ALABAMA DEPARTMENT OF MENTAL HEALTH

FREQUENTLY ASKED QUESTIONS RELATIVE TO PROVISION OF SUBSTANCE USE DISORDER SERVICES

Category	Date	Question	ADMH Response
Credentials	8/21/2019	Is there a grace period following the 30 months provided for through the Administrative Code for a QSAP to obtain one of the ADMH accepted licenses or SA counselor certifications?	No. If no license or certification is provided to ADMH within the allotted 30 months, the QSAP becomes ineligible to provide SA treatment services. Example, hire date of 5/10/2018 becomes ineligible on 11/10/2020.
	8/21/2019	Is the ALC an accepted license?	No. The ALC has not been accepted since the November, 2017, update to the Administrative Code; however, persons who had already provided an ALC to ADMH prior to that change were grandfathered in, and remain in good standing ***as long as their ALC does not expire*** .
Funding	8/21/2019	When my agency requests that additional amount be added in ASAIS so that claims will pay, is my agency's ADMH contract automatically amended?	No. Increases to the 'Contract' amount in ASAIS simply allows claims which pay from a state pooled amount, such as Medicaid, continue to pay. For any contract amounts which not pooled funds, an agency must submit a written request to SA director to request consideration of an increase to capped contract amounts.
Maximum Allowable Units	8/21/2019	If a person had an Intake Assessment [90791] paid through State, Block Grant, SOR or Medicaid funds, will ADMH also pay for an Institutional Assessment [90791 with QJ modifier] within the same year?	No. If the person needs an additional assessment, use the Mental Health and Substance Use Disorders Assessment Update (H0031) to bill for the additional assessment.
	8/21/2019	If a person had an Intake Assessment [90791] paid through State, Block Grant, SOR or Medicaid funds, will ADMH also pay for any additional assessment [90791 through a different ADMH funding source within the same year?	No. If the person needs the additional Assessment, use the Mental Health and Substance Use Disorders Assessment Update (H0031) to bill for the additional assessment.
	8/21/2019	Does the ASAIS system have controls in place to prevent billing services in excess of the maximum allowable units per day/month/year which are stipulated in the SA Billing Manual?	No. It is incumbent upon each provider agency to ensure familiarity with the rules and parameters set forth in the SA Billing Manual and to submit claims in accordance with those published rules and parameters. Overpayments will be recouped.
Miscellaneous	8/21/2019	Are DHR staff and jail staff incorporated into the “external service agency providers or individual practitioners” referenced in the Mental Health Care Coordination definition from the SA Billing Manual.	Yes, as long as the service documentation is clear in demonstrating that the service is utilized to meet the specific treatment needs of the service recipient and/or assure continuity of care to another setting. This response is currently under review.
Patient Enrollment	8/21/2019	How is "actively enrolled", as stipulated in the SAS Reporting Combination Restrictions from the SA Billing Manual, defined?	A patient is considered actively enrolled when they have an active ASAIS Facility enrollment for one of the levels of care for which your agency is certified ***AND*** receive a behavioral health ***treatment*** service other than an assessment.
Reporting Combination Restrictions	8/21/2019	Although SAS Reporting Combination Restrictions for assessments, from the SA Billing Manual, indicate "This service cannot be billed in conjunction with Individual Counseling (90832, 90834, 90837), Group Counseling (90853), Family Counseling (90846, 90847), Multi Family Group Psychotherapy (90849) or TB services (T1023 or 97799)", can these services still be provided on the same day as the Intake Assessment?	No, for billing purposes. If the agency chooses to provide the stated services, in addition to the assessment, only the assessment may be billed.

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Signatures	8/21/2019	Must the patient sign for each individual behavioral health service which they receive, or will one signature per service date suffice?	Patients must sign for each service received, with a start time and end time. This requirement comes from §580-9-44 of the Administrative Code and applies to all SUD treatment services offered by certified providers, regardless of funding source.
	9/1/2019	Must the patient sign for each individual behavioral health service which they receive ***in a residential treatment setting*** , or will one signature per service date suffice?	Yes. The above response applies. In addition, the patient must sign for having spent the night in the residential setting. The signature must be captured the morning following having spent the entire night in the residential setting.
	8/21/2019	Must the agency staff sign for each individual behavioral health service which they provide, or will one signature per service date suffice?	Staff must sign for each service provided to each patient. This requirement comes from §580-9-44 of the Administrative Code and applies to all SUD treatment services offered by certified providers, regardless of funding source.
	12/10/2019	Must licensed agency staff sign off on an Assessment which is appropriately completed by an approved QSAP I?	Not necessarily. For Medicaid, appropriately licensed staff [Licensed Physician, Licensed Psychologist, Licensed Physician's Assistant, Certified Nurse Practitioner, Licensed Professional Counselor] must assign the diagnosis. If the only document where the diagnosis is assigned is the Assessment, then the appropriately licensed staff must approve the diagnosis on the Assessment document. The licensed staff need not sign/approve the Assessment if said staff assigns/approves the diagnosis via alternative means such as on the treatment plan or on medical documentation which is included as part of the patient file.
Treatment Plan	8/21/2019	If a Treatment Plan is originated by a licensed clinician (LPC, LICSW, etc.), must another licensed clinician still come behind them and approve the Treatment Plan?	Yes. For a non-Medicaid patient, the treatment plan must be approved in writing by the program director, clinical director, or medical director, as appropriate to the level of care provided, as stipulated in §580-9-44 of the Administrative Code. A QSAP I may not approve a treatment plan which they worked with a patient to originate. For a Medicaid recipient, the treatment plan must also be approved in writing by appropriately licensed staff as stipulated in Chapter 105 of the Alabama Medicaid Provider Manual. A licensed person may not approve a treatment plan which they worked with a patient to originate.
	8/21/2019	Must the Treatment Plan be updated in conjunction with the Treatment Plan Review?	Not necessarily. If the reviewer's recommendation is to continue treatment as prescribed, then no update is necessary in conjunction with that review.
Treatment Plan Review	8/21/2019	For a Medicaid Treatment Plan Review, may this be accomplished by the reviewer signing off on a review of treatment/the treatment plan between a patient and the patient's counselor?	No. Appropriately licensed staff must independently complete the Treatment Plan Review, to include all documentation requirements as set forth in Chapter 105 of the Alabama Medicaid Provider Manual.
	8/21/2019	For a Medicaid Treatment Plan Review, may a counselor review their own patient's treatment plan?	No. An appropriately licensed staff member, who is neither the primary therapist nor routinely directly involved in providing services to the recipient, must independently complete the Treatment Plan Review.
	8/21/2019	For a Medicaid patient, what is the result of the Treatment Plan not being reviewed within the 3 months provided in Chapter 105 of the Alabama Medicaid Provider Manual?	The treatment plan expires. Services may not be billed under an expired treatment plan.

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	9/9/2019	For patients who have had multiple treatment plan updates since the original treatment plan, or since the last treatment plan review, must all updated treatment plans be reviewed during the treatment plan review process?	No. The currently active/most recent treatment plan update should be reviewed.
	9/9/2019	For agencies whose electronic health record does not allow for the treatment plan review to be done *on* the treatment plan, as specified in Chapter 105 of the Medicaid Provider Manual, is the agency required to create a separate form for the treatment plan review, or may the treatment plan review be done in the context of a progress note?	Either the separate form or the progress note would be acceptable to ADMH, as long as all of the requirements from Chapter 105 of the Medicaid Provider Manual are met, and the document is clear about what treatment plan is being reviewed in terms of identification of the patient and identification of the date of the treatment plan being reviewed. This process should be clearly documented in the agency's policies and procedures.