
 - Providers are encouraged to adopt policies and business procedures that best meet the needs of their consumers and their agency operations.
30. Can you please clarify the documentation requirement for “time/duration” for a pharmacologic management progress note that was noted in the FAQ Version 8, pg. 32, Question No.? # 28, 2nd bullet?
- All progress notes require either a notation of start / stop times or a notation of duration.
 - Pharmacologic management service is documented according to duration, which is noted as a visit or 1 visit.
31. The start & stop times need to be documented in a progress note, but do they also need to be part of a claim for Medicaid reimbursement?
- The Fiscal Agent for the Dept., Affiliated Computer Services, does not require start and stop times on a claim for reimbursement, and there is no data field on the claims form for start and stop times.
 - Providers must however, include on a claim form the total number of units of any service provided to a recipient.
32. Are Family psychotherapy and group psychotherapy included in the list of services that require start and stop times as described in the CPT codes?
- No. These two services only require documentation of the duration of service.
33. The previous regulations required that an adult’s treatment plan needed to be reviewed every 6 months. If a treatment plan is reviewed prior to the due date, is the next treatment plan review based on the previous due date or the date that the plan was actually reviewed?
- During the delayed implementation period the first treatment plan review date for any recipient cases opened prior to December 1, 2011 can be scheduled

according to the previous regulation requirements: 6 months for an adult case; 3 months for a child case.

- At the time of the first scheduled treatment plan review for these cases (adult or child), the new regulation requirements take effect, and the next (e.g. second) treatment plan review must occur within 90 – 135 days of the date of the first treatment plan review.
- All subsequent treatment plan reviews must minimally occur within 90-135 days of the date of the previous treatment plan review.

34. The Dept. has stated (FAQ Version IV) that there is no requirement for an annual comprehensive assessment and that the treatment plan must be kept current by a review every 90 – 135 days based on completion of a CSR. Is there a requirement that new [treatment] plans are written every 12 months or are the plans reviewed and kept current as described above?

- There is no regulation requirement to write a new treatment plan every 12 months.
- Treatment plans must remain current based upon a client status review conducted every 90 – 135 days.
- All professional behavioral health assessments should be updated as new information becomes available.
- Behavioral health services may only be provided if they are recommended in a behavioral health assessment and are identified in an individualized treatment plan.

35. According to regulation, treatment plans need to be based upon information from the AST, CSR and a behavioral health assessment. In our 45-day program we meet every other week to review and update the treatment plan as new information becomes available. Are these revisions to the treatment plan valid even though we did not complete a new CSR?

- Yes. Though regulations require the minimal standard to update treatment plans every 90-135 days based upon a client status review, any treatment plan update made at any time during active treatment that is based upon new recipient information is valid.
- Providers may only bill Medicaid for reimbursement of a client status review upon admission to services, once every 90 – 135 days, and upon discharge from treatment.

36. Is there any latitude for the completion of the CSR because of delays in seeing clients due to weather, etc.?

- No, the client status review may be completed any time within the allotted 90 – 135 day window which should accommodate delays in scheduling appointments with recipients.

37. Question deleted 2.20.13 – See Provider Letter 1.18.13 GD Pharmacologic Management Services.
38. Question deleted 2.20.13 – See Provider Letter 1.18.13 GD Pharmacologic Management Services.
39. For the Treatment Plan dates of service (3 month range for children, 6 months for adults (currently)), should the start of service date be the day the assessment is started (as written on the assessment itself), or the date the clinician signs it (as sometimes they begin work on the assessment but complete it a day or two later).
- All documentation is anchored to the date of signature.
40. Does the parent or guardian have to sign the treatment plan or just be present? Who is required to sign the treatment plan?
- The regulations require that the recipient or the recipient's representative must sign the treatment plan.
 - The only other signature required on a treatment plan is that of the Directing Clinician.
41. If a recipient refuses to complete a CSR, can the provider document this fact, or must the recipient be discharged for non-compliance with treatment? Is there a timeline for how long a recipient can go without completing a CSR before a provider must suspend or discontinue services?
- Providers are not encouraged to discharge recipients from services due to a refusal to complete a CSR.
 - Just as Providers work with recipients to address resistance to any other aspect of treatment, they should also help recipients understand that establishing a baseline of functioning and measuring change over time is good clinical practice and beneficial to the recipient's care. If necessary, providers may assist recipients in the completion of a CSR.
 - Providers are encouraged to obtain training for staff in areas of motivational interviewing.
 - Providers are encouraged to discharge recipients who are not engaged and maintained active treatment, and whose treatment plan has not been kept current by a periodic client status review as required by regulation.
42. We have a few patients we have scheduled follow-up every six months. If we exceed the 135 day requirement for conducting a client status review, what happens?
- A Provider runs the risk of non-compliance with regulation, and any Medicaid service delivered past the due date of the client status review may be denied and/or payment subject to recovery.
43. What should a provider do about conducting the client status review for a recipient that drops out of treatment prior to the next regularly scheduled review, but then resumes treatment at a later date?

- Providers are encouraged to discharge recipients who have failed to maintain active treatment, and whose treatment plan has not been kept current by a periodic client status review as required by regulation.
 - All new and returning recipients must receive an AST, and an initial CSR concurrent with a professional behavioral health intake assessment.
 - The next subsequent client status review is conducted within 90-135 days of the date of the initial CSR.
44. What are the minimum required signatures for the treatment plan that is in place upon admission, and does it require an actual meeting of the client's interdisciplinary treatment team?
- The regulations require that a treatment plan be signed by the Directing clinician, and the recipient or the recipient's representative.
 - A treatment plan must be completed prior to the provision of services (except for the AST, initial CSR and an assessment), and for minors under age 18 must be based upon the input of a treatment team.
45. For recipients that have already been screened using the AST and CSR, can or should Providers re-administer the AST and CSR if there has been a delay in admitting the recipient to an agency program?
- The AST is only administered at intake, or upon re-admission (following discharge from treatment).
 - The CSR (which is completed concurrently with a professional behavioral health assessment) is administered upon intake, and again every 90-135 days as based upon the date of the previous client status review.
 - For recipients with a completed assessment who are also delayed in receiving services, Providers would not re-administer the AST, and would only need to re-administer the CSR if the delay exceeded the initial 90-135 day review period.
46. May a provider document in the clinical record a custodial parent's agreement with treatment if that parent lives in a different community than the child and cannot provide a signature?
- Providers are obligated to obtain the signature of the recipient or recipient's representative on the treatment plan by whatever means available.
 - In the above case and with similar cases the Provider should document the agreement and approval of the treatment plan by the recipient's representative, and clearly identify why the signature could not be immediately obtained. Services may be provided as accounted for in the treatment plan during the interim between obtaining the representative's 'verbal' agreement and the time when the Provider is able to obtain the required signature(s).
 - Providers should document all subsequent attempts to obtain the required signatures for the treatment plan, and continue to identify the reason why they

were unable to obtain them until such time as they are able to finally secure the signature(s) as required by regulation [7 AAC 135.120].

47. How should Providers document changes in diagnosis when new information is discovered during active treatment and through a client status review?
- The Regulations do not specify how to document changes in recipient diagnosis. The regulations do require that assessments must be updated as new information becomes available.
 - Providers have flexibility in choosing how to best document updates to assessments.
 - For Providers who use AKAIMS as an electronic health record, the application has the capability to update assessments as needed, including diagnosis. Contact AKAIMS training staff if additional assistance is needed.
48. How should Provider's document and bill for conducting a client status review/CSR for unstable recipient's who cannot complete the answers or refuse to participate in the process?
- For recipients who demonstrate inability or lack of capacity to complete the initial or any subsequent client status review/CSR in-person due to an emotional or mental condition, the Provider should:
 - Complete as much information as might be known
 - If utilizing AKAIMS answer any remaining questions on the CSR form as "Not Collected / Not Available"
 - In all cases, the Directing Clinician by regulation must use the initial CSR as relevant clinical information concurrent with an initial professional behavioral health assessment.
 - In all cases, the Directing Clinician by regulation must use the client status review/CSR completed every 90-135 days during the course of active treatment to measure treatment outcomes, to make treatment decisions, and to revise the recipient's treatment plan.
 - The lack of a recipient's ability to answer the CSR is relevant clinical information that can inform assessment and on-going treatment.
49. For Providers who are utilizing an electronic health record, which is the legally acceptable treatment plan, the electronic copy or the 'hard-copy' with the recipient's or recipient's representative's signature?
- All treatment plans require the signature of the Directing Clinician, and the signature of the recipient or the recipient's representative.
 - Providers utilizing an EHR may fulfill this requirement by a combination of electronic signature and/or a 'hard-copy' document with signature(s). The name and credentials of the Directing Clinician and corresponding date on the EHR is sufficient because the treatment plan is completed within a password account.

- The Dept. understands however that Providers may experience a delay between completing the EHR and obtaining the other required signature(s) on the treatment plan. In this case, the Provider should document the agreement and approval of the treatment plan by the recipient's representative, and clearly identify why the signature could not be immediately obtained. Services may be provided as accounted for in the treatment plan during the interim between obtaining the representative's 'verbal' agreement and the time when the Provider is able to obtain the required signature(s).
 - Providers should document all subsequent attempts to obtain the required signatures for the treatment plan, and continue to identify the reason why they were unable to obtain them until such time as they are able to finally secure the signature(s) as required by regulation [7 AAC 135.120].
50. Does a subsequent assessment conducted during the course of treatment need to appear on the treatment plan, or documented in some other way in the clinical record?
- Any professional behavioral health assessment may be provided once every six months, with the exception of a psychiatric assessment which may be conducted four times per recipient within the state fiscal year.
 - Any assessment conducted subsequent to the initial intake assessment does not need to be noted on the treatment plan. However, the fact that a subsequent assessment is indicated and ordered should be documented somewhere in the clinical record (e.g. progress note). The inclusion of the completed assessment in the clinical record is sufficient documentation that the service was provided.
 - Other services that do not need to be included in a treatment plan, nor documented in a progress note are the AST, the client status review / CSR, and Short-term crisis intervention or Short-term crisis stabilization.
51. May another clinician, other than the clinician working with a child recipient, work separately with the child's parents without opening a separate clinical record, or conducting an assessment, etc. for the parents?
- Yes, as long as the services provided (see below) and the problems addressed appear in the child's treatment plan.
 - Services that may be provided without the recipient present include Family psychotherapy w/o recipient present, Therapeutic behavioral health services for children, and Case management.
 - When working with other family members of a recipient Providers should be alert to discovering additional information that may lead to updating the recipient's assessment and treatment plan.
52. Our treatment plan has a place for diagnosis. Since we don't always know the full diagnosis the client has at the time of assessment is it legal to have the client sign their treatment plan (that we determine with them) and then go back and add the diagnosis later after writing our clinical impressions/summary?

- Assessment services (any/all types) and updates to them must result in a diagnosis to be considered to be a complete assessment [reference 7 AAC 135.110 (b) (3), (c) (3), (d) (3), (e) (5), (f) (5)]
 - A treatment plan must (among other things) be based on the behavioral health assessment [reference 7 AAC 135.120 (a) (2)]; AND signed by the recipient or the recipient's representative [reference 7 AAC 135.120 (a) (4) and (5)]
 - The scenario posed in your question would not meet regulatory requirements.
53. Is it necessary to inquire about sexual orientation during an assessment?
- Please see 7 AAC 135.110 for the requirements of a professional behavioral health assessment.
54. Previous regulations required that the phrase "problem list" appear on the assessment and treatment plan. Is this terminology still required?
- No, the term "problem list" does not appear in the regulations in connection with assessment or treatment plan. Please see 135.110 for assessment requirements and 135.120 for treatment plan requirements.
55. How do SUD [substance use disorder] providers bill for family counseling service?
- For children, the provider may bill family therapeutic behavioral health support services.
 - For adults, the provider may bill individual comprehensive community support services whether or not the patient is accompanied by one or more family members.
56. How do you document TBHS for child if that service is provided variably in different units on different days?
- All services must be medically necessary and clinically appropriate. The extent and intensity for the provision of a service should be governed by the recipient's need as it relates generally to behavior, condition, and settings. The treatment plan should outline when and where a recipient should receive a service and to what extent that service should be provided in those circumstances. The progress note should include a description of the active treatment provided, the duration of the service, and the treatment goals targeted.
57. What is the procedure for conducting the CSR for Military personnel that are deployed on TDY beyond the 135 day limit?
- Providers are required to conduct a client status review for each recipient once every 90-135 days, or risk non-compliance with regulation. Any Medicaid service delivered past the due date of the client status review may be denied and/or payment subject to recovery. Providers are encouraged to discharge recipients who are unable to remain engaged in active treatment, and whose treatment plan has not been kept current by a periodic client status review.

58. Please clarify rules about age of consent for minors who's parents have voluntarily cut ties with their children (kicked the minor out of the home and/or have no involvement with the child) but the children has not gone to the court to request emancipation?
- The state law about this matter is located in Alaska Statute AS 25.20.025.
59. Court ordered treatment for substance use disorder only and the AST indicates the existence of a mental health problem, but the client refuses mental health treatment. What should be done in this instance?
- Document the fact that the AST revealed the existence of mental health problems, but the patient refused mental health treatment in the patient's clinical record.
 - Just as Providers work with recipients to address resistance to any other aspect of treatment, they should also help recipients understand that a comprehensive approach to treatment will provide more positive outcomes.
 - Providers are encouraged to obtain training for staff in areas of motivational interviewing.
60. According to the billing manual (pg 14) "The community behavioral health services provider is required to ensure that all recipients under the age of 18 have a behavioral health treatment team" that meets to review, revise, update the treatment plan every 90-135 days. However, it looks like from the way the manual is written, the Case Manager services [for time spent to set up, travel to or from treatment team meeting] are only reimbursable for SED youth, not SUD youth or ED youth. Are you requiring this for all you but only reimbursing it for SED youth?
- As a rehab service, case management services for children is limited to those children who are experiencing a severe emotional disturbance or a substance use disorder. Therefore, the time spent by the child's assigned case manager to set up, travel to or from the treatment team meeting is only reimbursable for clients who are eligible for rehabilitation services (children who are experiencing either a severe emotional disturbance and/or a substance use disorder). Case Management is not covered for children who are experiencing an emotional disturbance only.
61. Do providers need to use the exact DBH Crisis Intervention form or can all components contained in the form be loaded into the provider's own electronic health record?
- CBHS Providers with an electronic healthcare record may upload and use the information from the Dept. Short Term Crisis Intervention form.
62. From a program integrity audit perspective, for a client who has a legal guardian signs a treatment plan with the clinician, but the plan isn't signed by the guardian, will the treatment plan be active as soon as the client signs OR will services the client receives in the meantime not be billable until the guardian can sign or return the treatment plan document via mail or fax?

- The Regulations [7 AAC 135.120(a)(5)(B)] requires that the treatment plan be signed by the Directing Clinician and the recipient OR the recipient's representative. The Regulations do not require the signature of the recipient's representative if the recipient *him/herself* has signed the treatment plan. Services may be provided and billed upon receipt of the required signatures on the treatment plan.
63. May the CSR conducted at discharge be completed before the actual discharge from services (e.g. 1-2 weeks prior to end of treatment services)?
- The Dept. believes that the CSR, which measures change over time, provides important recipient information at the time of discharge. Providers are encouraged to conduct the CSR as close as reasonably possible to the end of active treatment.
64. In response to the training at the TA Teleconference, Wednesday July 11, is the client status review a self-report service or a *dialogue* with the client?
- The CSR is a self-report form that the client completes with or without assistance, and is then reviewed with a [directing] clinician (Alaska Screening Tool 2011 and Initial Client Status Review – Supporting Clinical Decision Making and Program Performance Measurement; Version 6.30.11; pg. 41).
65. Data from the CSR affects provider's performance based funding. Can the Directing Clinician modify the answers to the CSR based on an interview with a recipient who's self-report is unreliable?
- The CSR is a self-report form that the recipient may complete with or without assistance.
 - Provider's may not modify a recipient's answers, but may assist a recipient in completing the form, which may be indicated if the provider suspects that a recipient's responses to the CSR may be unreliable.
66. Because CSR data affects provider funding, and recipients often leave treatment without notice and do not complete a discharge CSR, what do providers need to do to document this fact?
- Providers are encouraged to document in a progress note, or an encounter note within AKAIMS, the reason a discharge CSR was unable to be completed. Providers should then close out the recipient record using the discharge summary form in AKAIMS.
 - DHSS/BH does not utilize discharge CSR data for any Performance Based Funding measure.
67. If an assessment is completed but not the initial CSR and services are then provided, and several days later the initial CSR is then completed, are the services provided between the assessment and the CSR billable?
- No. Services may be billed to Medicaid only upon completion of the initial CSR; (providers of course must also complete the AST, a professional behavioral health assessment and a treatment plan prior to service delivery).

- In the case presented, the provider may also need to update both the assessment and the treatment plan based upon the information in the initial CSR.
- The intent of the CSR is to help inform an assessment.

68. Can you clarify the meaning in 7 AAC 135.100(c)(6) that requires the CSR to be completed every 90-135 days (A) while the recipient is in treatment, or (B) from the date the behavioral health treatment plan was last reviewed?

- In this instance, the reference to ‘treatment plan review’ is synonymous with the client status review outlined in 7 AAC 135.100.
- “(A) while the recipient is in treatment”, refers to the time elapsed since the initial CSR was conducted concurrently with the professional behavioral health assessment.
- “(B) from the date the behavioral health treatment plan was last reviewed”, refers to any CSR completed subsequently to the second CSR, which is to be completed 90-135 days from the date of the initial CSR.

69. What are the documentation requirements for S.T. Crisis Stabilization?

- Short-term crisis stabilization must be documented on the form provided by the department, and needs to include:
 - Contact Profile information
 - Presenting Problem
 - An initial assessment
 - A short-term crisis stabilization plan
 - A description of all the services provided
 - Signature and credentials of the person delivering the service

70. How do Providers input CSR information into AKAIMS that is accurate or factual, but different from the recipient’s self-report?

- A recipient’s responses on the CSR cannot be changed by the Provider, and must be entered into AKAIMS as written.
- If a Provider has evidence that the recipient’s responses on the CSR are inaccurate or untruthful, the Provider should document that fact in the assessment.
- Though the CSR is a self-report form it is to be completed in-person with a Provider staff member, who may assist the recipient in filling out the information on the form.

71. Can two Providers share assessment information and services, especially case management, for a recipient who is receiving treatment from both agencies?

- A Provider may utilize an assessment developed by another agency, and takes responsibility to:

- Assure that the assessment was conducted and documented according to regulation requirements
 - Use the information in the assessment to develop their respective treatment plan for the recipient
 - Update the assessment as new information becomes available
 - Providers may certainly conjointly develop their respective treatment plans for a shared recipient so that services are delivered in the most effective manner according to recipient needs and agency capability. The following conditions would apply:
 - All patient privacy and confidentiality requirements are observed
 - Each Provider delivers services according to their respective treatment plan
 - The same service, except Case Management, cannot be delivered in the same clock hour by both Providers
 - All Medicaid service limits apply
72. For [residential treatment] recipients who are scheduled home visits as part of their treatment, should that info be included in the treatment plan, and should it also appear in the assessment?
- Though home visits are not a Medicaid billable service, they should be documented in the treatment plan. As described above, they are a part of treatment, and it is assumed that they are then linked to a goal, or used as an intervention. The regulations stipulate that a treatment plan should include treatment goals as well as the services and interventions that will be used to address these goals [7 AAC 135.130(a)(7)].
73. When the recipient's representative (e.g. OCS Case Manager) attends the Treatment Team meeting via teleconference, can the Directing Clinician sign for them, rather than delay treatment until a signature can be obtained?
- The Directing Clinician cannot sign for the recipient's representative. However, treatment can begin without the representative's signature as long as the clinical record shows:
 - They participated via teleconference
 - They agreed to the Treatment Plan
 - The agency describes their arrangements to obtain the representative's signature
74. Does a Provider need to update the Treatment Plan and the Assessment for a new service if Family Psychotherapy (90847) was originally ordered, but it is decided that the recipient's family should meet at times without the recipient present (90846)?
- No. The treatment plan only needs to reflect family psychotherapy, which is a standard clinic treatment service. The Department added the capability for

providers to flexibly deliver this service based on individual need by allowing the family to be seen without the recipient present. The decision to conduct a session without the recipient present cannot always be anticipated. Providers should use whichever procedure code is applicable for each family therapy session.

75. When changes are made to the Treatment Plan, do both the Directing Clinician and the recipient have to sign the new plan?
- No. The Directing Clinician is the only person required by regulation to sign a treatment plan whenever changes have been made to the plan.
76. What do we do about discharge CSR's when a client just stops coming and there is no contact at the time of discharge?
- Please see answer in Section IX, Question No. # 66.
77. How should a provider document and bill for time spent conducting emergency services intermittently for different recipients presenting concurrently in a hospital emergency room?
- Please see Section VI, Question No. # 44 for guidance on service delivery.
 - Please see Section IX, Question No. # 28 for guidance on documentation: The provider in the example above would apply this logic to each recipient in turn.
78. How should a provider correct an error on the treatment plan that called for fewer units of a service than was planned?
- The assessment must recommend and support the need for the services ordered in a treatment plan.
 - In the situation of an error on the treatment plan (as noted above) the Provider should update the treatment plan with the new service frequency / duration, etc. and note on that document the explanation for the error and the correction made.
 - Providers may retroactively request a Service Authorization [to exceed service limits] as needed.
79. May a provider still bill for services identified on a treatment plan if the recipient's representative (parent) signed the treatment plan late, after services began to be delivered?
- Providers by regulation [7 AAC 135.120(a)] may only be reimbursed for services provided to a recipient if all clinical record documentation requirements are met.
 - Please see FAQs Section IX, Question No. # 46 for further guidance.
80. If a rendering provider is unable to sign a progress note (due to illness / absence), may the agency have someone sign on their behalf, and then move forward with billing?

- No, regulations [7 AAC 135.130(a)(8)] require progress notes to include the name, signature, and credentials of the individual provider who delivered the service. Providers incur audit risk if they bill for services which are not properly documented.
81. Can you clarify whether Emergency Services (ES) “time spent” should be documented as face-to-face time only, or as total time spent on the matter? And how do you document total time spent per emergency services patient when the time expended by a clinician involves services to more than one patient concurrently?
- Providers must meet the service requirements in regulation for conducting S.T. Crisis Intervention [7 AAC 135.160].
 - This service may include time spent by the Provider which is related to managing the recipient’s crisis but which does not involve direct interaction with the recipient (e.g. provision of case management services).
 - Please see Section IX, Question No. # 28 for guidance on documentation.
82. How should the Directing Clinician document the one hour/week of case management services for observing a service as it is directly provided to a recipient?
- The Directing Clinician needs to include all the criteria noted in 7 AAC 135.130(a)(8) for a progress note.
 - For criteria (E) of this section the Directing Clinician should document if the interventions and techniques are:
 - Appropriate to the recipient’s needs
 - Delivered at an adequate skill level; and
 - Achieving the treatment goals
83. Can a provider with an electronic health care record utilize a “signature form” to capture the recipient’s signature for a treatment plan, and then scan that document and attach it to the clinical record? Can any signed, scanned copy of a document serve as an original for the clinical record?
- The Dept. has determined that a provider with an EHR may capture a recipient’s signature on a treatment plan “signature form” and scan that form into the clinical record.
 - However, providers should seek legal consultation regarding the question of utilizing “any signed, scanned copy of a document . . . as an original for the clinical record”.
 - Providers are referred to Alaska Statute for further information on electronic healthcare records and electronic signatures: AS 09.80.040.
84. What regulates the date of the Treatment Plan, the signatures, or the actual date of the plan?

- A treatment plan requires the signatures of the Directing Clinician and the Recipient, or the Recipient’s Representative before services may be delivered and billed.
- Regulation [7 AAC 135.130(a)(7)] requires “the date implementation of the behavioral health treatment plan will begin”.
- A treatment plan must remain current based upon the periodic client status review (conducted every 90 – 135 days). [7 AAC 135.120(a)(6)]
- Providers should base their client status review upon the date of implementation of the treatment plan.

X. Staff Qualifications & Issues Regarding Clinical Supervision

1. Do residential substance abuse treatment providers, at all levels of intensity, have to have a nurse available 24/7 to administer medications?
 - Medication Administration Services need to be provided by medical personnel as described in 7 AAC 70.990(26). The frequency of medication administration is based on each recipients individuals needs. The regulations do not specify the frequency or duration of time a nurse needs to be onsite.
 - The regulations do state that residential substance use treatment services be provided with the appropriate medical, psychiatric, and psychological services on-site or closely coordinated off-site as determined by the severity and urgency of the recipients condition.

2. We need clarification on 7 AAC 70.120 (c) (4) through (h) (5). Of the individuals listed in (f) (6), (g) (5) of this section, **ONLY** a physician or advanced nurse practitioner, or a licensed practical nurse supervised by a physician or advanced nurse practitioner may provide medication administration services... This is supported by the definition of Medication Administration, under 7 AAC 70.990 (26).

Substance abuse programs have only “monitored” medication at specific med call times in residential programs. They have not and do not have the medical staff necessary to serve for Medication Administration, nor are they funded to hire them. If we have missed the “monitoring” section reference, please tell us where it can be found, and if it is there how we square it with the reference in the earlier paragraph.

- This request for clarification centers around the issue of **Medication Administration** in Residential Substance Abuse facilities, listed under section **7ACC 70.120 “Additional requirements for providing residential substance use treatment services”**, as a service that must be offered, as needed, to clients in those facilities.
- Medication Administration, by definition, refers to the actual provision of oral or injectible medication by a M.D., R.N., or other licensed medical provider.

- Prevailing practice in existing Alaska residential substance abuse facilities, supported by ASAM Level III Criteria, has been for clients to self-administer prescribed medications.
- Facilities maintain central, locked storage for medications. Providers develop Comprehensive Medication Management policies and procedures that reflect both the medical clearance and the ongoing training program for staff.
- The Division's interest is to ensure the safe management of clients' medical needs while in residential substance abuse programs. At the same time, the Division's intention is not to impose unnecessary staffing requirements on providers.

The definition of Medication Administration can be met using the following methods:

- Medical staff are employed or contracted to provide medication administration services,
or
 - In conducting a Medical Clearance for clients before Intake - the physician or advanced nurse practitioner clearly document that "Biomedical issues, if any, are stable and predictable and do not require medical or nurse monitoring" and the resident is capable of self administering any prescribed medications,
and
 - Providers either employ or contract with an RN for regular training of staff in monitoring client's self-administration of medication, medication side effects, and safe storage of medications.
3. If a client is receiving services from two separate agencies, can each agency have its own internal Directing Clinician? For example, a dual diagnosed client receives an Integrated Behavioral Health Assessment. The client chooses to receive substance abuse treatment services from a different agency. Consequently, the client has a mental health treatment plan at agency A and a substance abuse treatment plan at agency B. Can directing clinicians at both agencies bill 1 hour of case management / week? Or, does agency A develop a comprehensive treatment plan and is the sole Directing clinician? If the answer is the latter, is the Directing Clinician at Agency A responsible for the implementation of services at Agency B?
- Yes, each agency may have their own internal directing clinician and may bill for their services accordingly. Collaboration among the two directing clinicians is beneficial for the recipient who is receiving services.
4. What is the minimum age for someone to provide peer support services? (For example youth who have survived and thrived after having experienced both the foster care and behavioral health systems providing support to youth currently in the system).
- Peer support providers **MUST** be employed by the agency as behavioral health associates. Minimum age is determined by labor laws for employment

and agency policy. Good practice indicates that all employees, and particularly peer support staff be aware of the prohibition of dual relationships with clients and maintain appropriate boundaries. These issues are likely to need closer monitoring with younger employees.

5. Peer support: How do you document in the agencies personnel file that a person has directly and personally experienced a mental illness or substance abuse disorder or within their family?
 - Your agency would advertise for peer support counselors and their experience would be disclosed as part of the hiring process in addition, sharing their experience with clients is an essential part of the job and those who do not want to do so would not be appropriate for working as peer support behavioral health associates.
6. How is a peer support BHA different from other BHAs?
 - They are providing support and guidance from the perspective of one who has 'been there'. See service detail sheets for information about how the active treatment is different.
7. According to 7 AAC 160.990 (b) (86), a behavioral health clinical associate is a person who has specialization or experience in providing rehabilitation services to recipients with a severe behavioral health condition, but may have less than a master's degree in psychology, social work, counseling, or a related field... The first portion of this description does not match what is in the regulations as it indicates it only applies to youth with SED and not youth with substance use disorders.
 - The question is directed to the definition of "severe behavioral health condition". The regulations do not define "severe behavioral health condition", however, it is the intent of the division that it is an all inclusive term and includes all targeted populations to be served, and includes mental health and substance use disorders.
 - In equal fashion, a behavioral health clinical associate, working within his or her training and experience in providing rehabilitation services to recipients with a severe behavioral health condition could include recipients with mental health and/or substance use disorders.
8. 7 AAC 135.180 (b) states: The department will pay only one case manager of a child experiencing a severe emotional disturbance for time setting up, traveling to or from, and attending a treatment team meeting conducted under 7 AAC 135.120 for that recipient. If 7 AAC 135.120 requires a treatment team to be involved the treatment plan (and therefore care of) in **any** recipient (substance use disorder or SED) under 18, why does reimbursement occur for arranging this to occur (as noted above) **only** if the youth is severely emotionally disturbed? This appears to be a contradiction from the Rehab services being both for youth with substance use and/or SED. Please clarify.
 - The regulation 7 AAC 135.180 (b) stipulates that "The department will pay only one case manager of a child experiencing a severe emotional disturbance

for time setting up, traveling to or from, and attending a treatment team meeting conducted under 7 AAC 135.120.

- This is an unintended exclusion and will need to be modified under a future regulation change.

9. Should a provider that delivers services for a recipient through multiple programs have a different directing clinician for each program?

- No. The directing clinician is the single staff member that is responsible for developing the recipient's treatment plan and monitoring the delivery of all services identified in the plan, regardless of where within the provider organization those services are provided.

10. For a CBHS provider, who is qualified to administer the AST or the CSR?

- According to 7 AAC 135.010(c) the Dept. will pay a provider for any rehabilitation service, including the AST and CSR, "if the service is provided by any member of the provider's staff who is performing that service as a regular duty within the scope of that staff member's knowledge, experience, and education".

11. The additional requirements for providing alcohol and drug detoxification services (7 AAC 70.110(d)(3)(D & E)) indicate that either a physician or Advanced Nurse Practitioner must supervise nurses. We currently use a physician's assistant (with oversight by a physician thru CAIHC) and a Registered Nurse to provide supervision to our nurses. Is this arrangement sufficient to meet this requirement and/or a contract with CAIHC to provide oversight to nursing staff, or do we need to have a physician or ANP on-site?

- All community behavioral health service providers delivering detoxification services must meet the requirements for the professional staff that deliver those services, as outlined in regulation.
- Except for the specific supervision requirements noted in regulation, Providers may establish any clinical supervision structure that best meets the needs of their agency.

12. Can a Certified Nurse Assistant (CNA) be added to the list of accepted providers to deliver Oral medication administration, direct observation on premises (H0033)?

- No. The Dept. has established the qualifications of staff eligible to provide Medication administration based on industry standards. The scope of practice for a CNA does not meet these qualifications.

13. Do residential substance use treatment providers of clinically managed medium and high intensity programs have to have a clinician on duty 24/7, or can the clinician be 'on-call'?

- Residential substance use treatment must be provided as prescribed by regulation during regular business hours and as needed during evening hours and on weekends.

- Additionally, all levels of residential substance use treatment services must be provided on-site and staffed 24hrs a day by any of the qualified staff listed in regulation (e.g. substance use disorder counselor, behavioral health clinical associate, mental health professional counselor, etc.).
14. How does the DC bill case management services for monitoring of services that are delivered in a group setting?
- How does the DC bill case management services for monitoring of services that are delivered in a group setting?
 - Please see FAQ's, Section V, answer to question No. # 27.
15. Can a clinical supervisor bill case management as a Directing Clinician while providing clinical supervision to a staff member?
- No. Though a clinical supervisor may also act in the role of a Directing Clinician for the recipients on their respective case-load, they cannot mix the roles of these two separate positions. A clinical supervisor cannot bill Medicaid for clinical supervision of another staff member.
 - The role and responsibility of the Directing Clinician is to develop a recipient's treatment plan, and to monitor the services identified in the plan.
 - A Directing Clinician may bill Medicaid for 1hr. per week per recipient of case management services for the monitoring by direct observation the delivery of services as those services are provided to the recipient.
16. If the DC is the rendering provider of a group service, can this individual bill case management for the monitoring of the service as they deliver it to their recipient?
- No. This would constitute the billing of two services simultaneously delivered by the same person.
 - A DC cannot monitor or 'directly observe' themselves delivering a service.
17. Can the DC bill case management for the monitoring of a service provided via Tele-Med.?
- Yes. Any service that can be provided via Tele-Medicine (other than case management), can be monitored by direct observation by the DC as that service is delivered to the recipient by another staff member.
18. The new Provider Policy & Billing Manual states that one of the requirements to be a CBHS provider is that clinic services are provided on the premises of the CBHS provider by a physician, physician's assistant, advanced nurse practitioner or mental health clinician (LPC, LCSW). However, mental health clinician is not listed in other restatements (7 AAC 70.100) of this requirement. Can a CBHS provider be run by a MH Clinician, or do we need a physician, PA or ANP?
- 7 AAC 70.100(a)(3) states that for a community behavioral health services provider to deliver clinic services the provider must have a documented formal agreement with a physician for the purpose of providing general direction and direct clinical services.

- Any Clinic service may be provided by a person who meets the qualifications of a mental health professional clinician, physician, PA or ANP if the person is working within the scope of their education, training, and experience (7 AAC 135.010(b)).
 - The definition for a mental health professional clinician may be found in 7 AAC 160.990(b)(49).
19. What definition does the Dept. use when referring to a mental health professional clinician; the Regulations or Title 47?
- In reference to the requirements for a community behavioral health services provider the Dept. utilizes the definition of a mental health professional clinician found in regulation: 7 AAC 70.990(28).
20. Can you clarify the requirement in 135.030(d)(2)(B) for an LPA who “renders services in association with a licensed psychologist”?
- The regulation reference has to do with adhering to ethical standards adopted by reference in 12 AAC 60.185.
 - In effect, a LPA delivers (i.e. “renders”) services under the same code of conduct they share (i.e. “in association”) with a licensed psychologist.
 - The psychiatrist operating a Mental Health Physician Clinic is the only person who is by regulation obligated to provide supervision to any other licensed staff member.
 - **12 AAC 60.185. Ethics and standards**
 - (a) The ethics to be adhered to by licensed psychologists and licensed psychological associates are the Ethical Principles of Psychologists and Code of Conduct (June 2003), of the American Psychological Association, Inc. Ethical Principles of Psychologists and Code of Conduct is incorporated by reference in this section.
 - (b) The standards to be adhered to by licensed psychologists and licensed psychological associates rendering psychological services in the state are General Guidelines for Providers of Psychological Services , (1987 edition), of the American Psychological Association. General Guidelines for Providers of Psychological Services is incorporated by reference in this section.
21. If a case manager is working with a youth and invites the Directing Clinician to the treatment plan review, but the DC is unable to attend, can the DC review the treatment plan afterwards and sign-off on it?
- The regulations state that the Directing Clinician is a required member of a child’s treatment team and shall attend meetings of the team in person or by telephone and be involved in team decisions.

- It is required that the clinical record shows documentation of the fact that any treatment team member is unable to attend a treatment team meeting because of weather, illness, or other circumstances beyond the member's control.
- The Directing Clinician must sign the treatment plan upon concurrence with the treatment team decisions.

22. If a client in long-term residential, after a couple months of active treatment, begins to utilize the mental health program, who would be the Directing Clinician; does it shift from the substance used disorder counselor to the mental health clinician?

- There are two issues raised by this question:
 - A mental health, or integrated mental health and substance use, assessment would need to be conducted that included treatment recommendations for a recipient to receive mental health or clinic services. These services and related treatment goals would need to be identified in a treatment plan before the agency could provide the services and bill for reimbursement.
 - The regulations define a Directing Clinician in 135.990(13) and lists the responsibilities for that position, which requires that the Directing Clinician “monitors and directs the delivery of all services identified in the plan”.
 - The Dept. defines “directs” as coordinating and assuring that the services are delivered as ordered.
 - The Directing Clinician carries out their responsibilities “by virtue of that individual’s education, training and experience”.
 - Providers may determine which individual might best serve in that role for each respective recipient.
- If the mental health program is provided through a separate agency, both agencies would maintain a Directing Clinician.

For “pharmacologic management only” recipients seen by a physician:

- The physician needs to act as the directing clinician for these recipients.
- A client status review must be conducted per regulation requirements every 90-135 days.
- Any staff member of a CBHS Provider may complete the Client Status Review form with the recipient.
- The physician utilizing the CSR, must measure treatment outcomes, make treatment decisions and revise the treatment plan as necessary for these recipients.

23. If a client in substance use treatment or mental health treatment seeks psychiatric services 2x / week, would the psychiatrist then become the Directing Clinician?

- The regulations define a Directing Clinician in 135.990(13) and lists the responsibilities for that position, which requires that the Directing Clinician “monitors and directs the delivery of all services identified in the plan”.
 - The Dept. defines “directs” as coordinating and assuring that the services are delivered as ordered.
 - The Directing Clinician carries out their responsibilities “by virtue of that individual’s education, training and experience”.
 - Providers may determine which individual might best serve in that role for each respective recipient.
24. Is the 1hr. / week / per recipient for case management billed by the Directing Clinician a requirement?
- No, this service is an opportunity for Providers to bill for improvement of services to recipients.
25. In the new regulations, nurses within a medically managed detoxification facility cannot be supervised by a physician assistant. Will the State allow a PA to supervise nurses?
- If a medically managed detoxification facility employs a physician assistant, and that physician assistant follows their licensing requirements which state that they must practice under the supervision of a physician, then the State will accept that arrangement as meeting the intent of this regulation.
26. If you have someone with a gambling addiction, but no substance use, can they be treated by a Substance Use Disorder Counselor?
- No. Pathological gambling is considered an impulse-control disorder [not elsewhere classified] within the DSM-IV-TR, and requires a Mental health professional clinician to diagnose and treat.
27. Is it possible for the directing clinician to bill case management for the time spent discussing with the rehab provider what services are being provided, what the client’s response is, and what the directing clinician wants done during rehab? Or is it only billable if the directing clinician stands in the room [or other location] and watches what’s being done?
- No, case management cannot be billed for the time spend by the directing clinician discussing with the rehab provider what services are being provided, what the client’s response is, and what the directing clinician wants done during rehab. Yes, case management may be billed for the time the directing clinician is in the room or other location and watches the rehab services being performed because this complies with the requirements in regulation for “monitoring, by direct observation by the directing clinician. The delivery of behavioral health services...”
28. I am supervising a woman who is working toward her CDC Certification. This woman was told by OCS that she is not able to conduct a substance use assessment

because she does not have a Master's Degree. Can a BHA perform a substance use assessment?

- The Behavioral Health Services Integrated Regulations allows for a Substance Use Disorder Counselor, or a Behavioral Health Clinical Associate to conduct a substance use intake assessment, and bill that service to Medicaid for eligible recipients. The Alaska State Courts may require other qualifications or credentials to be able to provide Expert Testimony during trials or hearings.

29. "What is the intent of new regulation 7 AAC 70.990 (28) defining mental health professional clinician? Was intent to refine or otherwise limit the present statutory definition of a "mental health professional" found in AS 47.30.915 (11)?...How do statutory and regulatory definitions relate? Do they relate? For what circumstances does one or the other apply?

- The Statute in question defines "mental health professional" as it applies to the requirements covered in the related chapter and section. All State Departments are authorized by Statute to establish regulations to govern their business. The Behavioral Health Services Integrated Regulations only apply to Community Behavioral Health Service Providers, Substance Use Treatment Providers not receiving money from the State, and Mental Health Physician Clinics. These regulations set forth the definition and requirements for a "mental health professional clinician" which is separate and distinct from the "mental health professional" defined in AS 47.

30. Do the regulatory requirements for clinical supervision extend to a contractor running an assisted living home? This is in reference to 7 AAC 70.225 (3) Interim Standards.

- Yes, the clinical supervision and all other regulatory requirements do apply to treatment services rendered by direct care staff providing through a contract with an assisted living home. Providers are reminded that treatment services provided through contracts are subject to ALL regulatory requirements.

31. I still need some clarification as to the qualifications of a directing Clinician. I was working with an agency (SEARHC) and one of the supervisors of a residential program brought up the fact that it was her understanding that the Division's position was that an agency would make the call as to who was qualified to be a directing clinician and that the person selected did not have to be qualified to recommend the services that were on the plan.

Determining the need for mental health services requires a professional mental health clinician. Based on this requirement and the information below, would the directing clinician on the treatment plan need to be a professional mental health clinician?

- It is correct that an agency may determine who is best qualified to serve as the Directing Clinician. Treatment and services must be recommended by a professional behavioral health assessment as conducted by qualified staff. A DC is not required to provide any of the services noted in a recipient's treatment plan, but is responsible to make sure those services are provided

according to the needs of the recipient and by qualified staff. The DC may recommend assessment of need for any treatment or service that falls outside the scope of their own individual training, education or experience.

32. Can a CBHS provider bill for a clinic service provided by a Master's level intern, if that person is being supervised via live video feed by a MHP Clinician?
 - A CBHS Provider may not bill for clinic services provided by an intern. The bottom line for behavioral health services is that the interventions must meet the descriptive criteria noted in regulation, and must be provided directly to the recipient by rendering staff that are qualified to deliver the service. Any service provided to a recipient by a CBHS Provider must meet this criteria regardless of billing. Though all CBHS staff must be supervised (per 7 AAC 70.225), clinical supervision is not a factor regarding the provision of services or the billing of services.
33. Can a Case Manager act as the Directing Clinician?
 - A Directing Clinician must meet the qualifications, and must fulfill the role and all responsibilities noted in regulation for this position [7 AAC 135.990(13); 7 AAC 135.100(c)]. Providers should determine who best meets these qualifications.
34. Is a provider obligated to provide clinical supervision to contractors, and if so, what is the frequency, and who must provide the supervision?
 - By regulation [70.225(3), and 70.150] and by CARF, COA or the Joint Commission standards, all providers must provide clinical supervision to all personnel providing clinical or direct services to a recipient. Contractors are considered personnel of a provider agency. However, providers are free to structure clinical supervision according to whatever means best meets the needs of the agency, its personnel, and recipients.
 - The requirement for clinical supervision as described above is not intended to obligate the provider to provide the type of clinical supervision that may be needed for an individual to obtain or maintain licensure or certification.

XI. Provider Questions Not Directly Related to Regulations

1. The information on pg. I-16 of the new Policy & Billing Manual is inaccurate because providers utilizing EDI cannot currently upload the required documentation for PA's to AKAIMS; what is required for submitting PA's during and after the delayed implementation period?
 - There has been no expectation that EDI providers would upload PA information into AKAIMS.
 - The Dept. is in the process of re-examining the required documentation for Service Authorizations, and will inform Providers of any changes prior to November 30.

2. The new crisis form does not have a place for the persons DOB, SSN, or address. Can the State please add that to the form?
 - The department has produced updates to the Crisis Intervention/Stabilization form to add these requested fields. The updated form is available on the DBH Website at: <http://www.hss.state.ak.us/dbh/bh-Regs.htm>
3. There are no blanks on the form for Axis I, Axis II, Axis III, Axis IV, and Axis V. Can these items (titles with blanks to write each) be added to the form?
 - No, the form includes multiple lines for free-form entry of content within the item labeled "Presenting Problem (Nature of Crisis)." The content the provider chooses to enter here could include a complete listing of all Axis I through Axis V diagnoses codes, but this is not required. Adding the titles for each DSM-IV code would lead providers to think that DSM coded content is all that is permissible or required which is not the case.
4. Would it be possible to link the risk categories on the Emergency Services Contact form to a list of objective behavioral criteria? (Central Penn Hospital)
 - No, the Emergency Services Contact form is designed to be brief, and to allow providers broad flexibility in their use of clinical judgment.
5. What is the regulatory requirement for the length of time that a Provider must retain recipient records?
 - There are two regulatory requirements regarding the retention of clinical records:
 - Medicaid Regulations require adult and child records to be maintained seven (7) years post the date of discharge from treatment [7 AAC 105.230(e)]
 - Grant Regulations require:
 - Adult records to be maintained seven (7) years post the date of discharge from treatment, and
 - Child records to be maintained seven (7) years post the date of majority for the child, or seven (7) years post the date of discharge from treatment – whichever is longer [7 AAC 78.250].
6. At what age can a client sign his/her own consent for treatment, and are there any related documentation requirements?
 - The state law regarding age of consent may be found in AS 25.20.025.
7. Our agency has hired a psychologist with a PhD obtained from a Russian university. Does this person meet the definition of a Mental Health Professional Clinician?
 - The hiring agency bears the responsibility to insure that a degree from another country is commensurate with the standards of the U.S. post-secondary educational system. The agency must also determine that the person's degree meets the regulatory criteria for the required field of study (i.e. psychology, counseling, child guidance, etc.). Finally, the agency must ensure that the

person has the requisite expertise for performing the services related to their position within the agency.

XII. AKAIMS Related Questions

1. Can AKAIMS have a function to document when a recipient moves from one level of ASAM of care to another?
 - Yes.
 - This proposed functionality has moved forward to develop the related specifications.
2. Can AKAIMS have a feature for assessment addendums? I.e. “as new information becomes available”- how should they ensure it makes into the assessment?
 - AKAIMS has this ability. Once an assessment is signed and in place, a ‘draft’ assessment can be created as an ongoing working document for new information as the timeline towards a new assessment.
3. Can AKAIMS have a template within the BH assessment’s that addresses functional impairment? It should, at a minimum ask the basic definition questions located in 70.990(22).
 - Yes.
 - This enhancement is under development. Delivery is imminent.
4. Can AKAIMS include the AST within the BH assessment? Since the AST must be “considered” during the BH assessment and the rule of thumb is “if there’s a yes, you should assess”. Providers feel it would be easier if the BH assessment had a specific area or pre-populated field where this could be addressed.
 - No. The AST is a separate and discrete service, and billed separately from the assessments.
 - However, an enhancement is under development that would bring the “screening outcomes” of the AST into the ‘info’ portion of the BHA. Delivery is imminent.
5. Does an electronic signature count for a signing and credentialing any part of the clinical record. Can AKAIMS develop a better way to show that something is signed?
 - Yes, the electronic signature is derived from the person who is logged into the account. Only the person who is “logged in” has the user name, password, and pin.
 - DBH has requested an estimate of the cost for incorporating a signature pad into the AKAIMS system. This envisaged signature pad is much like those found at supermarket checkout lines where a person scans their credit card and is then asked to provide a ‘signature. Estimate is still pending.
6. Is there an AKAIMS screen that is formatted especially for a Short-term crisis intervention or crisis stabilization progress note?

- Not at this time, but is under development.
7. For those services that require start and stop times, do we need to include that information in AKAIMS, or just the duration?
 - If the Provider is using AKAIMS as the electronic health record, start and stop times must be included in the encounter note.
 - If the Provider is using AKAIMS solely for the minimal data set, then start and stop times are not required.
 8. UA's are not billable anymore, need to know if they still need to be added to the AKAIMS as "Non-billable encounter" to show services provided to Participant's. Can you please provide direction on this situation?
 - AKAIMS requires that ALL billable and non-billable encounters are entered as part of the minimal data set.
 9. Because AKAIMS has a category "Emergency Services Reviews" is a provider obligated to conduct reviews for recipients who receive emergency services, and if so, who should conduct the reviews?
 - AKAIMS maintains a screen for Emergency Service Reviews as a clinical aid for providers, and to assist providers with their continuous quality improvement process.
 - Though Emergency Service Reviews are not required, providers are encouraged to use this screen to enhance their agency's clinical practice.
 - Providers should determine the staff most qualified to conduct follow up with recipients and other providers.

XIII. Mental Health Physician Clinic Related

1. Can Mental Health Physician Clinics bill Short Term Crisis Intervention (S9484) the same number of hours (22) as a Community Mental Health provider?
 - Yes. Mental Health Physician Clinics may bill any clinic service as described in regulation.
 - Providers may conduct a Professional behavioral health assessment every six months as clinically indicated, but the assessment is not mandatory.
 - The Directing Clinician is not obligated to provide the Professional behavioral health assessment. Any qualified staff may conduct an assessment for a recipient.
2. Mental Health Physician Clinics are required to have psychiatrist on-site 33% of operating hours to provide supervision, case management and case review, which is not billable. Can these services be added for MHPC's?
 - Not at this time. The requirements for a psychiatrist operating a Mental Health Physician's Clinic (see answer to question No. # 19 above) are not Medicaid reimbursable services.

- Though the Provider reference to “case management” is probably the requirement for a psychiatrist to sign off on each treatment plan, technically Case Management is a rehabilitation service and cannot be provided by a MHP Clinic at any time.
3. For a MHPC, is the directing psychiatrist required to sign off on each treatment plan, and also to review each treatment plan every 90-135 days?
 - That is correct. According to 7 AAC 135.030(d) and (e), the psychiatrist operating a mental health physician’s clinic must provide direct supervision to each provider in the clinic, and assume responsibility for the treatment given.
 - Direct supervision means:
 - The psychiatrist is on clinic premises to deliver medical services 30% of the time the clinic is open
 - Medical services include:
 - Approving the behavioral health treatment plan in writing
 - At least every 90-135 days reviewing each case to evaluate the need for continued care
 - Providing direct clinical consultation and supervision to clinic staff
 - Assuring that all services are medically necessary and clinically appropriate
 - Assuming professional responsibility for the services provided
 4. Is a Mental Health Physician’s Clinic able to continue to complete a psychiatric assessment for all Medicaid recipients as part of our “entry” assessment process?
 - A psychiatric assessment may serve as an intake assessment if the recipient’s condition indicates the need for a more intensive assessment, including an assessment to evaluate the need for medication.
 5. Can a licensed psychologist bill for Psychological testing & evaluation using their personal Medicaid billing number, then also provide other clinic services and bill those through the MHPC billing number?
 - A licensed psychologist must be enrolled as a Medicaid provider and must be practicing independently to provide psychological testing and evaluation services and bill Medicaid through their own billing number.
 - A licensed psychologist may be a member of the clinic staff of a Mental Health Physician’s Clinic and provide any Medicaid funded clinic service as billed through the MHPC billing number.

XIV. Private Providers, Not Publicly Funded

1. Must private providers (not publicly funded) maintain their clinical record to the Medicaid documentation standard?

- 7 AAC 70.130 states that a private provider must meet the record requirements of that section, and, if providing detoxification or residential services, must meet the additional requirements set forth under those regulation sections for the given service.
 - 7 AAC 70.110 for detoxification services, and 7 AAC 70.120 for residential services note that assessments and clinical documentation for these services must be done in accordance with 7 AAC 135.130; 7 AAC 135.130 further states that the requirements for provider records cited in 7 AAC 105.230 must be met. Thus a private provider that renders residential or detoxification services must maintain their clinical record to the Medicaid documentation standard.
 - If a private provider does not provide residential or detoxification services, then they are not currently required to meet the Medicaid documentation standards laid out in 7 AAC 105.230 and 7 AAC 135.130, but they must meet all elements of 7 AAC 70.130.
2. Can a private provider, not affiliated with a Community Behavioral Health provider, bill Medicaid for Peer Support Services?
 - No, private providers are not approved to deliver rehabilitation services and do not meet requirements to bill Medicaid.
 3. Can a private provider, not affiliated with a Community Behavioral Health provider, bill Medicaid for Peer Support Services?
 - No, private providers are not approved to deliver rehabilitation services and do not meet requirements to bill Medicaid.