ALABAMA DEPARTMENT OF MENTAL HEALTH

AUTISM SERVICES PROVIDER MANUAL

Alabama Department
of Mental Health
connecting mind and wellness

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Introductio*n*

The purpose of the manual is to set guidelines for providers of ADMH Autism Services and reference best practices in providing services to people and families affected by Autism Spectrum Disorder. The manual also provides general information regarding Alabama Department of Mental Health Autism Services. The manual content is reflective of the Alabama Medicaid Chapter 110 Autism Rehabilitative Services.

The manual will be revised and updated as policies change. Updates can only be made by ADMH Autism Services. When revisions are made to the manual, the revised manual content will be distributed to all service providers via email announcement and website updates.

Services Definitions and Overview

The Alabama Department of Mental Health (ADMH) provides services for Medicaid-eligible children and youth under the age of 21 with Autism Spectrum Disorder (ASD) that have intensive needs. Services are intensive in nature and are provided in home and community-based settings.

Rehabilitative Autism Services will be provided to Medicaid recipients based on medical necessity. Although limits are provided for guidance, the limitation(s) noted can be exceeded based on medical necessity. While it is recognized that involvement of the family in the treatment of individuals with Autism Spectrum Disorder is necessary and appropriate, provision of services where the family is involved must be directed to meeting the identified recipient's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified recipient's treatment needs are not covered by Alabama Medicaid.

Intensive Home-Based Services (IHBS), as applicable to children or youth with ASD or ASD with co-occurring IDD, means a collection of discrete clinical interventions including Intensive Care Coordination, Therapeutic Mentoring, In-Home Behavioral Support, In-Home Therapy/Mental Health Support, Family Support and Peer Support that are provided to a child or youth in any setting where he or she may reside or in other community settings. The six IHBS are described below:

Intensive Care Coordination- The Intensive Care Coordinator/ICC works directly with the child or youth and his or her family to identify needs and strengths and assist in gaining access to needed services. The ICC coordinates and monitors the array of supports allowing the child/youth to remain in the home and community. The ICC guides the treatment team and prepares and monitors the treatment care plan.

In-Home Therapy/Mental Health Support (Mental Health Support) is a one-on-one strength-based therapeutic relationship between a professional clinician and a child/ youth and his or her family to address behavioral health needs. In-Home Therapy/Mental Health Support also addresses the family's ability to provide effective support and enhances the family's ability to improve functioning in the home and community.

Behavioral Support is positive behavior support therapy to address challenging behaviors. Objectives and interventions are designed to diminish, extinguish, or improve specific behaviors. In-home behavior support includes, but is not limited to, Applied Behavioral Analysis. Services may be delivered by a Behavioral Support team to include a Behavior Therapist and Behavior Support Monitor. Services include behavioral assessment, planning, monitoring, follow-up, and crisis services.

Therapeutic Mentoring is a structured one-on-one strength-based intervention to address daily living, social, and communication skills. This service includes supporting, coaching, and preparing the child/youth in age-appropriate behaviors, interpersonal communication, problem solving and conflict resolution, and in relating appropriately to other children and adolescents, as well as adults, in social activities.

Psychoeducational Services (Family Training) is provided to families and/or child/youth to assist in understanding the nature of the illness of their family member and how to help the child or youth be maintained in the community. Psychoeducational Services is structured and topic- specific and may be provided in an individual or group setting. Goals are focused on understanding the diagnosis, maintaining the child/youth in the community, and identifying strategies to support the best level of functioning.

Peer Support (Child/Youth and Parent/Family) includes structured, scheduled activities that actively engage and empower the child/ youth and /or family. Peer Support follows a treatment plan to promote socialization, self-advocacy, development of natural supports, and maintenance of community living skills. Additionally, this service provides support and coaching interventions to promote resiliency and healthy lifestyle, reduce behavioral health and physical health risks, and increase healthy behaviors to prevent the onset or lessen the impact of health conditions.

Minimum Qualifications for Rehabilitative Autism Service Professional Staff

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

- Physician
- Psychologists
- Licensed Professional Counselors (ALC, LPC)
- Licensed Marriage and Family Therapists (LMT)
- Licensed Social Workers (LMSW, LCSW, LICSW)
- Behavior Therapists (BCBA, BCBA-D, Psychologist)
- Behavior Support Monitors (RBT, BCaBA, Behavior Therapist, SLP, LPC)
- Speech Pathologists
- Occupational Therapists
- Physical Therapists
- Registered Nurses

A Professional Autism Services Specialist (PASS) I is defined as the following:
An individual licensed in the State of Alabama as a:

Physician
Clinical Psychologist
Professional Counselor (ALC, LPC)
Marriage and Family Therapist
Graduate Level Social Worker (LMSW, LCSW, LICSW)
Registered Nurse (RN)
OR
An individual who has a master's degree or above from a nationally or regionally accredited university or college in psychology, counseling, social work, or other behavioral health area with requisite course work equivalent to that degree in counseling, psychology, or social work.

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

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

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

A person with an associate degree or high school diploma or GED and Registered Behavior Specialist supervised by a Professional Autism Services Specialist I.

A Parent Autism Peer Support Specialist provider who is parenting or has parented a child with ASD and can articulate the understanding of their experience with another parent or family member. This individual may be a birth parent, adoptive parent, or guardian or youth to have the role of parent. This person must satisfactorily complete the Autism Parent Peer Support Provider training program approved by state. A Parent Autism Peer Support Specialist must be supervised by a Professional Autism Services Specialist I.

A Youth Autism Peer Support Specialist must be 18 years of age or older and serves youth and uses his/her life experience with ASD and specialized training to promote resiliency. Youth Autism Peer Support service can be provided in an individual, family, or group setting by a Certified Child/Youth Autism

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

ADMH Autism Services reserved the right to determine if a person or agency can provide services.

Intensive Care Coordination

A single case manager (and/or a single treatment team) and a treatment plan that guides the provision of all behavioral health and related support services. The case manager works directly with the child or youth and his or her family, coordinates a child and family team, and prepares and monitors a service plan and/or case plan. Intensive Care Coordination ensures that Intensive Home-Based Services help meet all the child's or youth's individual behavioral health needs by identifying, coordinating, and monitoring the array of supports and staff that allow the child or youth to remain in his or her home and community. Intensive Care Coordination services assist eligible individuals in gaining access to needed medical, social, educational and other services. The case manager provides these services through telephone contact with child/youth, face-to-face contact with child/youth, telephone contact with collaterals, or face-to-face contact with collaterals. This is accomplished via needs assessment, case planning, service arrangement, social support, re-assessment and follow-up and monitoring.

Eligible Provider: Intensive Care Coordinator through ADMH or Contracted Targeted Case Management provider.

Qualifications: Bachelor of Arts or a Bachelor of Science Degree, preferably in a human service-related field from an accredited college or university or having earned a degree from an accredited school of Social Work or a Registered Nurse with current licensure. ICCs must have at least one-year experience in working with individuals with disabilities, families and/or planning and arranging services.

Training Requirements: Online Relias course sequence; In-person, service-specific ADMH training; Therap documentation training; CANS training

Other requirements: 16 hours of continuing education units annually; valid driver's license; CPR

Caseload Max: 25 with a maximum of 12 Target 10 .

Billing Unit: 5 Minutes (Target 3), Monthly (Target 10)
Annual Max Units: - (Target 3), 12 (Target 10)

Billing Location: Office (11), Home (12)
Component Services:
Needs Assessment
Case Planning
Service Management
Social Support
Reassessment
Monitoring and Follow Up

Intensive Care Coordination Provider Timeline

To be Completed by:	Task
Start process	RAC/CTCM Supervisor assigns the client to an ICC via email/SComm.
Within 10 days	Contact client/family and set up initial meeting. Leave a message and follow up if there is no answer.
Within 15 days	Conduct needs assessment (CANS), select outcomes and goals, and identify needed supports.
Prior to day 30	ICC provides ICC Treatment Plan draft to the family for review and approval by the client/family.
By day 30	ICC will create and approved ICC Treatment plan in Therap
	ISP PLANNING
Day 1 of ISP Planning	Send referrals to Rehab providers (if applicable) with required documentation including outcomes and goals, and present choices to family (approve/deny accepting providers in line with family selections before completing next task).
Within 5 days	After the referral has been closed, contact client/family and providers and set date for ISP planning meeting.
On meeting date	Hold planning meeting, Rehab provider finalize objectives/measurable steps, and the team determine service hours. Submit service authorization to TCM supervisor after meeting.
Within 7 days	Review and acknowledge approved ISP from Rehab Provider
At least Monthly	Follow-up with team on progress, needs, and satisfaction. Address reported issues as appropriate.
As Needed	Complete plan(s) revisions or addendums and provide to all team members within 5 days of provider/client communication, change Form approval, and team meeting (if held).
Every 6 months	Update CANS, hold Treatment plan and ISP planning meeting, and update current plan(s).
Discharge Date	Fading of/discharge from provided services, to include completion of final CANS assessment and discharge summary. **TCM supervisor will conduct 30 and 90-day follow-ups with individual/family to promote stable transition from services.*

See corresponding Rehab timeline for additional information

Target 3 Provider Requirements

For ICCs working with clients from Target 3, a max caseload is 12 individuals. If you have a mixed caseload of Target 3 and Target 10 clients, you can still only maintain a maximum caseload of 12. While managing an Autism Services caseload, you may also manage cases under a different system of care or TCM group, however, you cannot manage under more than one system for the same individual.

The ICC must have at least 2 contacts with the client each month. One of those contacts must be face-to-face, and the other can be in any modality whether in person or over the phone.

The ICC must contact every provider at least once per month, but it can be in any form. If the client is receiving just In-Home Therapy/Mental Health Support, you only have to make one total contact. If the client is receiving In-Home Therapy/Mental Health Support, peer support, and psychoeducation, you must have at least one contact with each of the providers, for a total of 3 monthly contacts across providers.

The individual support plan for a Target 3 client must be reviewed at least quarterly by the ICC. The review may or may not be part of or result in a team meeting, but it as well as all monthly contacts, must be documented in a case note.

Target 10 Provider Requirements

For ICCs working with clients from Target 10, a max caseload is 12 individuals. If you have a mixed caseload of Target 3 and Target 10 clients, you can only maintain a maximum caseload of 12. While managing an Autism Services caseload, you may also manage cases under a different system of care or TCM group, however, you cannot manage under more than one system for the same individual.

The monthly encounter rate for case management services of Target Group 10 may expand to more than one recipient per family unit, per month when there is more than one child within a family unit and no child is in an out-of-home placement.

The ICC must have a total of 4 monthly contacts with each client, 2 of which must be face-to-face, with the other two modalities left to the ICCs clinical judgement and availability. Due to current COVID concerns, one face to face per month is acceptable at this time.

The ICC must contact every provider at least twice per month, but the contact can be in any form. Therefore, if the client is receiving just In-Home Therapy/Mental Health Support, you are required to make two total contacts; whereas, if client is receiving In-Home Therapy/Mental Health Support, peer support, and psychoeducation, you must have at least two contacts with each of the providers, for a total of 6 monthly contacts across providers. Because there are more intensive needs (for example, multiple diagnoses or at risk of out-of-home placement) need for intervention is more immediate and/or intense, we want to be sure we are monitoring these cases a little more frequently.

To ensure services and supports are adequate to keep the child in the home and community, the individual support plan for a Target 10 client must be reviewed by the ICC more frequently, occurring at least every other month. The review may or may not be part of or result in a team meeting, but it as well as all monthly contacts, must be documented in a case note.

For Target 10 only:

If a client is enrolled in TCM twenty (20) days or more, the standard monthly rate applies. If the client is enrolled nineteen (19) days or less within a month, a partial rate of $296.08 will apply and should be reflected in the service authorization.

In-Home Therapy/Mental Health Support

A structured, consistent, strength-based therapeutic relationship between a licensed clinician and a child or youth with ASD or ASD and co-occurring IDD and his or her family for treating the child's or youth's behavioral health needs. In-Home Therapy/Mental Health Support also addresses the family's ability to provide effective support for the child or youth and enhances the family's capacity to improve the child's or youth's functioning in the home and community. This service focuses on the mental health needs of the child or youth. The In-Home Therapy/Mental Health Support will also provide crisis services.

Eligible Provider: Professional Autism Services Specialist I (PASS I), Professional Autism Services Specialist II (PASS II),

Training Requirements: Online Relias course sequence; In-person, service-specific ADMH training; Therap documentation training

Other Requirements: Sufficient continuing education units related to license; valid driver's license; CPR

Caseload Max: 30; Caseloads should be commensurate with provider experience, amount of support staff, client goals and behaviors, supervision required, and hours provided to each client.
Billing Unit: 15 Minutes
Billing Location: Office (11), Home (12), Other Unlisted Facility (99)

Component Services:
Psychoeducational Services- PASS I, PASS II
Individual counseling/therapy- PASS I, PASS II
Family counseling/therapy- PASS I, PASS II
Group counseling/therapy- PASS I, PASS II
Coping Skills Training (has further description in text of other services)- PASS I, PASS II
Assessment- PASS I
Therapeutic Treatment- PASS I, PASS II
Crisis Intervention- PASS I, PASS II
Basic Living Skills- PASS I, PASS II
Social Skills Therapy- PASS I, PASS II
Progress Reporting- PASS I
Development of Individual Program Plan- PASS I
Transition Planning- PASS I

Eligible Provider: Professional Autism Services Specialist I (PASS I), Professional Autism Services Specialist II (PASS II), Certified Autism Support Specialist (CASS) (performed by an RBT)

Behavioral Support

Positive behavior support therapy and monitoring designed to address challenging behaviors in the home and community for children and youth with ASD or ASD with co-occurring IDD. A behavioral therapist writes and monitors a behavioral management plan that includes specific behavioral objectives and interventions that are designed to diminish, extinguish, or improve specific behaviors related to the child's or youth's behavioral health condition. The behavioral therapist supervises and coordinates the interventions and trains others, including a behavioral aide who works with the family to implement the plan in the home and in the community. In-home behavior support includes, but is not limited to, Applied Behavioral Analysis. The Behavioral Support provider will also provide crisis services.

Eligible Provider: Behavior Therapist (PASS I), Behavior Support Monitor (PASS I, PASS II, CASS)

Qualifications:

Behavior Therapist

Professional Autism Services Specialist I (PASS I) - Masters or doctoral degree and be a licensed clinician with the appropriate training to develop behavioral intervention plan, including: Licensed and Board-Certified Behavior Analyst (BCBA/BCBA-D, LBA) OR Licensed Psychologist.

Behavior Support Monitor

Professional Autism Services Specialist I (PASS I) – Masters or doctoral degree and be a licensed clinician with the appropriate training to implement behavioral intervention plan, including: Licensed and Board-Certified Behavior Analyst (BCBA/BCBA-D, LBA), Board-Certified assistant Behavior Analyst (BCaBA), OR Licensed Psychologist, Speech Language Pathologist (SLP), Licensed Professional Counselor (LPC), Licensed Occupational Therapist (OT), Licensed Independent Clinical Social Worker (LICSW), Registered Behavior Technician (RBT).

Professional Autism Services Specialist II (PASS II) - Bachelor's degree in a relevant human services field and the appropriate in-service training in implementing behavioral interventions, including: Behavioral Therapist, Licensed and Board-Certified Assistant Behavior Analyst (BCaBA, LABA), Registered Behavior Technician. A Behavior Support Monitor with a bachelor's degree. Minimum one-year experience working with individuals with disabilities, families and/or service coordination.

Certified Autism Support Specialist (CASS) – Registered Behavior Technician certification; Associate's degree, high-school diploma or GED and Registered Behavior Technician. The CASS must be supervised by a PASS I.

Training Requirements: Online Relias course sequence; In-person, service-specific ADMH training; Therap documentation training

Other Requirements: Appropriate training to develop behavior intervention plans**;** sufficient continuing education units related to license; valid driver's license; CPR

Caseload Max: 30; Caseloads should be commensurate with provider experience, amount of support staff, client goals and behaviors, supervision required, and hours provided to each client (See BACB's *Practice Guidelines for Healthcare Funders and Managers,* p. 35, https://bhcoe.org/project/practice-guidelines-healthcare-funders-managers/)

Billing Unit: 15 Minutes

Billing Location: Office (11), Home (12), Other Unlisted Facility (99)

Component Services: (Case note activity types noted within parentheses; if service is not listed under another activity type, service will be listed under same name)
Discrete Trial Training- PASS I, PASS II (Replacement Skills Training)
Incidental Teaching- PASS I, PASS II (Replacement Skills Training)
Pivotal Response Training- PASS I, PASS II (Replacement Skills Training)
Verbal Behavior Intervention- PASS I, PASS II (Replacement Skills Training)
Functional Communication Training- PASS I, PASS II (Replacement Skills Training)
Coping Skills Training- PASS I, PASS II (Replacement Skills Training)
Assessment- PASS I, PASS II
Reduction of Environmental Barriers to Learning- PASS I, PASS II (Environmental Modification)
Maladaptive Behavior Reduction- PASS I, PASS II (Behavior Reduction/Management)
Functional Behavior Assessment- PASS I, PASS II (FBA/FA)
Functional Analysis- PASS I (FBA/FA)
Crisis Intervention- PASS I, PASS II
Social Skills Therapy- PASS I, PASS II (Replacement Skills Training)
Basic Living Skills- PASS I, PASS II (Replacement Skills Training)
Psycho-educational Services- PASS I, PASS II (Client/Family Training)
Sensory Integration- PASS I, PASS II
Development of Individual Program Plan- PASS I
Progress Reporting- PASS I
Transition Planning- PASS I
Family Training- PASS I, PASS II (Client/Family Training)
*Augmentative Communication Training- PASS I, PASS II (Replacement Skills Training)

*If individual already has a speech generating device, the provider of Behavior Support services should consult with an SLP knowledgeable in the area of augmentative communication, preferably specific to that device/language system.

Reference:
Alabama Medicaid Billing Manual Chapter 110 Rehabilitative Services and *Chapter 37 Therapy (Occupational, Physical, Speech, and Applied Behavior Analysis)*

Therapeutic Mentoring

Provision of a structured one-on-one intervention to a child or youth and their families that is designed to ameliorate behavioral health-related conditions that prevent age-appropriate social functioning. This service includes supporting and preparing the child or youth in age-appropriate behaviors by restoring daily living, social and communication skills that have been adversely impacted by a behavioral health condition. These services must be delivered according to an individualized treatment plan, and progress towards meeting the identified goals must be monitored and communicated regularly to the clinician so that the treatment plan can be modified as necessary. Therapeutic mentoring may take place in a variety of settings including the home and community. The therapeutic mentor does not provide social, educational, recreational, or vocational services.

As pertaining to Autism Services:
This service includes supporting, coaching, and preparing the child or youth in age-appropriate behaviors, interpersonal communication, problem solving and conflict resolution, and in relating appropriately to other children and adolescents, as well as adults, in social activities. Therapeutic Mentoring also helps a child or youth develop independent living, social and communication skills, and provides education, training, and support services for children and youth and their families through structured, one-to-one, strength-based support services between a therapeutic mentor and a child or youth.

Eligible Provider: Professional Autism Services Specialist I (PASS I), Professional Autism Services Specialist II (PASS II), Certified Autism Support Specialist (CASS) (RBT)

Training Requirements: Online Relias course sequence; In-person, service-specific ADMH training; Therap documentation training

Other Requirements: Sufficient continuing education units related to license (if applicable); valid driver's license; CPR

Caseload Max: 30; Caseloads should be commensurate with provider experience and client hours and goals.

Billing Unit: 15 Minutes

Billing Location: Office (11), Home (12), Other Unlisted Facility (99)

Component Services:
Basic Living Skills
Assessment
Social Skills Training
Plan Review
Coping Skills Training
Progress Reporting
Transition Planning

Reference:
Alabama Medicaid Billing Manual Chapter 110 Rehabilitative Services

Psychoeducational Services

Services provided to families of children and youth with ASD or ASD with co-occurring IDD to assist them in understanding the nature of the illness of their family member and how to help the child or youth be maintained in the community.

Structured, topic- specific psychoeducational services may also be provided directly to the child or youth to assist him or her in understanding the nature of the identified behavioral health disorder and to identify strategies to support restoration of the child or youth to his or her best possible level of functioning.

Eligible Provider: Professional Autism Services Specialist I (PASS I), Professional Autism Services Specialist II (PASS II), Certified Autism Support Specialist (CASS) (RBT)

Training Requirements: Online Relias course sequence; In-person, service-specific ADMH training; Therap documentation training

Other Requirements: Sufficient continuing education units related to license (if applicable); valid driver's license; CPR

Caseload Max: 30; Caseloads should be commensurate with provider experience and client hours and goals.

Billing Unit: 15 Minutes

Billing Location: Office (11), Home (12), Other Unlisted Facility (99)

Component Services:
Individual Training or Group Training on the following topics: nature of the disorder, expected symptoms, ways in which the family member can support individuals with the disorder.

Reference:
Alabama Medicaid Billing Manual Chapter 110 Rehabilitative Services

Peer Support

Provision of structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, provided by Certified Peer Specialists (Adult, Child/Adolescent, and Family Peer Specialists).

Peer Support service actively engages and empowers a child or youth and his or her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the child or youth (and family when appropriate) with the goal of active participation in this process.

Additionally, this service provides support and coaching interventions to children and youth (and family when appropriate) to promote resiliency and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions.

Peer supports provide effective techniques that focus on the child's or youth's self-management and decision making about healthy choices which ultimately are expected to extend the child's or youth's lifespan.

Family peer support specialists assist children, youth, and families to participate in the wraparound planning process, access services, and navigate complicated child-serving agencies.

Eligible Provider: Child/Youth Autism Peer Support Specialist, Parent Autism Peer Support Specialist, Professional Autism Services Specialist I (Supervision only)

Qualifications:
Professional Autism Services Specialist I (PASS I) An individual licensed in the state of Alabama as a Professional Counselor, Graduate Level Social Worker, Registered Nurse, Marriage and Family Therapist, Clinical Psychologist, Physician or an individual licensed in the state of Alabama and has a Master's Degree from a nationally or regionally accredited university or college in psychology, counseling, social work, or other behavioral health area with requisite course work equivalent to that degree in counseling, psychology, or social work with a minimum of two years' experience working with the IDD population, including ASD.

Child/Youth Autism Peer Support Specialist - A Child/Youth Autism Peer Support Specialist uses his/her life experience with ASD and specialized training to promote resiliency. Child/Youth Autism Peer Support service can be provided in an individual, family, or group setting by a Certified Child/Youth Autism Peer Support Specialist. A Child/Youth Peer Support Specialist must be supervised by an Autism Services Specialist I. A Child/Youth Autism Peer Specialist must be age 18 or older and has satisfactorily completed a Youth Autism Peer Support Provider training program.

Parent Autism Peer Support Specialist - provider who is parenting or has parented a child with Autism Spectrum Disorder and can articulate the understanding of their experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED and has satisfactorily completed an Autism Parent Peer Support Provider training

program approved by state. A Parent Autism Peer Support Specialist must be supervised by a Professional Autism Services Specialist I.

Training Requirements: Online Relias course sequence, In-person, service-specific ADMH training, Therap documentation training

Other Requirements: Have reliable transportation; CPR

Caseload:
Youth Peer Support - up to 20 in first year; up to 40 in subsequent years; Caseloads should be commensurate with provider experience and client hours and goals.

Parent Peer Support - up to 30 in first year; up to 40 in subsequent years; Caseloads should be commensurate with provider experience and client hours and goals.

Billing Unit: 15 Minutes

Billing Location: Office (11), Home (12), Other Unlisted Facility (99)

Component Services:
Mentoring, Advocacy, Development of coping/problem solving skills
Promotion of socialization and development of natural supports
Engagement of community services

Documentation: The provider must complete case note within Therap to document session, satisfaction, and any other information regarding client.

Reference: *Alabama Medicaid Billing Manual Chapter 110 Rehabilitative Services*

Mental Health Care Coordination

Services to assist an identified Medicaid recipient to receive coordinated mental health services from external agencies, providers or independent practitioners. Key service functions include written or oral interaction in a clinical capacity in order to assist another provider in addressing the specific rehabilitative needs of the recipient, as well as to support continuation of care for the recipient in another setting. Acceptable service provision that qualifies as Mental Health Care Coordination includes but is not limited to: Telephone or face to face consultation with a contract provider, doctor, therapist, schoolteacher, school counselor and/or other professional that is working with the child external to your agency regarding the treatment needs of the child.

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

Eligible Provider: Professional Autism Services Specialist I (PASS I), Professional Autism Services Specialist II (PASS II), Certified Autism Support Specialist (CASS)

Qualifications:
Professional Autism Services Specialist I (PASS I) A master's degree in a human service field and one-year experience working with children/adolescents/transition-age youth and two years' experience working with the target population, and adequate ongoing supervision

Professional Autism Services Specialist II (PASS II) An individual who has a Bachelor of Arts or Bachelor of Science in a human service-related field from an accredited college or university with a minimum of one-year experience working with individuals with disabilities, families and/or service coordination. The PASS II must be supervised by a PASS I.

Certified Autism Support Specialist (CASS) Associate's degree, high-school diploma or GED and RBT. The CASS must be supervised by a PASS I.

Training Requirements: Online Relias course sequence; In-person, service-specific ADMH training; Therap documentation training

Other Requirements: Sufficient continuing education units related to license (if applicable); valid driver's license; CPR

Billing Unit: 15 Minutes

Billing Location: Office (11), Home (12), Other Unlisted Facility (99)

Reference: *Alabama Medicaid Billing Manual Chapter 110 Rehabilitative Services*

Rehabilitative Services Provider Timeline

Prompt	Rehab Provider Action	Time to be Completed (Response time does not include weekends and holidays)
Referral received from ICC for potential client	Respond with availability of services. If opening is not available, you may provide an estimated date of availability	Within 2 days
Referral is closed and ICC request initial meeting date ICC will send the Outcomes and Goals page found in the *Rehabilitation Services and Next Step* section of the ICC Treatment Plan.	Respond with availability to meet for the provided dates. The Rehab provider will review to outcomes and goals page, psychosocial and any other pertinent documents prior to the team meeting.	Within 2 days
ICC confirms ISP team meeting date	Attend planning meeting- develop objectives to address, determine service hours, and select start date of services.	On Designated Date
ICC submit service authorization	1. The Rehab provider will create and submit an Individual Support Plan (ISP) in Therap including measurable step(s) from the goal(s) discussed in the team meeting. 2. The Rehab provider's (Supervisor) PASS 1 will review and approve the ISP in Therap. 3. The Rehab provider will SComm the ICC when the ISP is approved in Therap	Within 7 days
ICC acknowledged the approved ISP Service authorization approved	Implement services as prescribed by the ISP.	On designated date
Change of Plan Required	Alert ICC of any need for changes to plan prescribed services. Provider must continue to comply with plan prescribed services to fullest degree possible until revision meeting/ communications can be held, and changes approved by the team. The provider will initiate and complete the Change Approval Process. Formal changes to the ISP will be made at this time by the Rehab provider. If there are any substantive changes, a new signature page should be completed by the provider and family/client. The signature page should be attached to the ISP.	Within 7 days of the team's approval.
ICC contacts to schedule ISP review or specialty meeting (to include mandated 6-month team meeting).	Respond with availability to meet for the provided dates.	Within 2 days
Decision of Service Termination	Discharge from any services requires a team meeting. Rehab Provider notes reasons for termination in the Discussion Record.	By Designated Date

Supervision

ADMH Autism Services requires Professional Autism Services Specialist II (PASS II), Certified Autism Support Specialist (CASS), and Behavior Support Monitor (PASS II, CASS) to be supervised in the field. Professional Autism Services Specialist I (PASS I) and Behavior Therapist (PASS I) must supervise at least 5% of total monthly supervisee hours. Minutes should round up to the next half hour. It is expected that supervision occurs across the supervisee's caseload. Supervision should be prohibited when there is an inability to remain objective which judgment is impairment Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities.

For example:	**minimum**
Client A- 10 hours/month=	½ hour supervision
Client B- 40 hours/month=	2 hours supervision
Therapist 1 Supervision =	2.5 hours supervision
Client A- 20 hours/month=	1-hour supervision
Client B- 5 hours/month=	½ hour supervision
Therapist 2 Supervision =	1.5 hours supervision

A case note should be completed for every supervisory session within Therap

- Non-billable
- Complete questionnaire- Required information

Supervision Activities

- Monitoring and feedback
- Case consultation
- Training on new programs, techniques, etc.
- Program revisions and updates
- Staff observation
- Staff performance
- Review and approve ISP
-

Supervision Caseloads Considerations

- Commensurate with best practice for service
- Number of service hours scheduled/provided
- Intervention intensity
  Funded at an 8:1 ratio

Reference: *Alabama Medicaid Billing Manual Chapter 110 Rehabilitative Services,* Alabama Medicaid Billing Manual Chapter 37 *Therapy (Occupational, Physical, Speech, and Applied Behavior Analysis)* Alabama Medicaid Billing Manual Chapter 106 Targeted *Case Management*

Provider Responsibilities

ADMH Autism Services providers should ensure that they provide services utilizing best practices in the safest and most therapeutic manner. The provider must comply with all rules and regulations of Alabama Medicaid, ADMH Autism Services and the provider's contract. The provider must complete assessments, documentation, surveys, Individual Support Plan (ISP) etc. in a timely manner, attend collaboratively scheduled appointments, actively participate in planning and service activities, engage in open communication, and mutually respect all service and support staff. Consistent participation and attendance are essential for the most successful outcomes to occur.

Some expectations of providers, but not limited to the following:

- Providers are expected to comply with requirements of their provider contract.
- Providers are expected to provide services as outlined in the client's treatment/service plan. Each visit should be documented in the case notes, to include non-billable contacts.
- Providers are responsible for implementing their internal policies regarding attendance, punctuality, and participation.
- Providers are expected to provided services with dignity, respect, and professionalism. *Please refer to the Professionalism section of the Provider Manual*.
- Provider should be able to effectively communicate with the client to provide quality services. The provider has an obligation to inform their client when they no longer will provide services. If possible, they should be notified at least 30 days prior to the change.
- The provider must notify the ICC when there are any changes in service provider staff, times and/or days of service delivery.
- The provider is only required to wait 15 minutes after scheduled appointment for individual/family to show. In the event of an absence, the provider should reschedule with family for a later time/date. This information should be documented in a case note, made non-billable as applicable.
- Provider supervisors are expected to guide and monitor staff performance and documentation.
- Provider supervisors are prohibited from engaging in supervisory relationships with individuals with whom they have an inability to remain objective.

Provider staff that are determined to have failed to comply with any of the outlined provider responsibilities can be subjected to:

- full case and site review
- an agency investigation
- evaluation for the continuation of the provider agency's contract.

Reference:
Alabama Medicaid Billing Manual Chapter 110 Rehabilitative Services
Alabama Medicaid Billing Manual Chapter 37 *Therapy (Occupational, Physical, Speech, and Applied Behavior Analysis)*
Alabama Medicaid Billing Manual Chapter 106 Targeted *Case Management*
ADMH Provider Contract Exhibit-Autism Services

Provider Enrollment

The Alabama Department of Mental Health (ADMH) enrolls Rehabilitative Autism Services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of ADMH and the State of Alabama, the Code of Federal Regulations, and the Alabama Medicaid Agency Administrative Code. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Agencies already enrolled as ADMH providers should be in good standing with that division in order to move forward in the contract process, as well as other governing state agencies (i.e. Medicaid).

New Provider Agency Enrollment

The following are the steps to becoming a new credentialed provider:

Before applying to become an Autism Services Provider complete the following:

1. Become a Business Entity
    - Visit the Sectary of State website for more information
        - https://www.sos.alabama.gov/government-records/business-entity-records
2. Obtain an NPI Number
    - https://nppes.cms.hhs.gov/#/
3. Obtain Liability Insurance
4. Create a STAARS account (it's how you get paid)
    - http://vendors.alabama.gov/
    - https://procurement.staars.alabama.gov/webapp/PRDVSS1X1/AltSelfService
    - The agency should forward their vendor STAARS vendor number to the Enrollment Specialist

Applying to become an Autism Service Provider:

1. Provider completes Medicaid Agency Application. Applicants must submit application material via mail, even if documentation was emailed. Original documentation/signatures must be on file with the ADMH Autism Services Department.

    a. Agencies will need to complete the "Medicaid Application 2019" which includes "Provider Disclosure Form", "Corporate Board of Directors Resolution Form" (if applicable), "Civil Rights Compliance Form", and "Provider Agreement Form".

2. Provider completes Performing Provider Application (for each provider staff within the agency
3. Application will be reviewed for completion. If any documents or information is missing, the Program Enrollment and Training Specialist, P and T Specialist, will contact the agency for needed information.

4. Autism Services sends Background Check Packet to provider agency for completion within 5 working days of receiving the Medicaid Application.
5. Provider completes Background Check Packet and return to Alabama Department of Mental Health Bureau of Special Investigation.

a. Background check results can take up to 4-6 weeks to process; applicants may begin provider training.
b. Once satisfactory background check results have been received, the applicant will be notified by ADMH AS within 5 business days from receiving the results.
c. Autism Services will notify the agency in writing that they can begin training and provide them with upcoming training dates and times within 5 business days after receiving background check results. No training can begin until the agency receives satisfactory background check results.

6. Providers register and complete Relias Training
    a. https://mh.alabama.gov/wp-content/uploads/2020/11/Part-I-Training-Notification.pdf
7. Provider Wide Training all providers required to complete.

8. Providers register and complete Rehabilitation Training
    a. Behavior Support Training
    b. In-Home Therapy/Mental Health Support Training
    c. Psychoeducational Services Training
    d. Therapeutic Mentoring Training
    e. Family/Youth Peer Support Training
        i. Register for training at https://mh.alabama.gov/autism-services/, the training schedule will be under Resources and Documents.

9. Autism Services will schedule a Site Visit review with Provider Agency within 5 business days and complete within 10 business days from receiving satisfactory background check.
    a. An email will be sent by the ADMH Autism Services Compliance Officer to schedule a site visit with the agency after notification of a satisfactory background check.
    b. After receiving a satisfactory site visit, applicants will be notified of their approval status via email within 5 business days.
    c. If the site visit is not satisfactory, the agency will receive via email any findings, recommendations for corrections and follow up dates.
    d. The agency will have to pause any trainings until the site visit review is satisfactory.

Contracting Process Begins

10. ADMH Fiscal Manager and ADMH Contracting department will execute contract with Provider Agency
11. Provider complete contract process by signing contract and returning to ADMH Contract department.
12. Autism Services Enrollment Specialist enrolls Provider Agency in Medicaid.
13. Enrollment Specialist forwards a letter to Providers to inform the agency that they have been enrolled in Medicaid.
14. Provider will be contacted by Therap to complete three-part training. This training can take several meetings to complete.
    a. Part I- Account setup-completed prior to client referral
    b. Part II- Module training
        i. Part II section of training must be done once a client is referred to the agency and a service authorization is in place.
        ii. Module training includes GER, case notes, and CANS assessment upload (CANS for ICCs only)

iii. Once an ISP is created, additional Therap training will be provided for this section

c. Part III-Billing training
    i. It is important that the person has billable case notes to complete this section of the training.

15. Autism Services ICC will initiate client referral to the provider.
16. Provider complete Part II of the Therap training with Therap after receiving contact from the RAC.
17. Services can begin

Existing Provider Agency Enrollment for New Staff

The following are the steps to adding a new credentialed provider staff to an existing agency:

1. Providers complete Performing Provider Application
2. Providers register and complete Relias Training
    a. https://mh.alabama.gov/wp-content/uploads/2020/11/Part-I-Training-Notification.pdf
3. Provider Wide Training (all providers)
4. Providers register and complete Rehabilitation Training
    a. Behavior Support Training
    b. In-Home Therapy/Mental Health Support Training
    c. Psychoeducational Services Training
    d. Therapeutic Mentoring Training
    e. Family/Youth Peer Support Training
        i. Register for training at https://mh.alabama.gov/autism-services/, the training schedule will be under Resources and Documents.

5. Autism Services refers to Therap for additional training
6. Complete Therap training
7. Services can begin.

Annual Provider Requirements:

- Annual Provider Wide Training Requirement
- Annual CEU Requirement (see training requirement section)
- Background checks will need to be completed every five years to remain in compliance with Autism Services.

Re-enrollment

Federal requirements mandate providers re-enroll periodically with Alabama Medicaid under ADMH Autism Services. Providers will be notified when they are scheduled to re-enroll.
Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file.

Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Re-enrollment will occur every five years in which Autism Services providers will need to complete all forms in the Agency Medicaid Application and submit to ADMH Autism Services.

**Applications and information on required documentation can be obtained on the ADMH website at https://mh.alabama.gov/autism-services/.

**Completed applications, required documentation, and proof of Relias coursework completion should be submitted to autism.dmh@mh.alabama.gov.

Enrollment Training Requirements

Potential providers will be required to complete specific training to become a credentialed vendor with ADMH Autism Services.

Upon receiving approval of application and documentation from ADMH Office of Autism Services, providers will be required to complete online Relias course sequence as shown below.

All staff who deliver Autism Services must complete each course with an 80% competency score to pass each course and save the certificate to show as proof of completion.

When all courses have been completed, the agency should send all required documentation and all staff (staff to deliver Autism Services) proof of completion of online Relias coursework to ADMH Office of Autism Services.

Autism Overview
Intellectual Disability Overview
Introduction to Case Management Basics
Respecting Cultural Diversity in Persons w/ IDD
Person Centered Planning for Individuals w/DD
Client/Patient Rights
Identifying and Preventing Child Abuse and Neglect
Boundaries
HIPAA Overview
Addressing the Needs of Transition Age Youth
Human Growth and Dev. Across the Lifespan
Risk Management for Individuals with IDD
Crisis Management
Positive Behavior Support for Children
Maintaining Client Dignity Thru the Behavior Change Process
Ethical Decision Making

- Providers enrolled with ADMH Autism Services will be required to complete annual continuing education to show adequate and up-to-date training to deliver Autism Services.

- Annual refreshers of service-specific training will be required to provide Autism Services. ADMH Autism Services seeks to provide services in a safe and appropriate manner; therefore, crisis management requires training only in de-escalation and non-restraint blocking techniques
    a. Training in crisis identification and services required annually (i.e., Professional Crisis Management) for staff.

- All service providers (both case management and rehabilitation service providers) must complete a minimum of 16 CEU or contact hours related to ASD, service delivery, case management and/or other associated DMH-approved topics annually.
    - Providers should forward documentation for completed CEU or contact hours at the end of the calendar year or once completed to Enrollment Specialist.

- ADMH Autism Services providers are responsible for internal training on the following topics:
    - Rights of people served
    - Abuse, neglect, and mistreatment and exploitation policy and procedures
    - Infection control and universal precautions
    - CPR and First Aid
    - Mandated reporter training which is included in annual Provider Wide training

- Rehab service providers are responsible for maintenance of licenses/certifications by obtaining sufficient continuing education units annually/bi-annually as required by discipline.

Provider Information Update

In the event of change of agency demographic information, the provider is responsible of completing the "Provider Update Information Form", scanning, and sending to ADMH Office of Autism Services for notification of change. This form can be found on the ADMH Autism Services website at https://mh.alabama.gov/autism-services/. Any new staff must complete the "Application for Autism Spectrum Disorder Performing Provider Medicaid Eligibility" and send all required documentation.

Billing

Upon receiving approval to be an Autism Services provider, the provider's information will be imported into Therap documentation system by a Therap Provider representative.

This includes but not limited: 1) Provider code, 2) funding source, 3) service description code, 4) 5) taxonomy code (generated by Medicaid found in the enrollment letter), 6) claim template, 7) billing provider, 8) revenue code, 9) unit calculation rule for case note billing.

All service documentation will be recorded within Therap, and therefore serve as the mechanism for billing with Autism Services. The service documentation includes case notes completed by providers.

Providers will complete case notes and submit them via Therap. The case notes will provide documentation for claims through Therap. These claims are required for reimbursement for services by Alabama Medicaid.

Please refer to Chapter 106 for Intensive Care Coordination (Targeted Case Management), and Chapter 110 for Autism Rehabilitation services of the Alabama Medicaid Billing Manual.

Individuals and organizations can bill under single group NPI. For account reconciliation, please contact Autism Services Fiscal Manager at 800-499-1816 with questions and concerns.

See detailed step by step training in Therap Electronic Billing web training

Instructions for billing in the instance where a client has Medicare coverage in addition to their Medicaid:

These are the steps to if there is a Delay reason code to a claim:

After claims have been sent:

Go to Professional Claim Search
Go to the bottom of the claim and click Update Status
Update the claim to the Billable Status
Go to the X12-837 Note Section
Select Note Reference Code - ADD - Additional Information
Note Section - add any additional information here
Go to the bottom and click Update
Send the claim

Billable Services

It is important for each provider to bill for services that the Medicaid guidelines consider billable activities/services.
For specific billable component services, refer to "Service Descriptions" section of this manual.
Activities may take place face-to-face, by phone, or through electronic communication (Zoom, email, etc.).

Examples include:

- Meeting with client and team to complete support plans Care Plan, IEP, ISP, Team meeting, etc.
- Contact to gather information for an assessment
- Visiting the home/community setting to meet with client, family, and service providers to assess progress
- Communication with collaterals to develop, arrange, or coordinate supports
- Reviewing provider records to ensure proper documentation is in place
- Research of appropriate resources
- Development of resource tools and materials
- Objective writing
- Program creation in Therap
- Plan writing
- Meeting preparation/report creation
- Providing client/family with information on advocacy groups
    - ADMH Advocacy Hotline, ADAP, Parent Groups, etc.
- Documentation of assessments

Non-Billable Services

- Travel
- The actual scheduling of meetings with youth/family
- Transporting child/youth and family
- Documentation of case notes
- Checking an individual's Medicaid eligibility
- Visiting an individual who is in a hospital or nursing home. (Exception, services will be available for up to 180 consecutive days of a covered stay in a medical institution (for TCM only)
- Visiting an individual in an ICF/ID facility
- Visiting an individual in a prison or jail
- Supervisor reviewing of rendering provider case notes
- General Office Activities
    - Completing travel forms, leave slips, etc.
    - Copy work
    - Other clerical activities

See Medicaid Provider Billing Manual Chapter 106 and 110 full examples of examples considered billable and non-billable activities.

Duplicate Billing

Autism Services providers who are enrolled with Medicaid to provide specialty services under another chapter, may not bill Autism Services to provide the same service(s) for a given client under Chapter 110 (ABA, Counseling, Psychological Services, etc.). Credentialed Autism Services providers who are also enrolled and providing services under another Medicaid chapter cannot bill duplicate services under both chapters. If a duplication of services is determined by Medicaid, a reimbursement of funds would be required.

If the recipient receives additional case management services, but the TCM services would not be duplicative, ADMH Autism Services must document in writing to Medicaid how their services would not present a duplication of services from other case management services received. Medicaid will pay for one case management fee per month and will recoup any claims paid in error unless Medicaid has determined there is no duplication of services and gives prior approval for the TCM services provided.

It is the provider's responsibility to ensure no duplication of services or billing occurs. Service providers can work with their ICC and DMH Autism Services staff to ensure adherence to these guidelines. The family may choose to receive services under a different chapter (ex: Ch. 110 Behavior Support v. Ch. 37 ABA).

For prior authorization from Medicaid for ABA Therapy, providers will need to complete the "ABA Non-Duplication Service Authorization" form and submit for review by intensive care coordinator at each new reporting period - at least one week prior to the 6-month case planning meeting. The ICC will approve. The ICC should then send to the Regional Autism Coordinator for approval. The Regional Autism Coordinator will approve. This form can be located on the ADMH Autism Services website at https://mh.alabama.gov/autism-services/.

When a client enters an inpatient stay at a medical institution, only ICC services can be billed, and this is only allowable within consecutive 180 days of discharge from a medical institution. If a client were to enter such an inpatient stay, services should be suspended until the client is discharged. Rehab providers under Autism Services are required to maintain a client's spot for at least 30 days from admission into the medical facility.

False Claims

Federal and Alabama laws strictly forbid any health care provider from submitting false or fraudulent claims to health care payers including Medicare, Medicaid, and other Federal, State, or private health care programs.

DMH has long established policies that all Departmental personnel, contractors, agents, or other providers of services to consumers, comply with all relevant federal and state laws and regulations, including, but not limited to, those laws and regulations related to billing and billing documentation practices. Contractors, agents, or providers are subject to sanctions for violations which may include loss of contract rights, or certifications. This policy applies to all persons providing services to the DMH including employees, officers, and directors of the DMH. This policy was created to ensure compliance with the federal False Claims Act and the Deficit Reduction Act of 2005 policy and educational requirements.

Any DMH employee, contractor, agent, or provider who knows or reasonably believes that DMH or any of its facilities, divisions, or staff may be involved in any activity prohibited by the FCA, similar state laws, or other fraud and financial abuse laws, is required as a condition of employment, contract, or business relationship to immediately report such belief to their supervisor, any member of senior management.

Procedure Codes and Units

Service	Procedure Code	Caseload	Unit
ICC Target 3	G9002-UA	12	5 Minutes
ICC Target 10	G9003-UA	12	1 Month
In-Home Therapy/Mental Health Support	T1027	30	15 Minutes
Behavior Support	H2019	30	15 Minutes
Thera. Mentoring	H2014	30	15 Minutes
	H2014-HQ		15 Minutes
Psychoeducational Services	H2027	60	15 Minutes
	H2027-HQ		15 Minutes
Youth Peer Support	H0038-HA	YP 40 / FP 40	15 Minutes
	H0038-HA;HQ		15 Minutes
Family Peer Support	H0038-HC	12	15 Minutes
	H0038-HC:HQ	12	15 Minutes
Mental Health Care Coordination	H0046	30	15 Minutes

Service Rates

Service	Rate	Daily Max	6 months Max Units	ANNUAL MAX UNITS
ICC Target 3	$6.01 / 5 minutes		-	
ICC Target 10	$592.17 / month		12	
In-Home Therapy/Mental Health Support/Mental Health Support	$19.97 / 15 minutes	8	208	416
Behavior Support	$24.76 / 15 minutes	16	416	832
Therapeutic Mentoring	$17.89 / 15 minutes	8	208 Ind	416
	$5.11 / 15 minutes	8	208 Group	416
Psychoeducational Services	$14.17 / 15 minutes	8	208 Ind	416
	$4.05 / 15 minutes	8	208 Group	416
Peer Support	$12.25 / 15 minutes	20	100 Ind	200
	$3.50 / 15 minutes	20	100 Group	200
Mental Health Care Coordination	$22.00 / 15 minutes	24		38 Per services
A request for Prior Approval of Hours exceeding Autism Services available units is required when an excess of limits is warranted.				

Telehealth

The Public Health Emergency ended May 11, 2023. This provided for more telemedicine allowances. Starting September 1, 2023, new modifiers will be in use to indicate telemedicine. The GT modifier will indicate Audio + Visual services. The FQ modifier will indicate Audio Only services. The intent of the FQ modifier is to address emergent issues only. The FQ modifier is not to be used as the standard form of communication for treatment. It is anticipated that the rate for the FQ modifier will be reduced after October 1, 2023. Otherwise, all rates will be consistent.

Services Available for Telemedicine:

Targeted Case Management – Office (GT and FQ)
Behavior Support – Office (GT & FQ)
In Home Therapy/Mental Health Support – Office (GT and FQ)
Mental Health Care Coordination – Office and Home (GT and FQ)
Peer Support (Family) – Individual - Office (GT and FQ)
Peer Support (Family) – Group - Office (GT only)
Peer Support (Youth) – Individual – Office (GT and FQ)
Peer Support (Youth) – Group – Office (GT only)
Psychoeducational Services – Individual – Office (GT and FQ)
Psychoeducational Services – Group – Office (GT only)
Therapeutic Mentoring – Individual – Office (GT only)
Therapeutic Mentoring – Group – Office (GT only)

Telemedicine Provider Requirements

• Providers must submit the Telemedicine Service Agreement/Certification to Medicaid's fiscal agent. The form is located on the Medicaid website at: www.medicaid.alabama.gov.
• Providers must be enrolled with Medicaid with a specialty type of 931 (Telemedicine Service). *This will be submitted to ADMH Autism Services at enrollment or during an update.*
• Providers must identify themselves to the recipient with their credentials and name at the time of service.
• Providers must obtain prior written or verbal consent from the recipient before services are rendered.
• Telemedicine services may only be provided as a result of a patient's request, part of an expected follow up, or a referral from the patient's licensed physician with whom the patient has an established patient-physician relationship.
• Services rendered via telecommunication system must be provided by a provider who is licensed, registered, or otherwise authorized to engage in his or her healthcare profession in the state where the patient is located. Per Alabama law, the provision of telemedicine medical services is deemed to occur at the patient's originating site within this state.
• Services must be within the provider's scope of license.
• Services must be provided to a recipient that is an established patient of the provider or practice or due to a referral made by a patient's licensed physician with whom the patient has an established physician-patient relationship, in the usual course of treatment of the patient's existing health condition.
• Telemedicine services provided to minors under the age of medical consent must have a parent or legal guardian attend the telemedicine visit.
• Only the provider rendering the services via telemedicine may submit for reimbursement for services.
• Providers must indicate an in-state or qualifying bordering state site of practice address from which telemedicine services will be provided.

Delivery Requirements of Telemedicine Services

• Services must be administered via an interactive audio or audio and video telecommunications system which permits two-way communication between the distant site provider and the site where the recipient is located (this does not include electronic mail message or facsimile transmission between the provider and recipient).
• Telemedicine health care providers shall ensure that the telecommunication technology and equipment used is sufficient to allow the health care provider to appropriately evaluate, diagnose, and/or treat the recipient for services billed to Medicaid and is HIPAA compliant.
• Transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.
• The provider shall implement confidentiality protocols that include, but are not limited to: a. specifying the individuals who have access to electronic records; b. usage of unique passwords or identifiers for each employee or other person with access to the client records; c. ensuring a system to prevent unauthorized access, particularly via the internet; and d. ensuring a system to routinely track and permanently record access to such electronic medical information.
• These protocols and guidelines must be available for inspection at the telemedicine site and to Medicaid upon request.

Services not Eligible for Reimbursement for Telemedicine Services

Common examples of services via telemedicine not considered for reimbursement (not exhaustive):
• Chart reviews
• Electronic mail messages (between providers and recipients)
• Facsimile transmissions (between providers and recipients)
• Consultation between two providers
• Internet based communications that are not HIPAA-compliant or secure
• Services not directly provided by an enrolled provider or by office staff
• Services not normally charged for during an office visit
• Services not specifically listed in Provider Billing Manual chapters
• Communication that is not secure or HIPAA-compliant (e.g., Skype, FaceTime)
Exceptions may be made to the lists for providers and services not reimbursable under this policy in the event of a public health emergency, however, separate guidance would be issued in those instances.

References:
https://medicaid.alabama.gov/documents/4.0_Programs/4.1_Covered_Services/4.1_Telemedicine_Policy_Updated_5-26-23.pdf and https://medicaid.alabama.gov/alert_detail.aspx?ID=16119

Third Party Liability Coverage

ADMH Autism Services clients who has Third Party Liability (TPL) – other private insurance in addition to their Medicaid are unable to receive In Home Therapy or Behavior Support through ADMH Autism Services.

If any of the clients on your caseload have other insurance and are receiving either of these 2 services through ADMH, a transition/discharge plan will need to occur.

The other services are not affected, but because ABA and psychological/counseling services are available via private insurance, it would be considered a duplication.

Medicaid is the payor of last resort, so that coverage must come from their private coverage. However, dental and pharmaceutical coverage does not impact services, this process only involves health coverage.
Individuals with Medicare have access to all ADMH Autism Services; however, for billing, all claims must reflect an "11-Other" for the Delay Reason Code on the claim form.

See Alabama Autism Providers Therap Support Page for further directions for how to bill for individuals with Medicare

Referrals to Rehab Services and TCM

Once a person is determined eligible for Rehabilitative Services, the Intensive Care Coordinator will refer the person to appropriate rehabilitative autism service.
All referrals will be processed through Therap.

The following is the process for providers to accept clients for services:

- Receive referral from ICC
- Review provided information
- Request additional information (as needed)
- Accept or Deny Referral
    - Must record reason for denial
    - Client has ultimate choice
    - Meeting with ICC and client/family arranged to discuss outcomes of services after acceptance of the referral.

Prior Authorizations

Rehabilitative services procedure codes generally do not require prior authorization (PA), except for circumstances when a Rehab Option provider determines that it is medically necessary to provide treatment services that goes beyond the indicated service limits for a recipient eligible under EPSDT (under age 21). Medical necessity will be established from the recipient's condition at the time of the request, not the diagnosis alone.

Approval is required if number of service hours will be exceeded for a particular service.

All prior approvals of additional Autism Services units require approval from the Regional Autism Coordinator.

All requests must be received at least 10 days prior to the anticipated date of need.

All approvals for additional units are based on the individual's needs and extraordinary circumstances

The ICC will then be responsible of updating authorization in Therap. To access the "Request for Additional Hours" form, refer to the ADMH Autism Services website at https://mh.alabama.gov/autism-services/. Rehabilitative services do not require an ACHN referral.

If client is receiving case management services within a different Target Group, a prior approval is required before Autism Services Intensive Care Coordination can begin for that client.

If the recipient receives additional case management services, but the TCM services would not be duplicative, ADMH Autism Services must document in writing to Medicaid how their services would not present a duplication of services from other case management services received.

Medicaid will pay for one case management fee per month and will recoup any claims paid in error unless Medicaid has determined there is no duplication of services and gives prior approval for the TCM services provided.

The RAC completes the *TCM PA Information Form* for an individual that needs PA for services.

The TCM PA Information Form is forwarded to ADMH AS Administrator and entered Medicaid portal when received.

A prior authorization number is generated for the PA, and it is placed in "evaluation status" pending Medicaid review.

Once approval is granted, an approval letter is received from Medicaid and this letter is forwarded to the TCM supervisor agency for notification and the SA can be completed.

If the PA request is not approved, services will not be delivered.

Service Authorization

The purpose of service authorization is to govern the billing set up process. This process includes tracking total numbers of service authorization units, unit rate, case note documentation, set up maximum units and identify low remaining units.

The service authorization form documents the following:

1. Service Target Group,
2. Procedure code and modifier,
3. Service authorization status,
4. Service authorization period of service
5. Total billable units.

To request additional units, the provider must complete the "Request for Additional Hours" form and submit for review by Intensive Care Coordinator (ICC). The ICC will determine need and approve if appropriate. The client/family should be made aware of request. The ICC should then send to their TCM supervisor for approval of increase. The TCM supervisor will determine need and approve if appropriate. The Regional Autism Coordinator will provide the final approval. All approvals for additional units are based on the individual's needs and extraordinary circumstances.

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

Documentation

Providers should maintain complete and accurate medical, psychiatric, and fiscal records that fully disclose the extent of the service. Providers must provide all information on services to recipients to Medicaid at no charge. They must permit access to all records and facilities to authorized representatives for the purposes of claims audit, program monitoring, and utilization review. There should be clear continuity within the documentation.

All entries must be legible and complete and must be signed and dated by the person (identified by name and discipline) who is responsible for providing the service. All Autism Services provider records must contain name of recipient, dates of service, name of provider agency and person providing services, nature, extent, or units of services provided, and place of service.

Any physical files must be kept for three years beyond the current year for record retention.

Case Notes Documentation

Case Note Template Guide

Template User	**Template Name**
ALL	All Provider Non-Billable Case Note
Intensive Care Coordinator	ICC Meeting Note
Intensive Care Coordinator	ICC Monitoring/Progress Note
Intensive Care Coordinator	ICC Plan/Record Review & Provider Monitoring
Intensive Care Coordinator	Monthly Eligibility Check
Behavior Support	BxS Case Planning & Reporting
Behavior Support	BxS Session Note
Behavior Support	BxS/IHT Crisis Intervention
In-Home Therapy/Mental Health Support	IH- Individual Session
In-Home Therapy/Mental Health Support	IHT- Group Session
In-Home Therapy/Mental Health Support	IHT Planning/Meeting Note
Peer Support	Peer Support Planning/Meeting Note
Peer Support	Peer Support-Family/Youth Indiv & Group Note
Psychoeducational Services	Psy-Ed Case Planning & Reporting
Psychoeducational Services	Psy-Ed Ind/Group Session Note
Therapeutic Mentoring	TM - Case Planning & Reporting
Therapeutic Mentoring	TM - Session Note
Rehab Providers	Rehab Mental Health Care Coordination
Rehab Providers	Rehab Service Supervision
ADMH staff only	RAC Case Note

Case Notes should include the minimum information below:

- ***Who*** received services? Client
- ***What*** services were provided? Type of service, extent, units
- ***When*** were they provided? Date and Time
- ***Where*** did services take place? Place (home, school, playground)

- ***By Whom*** were services rendered? ICC/Practitioner
- ***Why*** were the services provided? Goal, diagnosis, progress monitoring
- ***How*** were they provided? Face-to-face, phone, etc.
- ***Next*** steps… linkage, referral, new goal, continue, follow-up date

Case notes are to be created by next business day after meeting with family/client and available in Therap for review.

Documentation should not be repetitive. Unacceptable examples include, but are not limited to the following scenarios:

- Case notes that look the same for other recipients.
- Case notes that state the same words day after day with no evidence of progression, maintenance, or regression.
- Treatment plans that look the same for other recipients
- Treatment plans with goals and interventions that stay the same and have no progression.

Case Notes should:

1) Match the goals/measurable steps in the plan, and the plan should match the needs of the recipient.
2) The interventions should be appropriate to meet the goals.
3) Case notes must provide enough detail and explanation to justify the amount of billing.
4) Case notes should include a written assessment of the recipient's progress, or lack thereof, related to each of the identified clinical issues discussed.

Written assessment of progress should include but not limited to:

1) Evidence of progress-how progress was determined could include data method**,** example: Frequency/Count Duration (in minutes) Percentage (%) Prompt Level
2) Level of progress- N) No Progress (NP) Non-Participation (Mi) Minimum Progress (Mo) Moderate Progress (Si) Significant Progress R- Regression (Ma) Mastered
3) Plan for next session- Continue current goal, indicate a need for any changes, if needed,

See Therap training- creating a CaseNote for more detailed training.

Uploading documents into Therap's system:

Document Storage

- Utilized for long term storage of important documents related to overall client status and service eligibility.
- Psychological, Physical, Birth Certificate, Medicaid Card, IEP, etc.
- Signature documentation for each session
- Limited upload privileges

Document Attachment

- Files attached directly to case note, ISP data, etc.
- Signature page, Work Sample, Med change note, etc.

Naming

- Client First Name.Last Name.4 Digit Year.File Type

Common File Type Names

- Psychological Report – PsychReport

- Diagnostic Report – DxReport
- IEP – IEP
- 504 Plan – 504
- Medical Exam/Physical – Physical
- Work Sample – ISPWorkSample
- Client Provided Notes – ClientNote, FamilyNote, TeacherNote, etc.
- Meeting Notes – (type of meeting) ex: IEPNote, ISPNote
- Birth Certificate – BirthCert
- Medicaid Card – MedCard
- Social Security Card – SSCard
- Client Photo – ClientPhoto
- GER Related Document – GER Note

Limitations

- 10 MB per file/1 GB total Document Storage
- 3 MB per case note attachment- Multiple attachments up to 10 MB total per note
- Additional information regarding file size limits can be found on Therap's website at https://help.therapservices.net/app/answers/detail/a_id/2342/~/attachment-limit-for-therap-modules.

Medication information should be tracked and recorded within Therap in the event of monthly follow-ups, planning meetings, inpatient stay, change in behavior plan, observation of new behavior. Documentation should include category (Psychotropic, other prescribed, OTC, herbal) and other important information (prescriber, dose, schedule, pertinent side effects).

Documentation: Providers must upload supporting documentation (post measures, data forms, action items, etc.) and/or complete questionnaire within a case note for each individual attendee of each training session.

- **Required items to complete:** Name, Date, Time, Provider Generated Questions (or ADMH Example Questions), Client Signature/Printed Name

Provider and Recipient Signature Requirements

A designee is any person who can sign on behalf of the recipient. The Designee must indicate his/her relationship to the recipient next to his/her signature (e.g. spouse, power of attorney, authorized representative, etc.).

The Designee's signature must be legible. If the signature is not legible, the name of the Designee should be printed next to his/her signature.

Handwritten Signatures: A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation. Provider signatures must be legible and clearly identify the provider performing the billed service. Illegible provider signatures must be supported by a valid signature log or attestation statement to determine the identity of the author. A handwritten signature must be an original signature on the original record or document; it must not be a photocopy or otherwise adhered to the original document.

Electronic or Digital Signatures: An electronic signature validates an electronic medical record in the same way a handwritten signature validates a written medical record. An electronic signature is an

electronic sound, symbol, or process, attached to an electronic record and executed or adopted by a person with the intent to sign the record. The responsibility and authorship related to the signature should be clearly defined in the record.

The system should be secure, allowing sole usage or password protection for each user. Digital signatures are an electronic method of a written signature that is generated by special encrypted software that allows for sole usage. Electronic and digital signatures are not the same as 'auto-authentication' or 'auto-signature' systems, some of which do not mandate or permit the provider to review an entry before signing. Therefore, “auto-authentication” or “auto-signature” systems are not allowed. Indications that a document has been 'Signed but not read' are not acceptable.

Acceptable electronic or digital signatures include, but are not limited to, the following:
1) Chart 'Accepted By' with provider’s name
2) 'Electronically signed by' with provider’s name
3) 'Verified by' with provider’s name
4) 'Reviewed by' with provider’s name
5) 'Released by' with provider’s name
6) 'Signed by' with provider’s name
7) 'Signed before import by' with provider’s name
8) 'Signed: John Smith, M.D.' with provider’s name
9) Digitized signature: Handwritten and scanned into the computer 14
10) 'This is an electronically verified report by John Smith, M.D.'
11) 'Authenticated by John Smith, M.D'
12) 'Authorized by: John Smith, M.D'
13) 'Digital Signature: John Smith, M.D'
14) 'Confirmed by' with provider’s name
15) 'Closed by' with provider’s name
16) 'Finalized by' with provider’s name
17) 'Electronically approved by' with provider’s name
18) ‘Signature Derived from Controlled Access Password

All providers must obtain a signature to be kept on file as verification that the recipient was present on the date of service for which the provider seeks payment (e.g., release forms or sign-in sheets).

Documentation of Medicaid recipients’ signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the recipient’s signature and the date of service. The master signature log located in the agency document storage can be utilized.

The recipient’s signature is only required one time per day that services are provided.

Any non-face-to-face services provided do not require recipient signatures.

Treatment Plans: Unless clinically contraindicated, the recipient will sign the treatment plan to document the recipient’s participation in developing or revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent or foster parent or legal guardian must sign the treatment plan.

Reference: Alabama Medicaid Administrative Code 560-X-1-.18: Provider/Recipient Signature Requirements

General Procedures

Confidentiality

ADMH Autism Services facilitates communication and collaboration with other service providers that are a part of the multi-disciplinary and multi-agency treatment plan. This is necessary to ensure that efforts are coordinated across multiple environments/services to aid in the client's success and avoid duplication of effort.

All information obtained and/or received through ADMH Autism Services is confidential. Client information should be kept in folders in monitored and locked areas for confidentiality. No information should be released without a signed Release of Information (ROI). Special authorization is required to disclose information such as treatment, payment, healthcare operations or other legal documentation. Only ADMH records are authorized to be released. Third party records (IEPs, psychological evaluations, assessments, etc.) must be requested from the party that originated the document.

A "Notice of Privacy Practices" should be provided at various times for client to keep [at or before 1st visit, when changes are made (legal, provider policy, etc.), or at client request]. This notice will explain all limitations of privacy and how client information will be used.

If there is a breach in confidentiality, reporting of the violation is critical. If the violation is internal, individuals should contact their supervisor immediately, the security officer immediately, and the impacted client(s) without unreasonable delay. If the violation is external, the Secretary of Department of Health and Human Services should be contacted. If the violation impacts fewer than 500 clients, then the violation should be submitted through the Web Portal and within 60 days of the end of the calendar year in which the breach was discovered.
If the violation impacts more than 500 clients, the violation should be submitted and filed without unreasonable delay from the discovery of the breach.

E-Mail, Internet and other Network Service Usage

Professionals, staff, and data users shall adhere to proper usage of the Internet, e-mail, and other network services, to maintain the accuracy, security and confidentiality of personally identifiable information including Protected Health Information (PHI) and other sensitive data.

All Internet, e-mail, or other network service communications and related logging events that are sent, received, or otherwise generated by a data user are the property of the State of Alabama and are subject to the provisions of applicable state and federal law regarding their maintenance, access and disposition. The misuse of these services may be a violation of the Alabama Computer Crime Act and/or the Alabama Ethics Act as well as HIPAA regulations. The State reserves the right to monitor and record the transmission, receipt or storage of Internet, e-mail, or other network service communications and to implement content filtering systems.

The following list of activities contains examples of improper or unacceptable use and is neither exhaustive nor all-inclusive. This list serves as a guide to the user, so they may avoid certain activities and actions while utilizing the e-mail, Internet, network services or other technological resources

provided by DMH. If any staff member is unsure about whether an activity would be considered unacceptable, he or she should discuss the issue with their supervisor.

A. Staff shall not submit, display, store, archive, transmit or access files that violates or infringes on the rights of any other person, including the right to privacy; Staff will not create or exchange information that is in violation of copyright or any other law. The department is not responsible for any staff's use of e-mail that breaks laws.
B. Staff will not initiate personal communication that interferes with work responsibilities.
C. Staff will not open file attachments from an unknown or untrustworthy source, or with a suspicious or unexpected subject line.
D. Staff will not send confidential information or PHI to unauthorized people or otherwise violate the department's data protection policies or HIPAA guidelines, or otherwise increases the department's legal or regulatory liabilities.
E. Staff will not circulate unprotected healthcare data and personally identifiable consumer data that would violate U.S. Federal HIPAA regulations. Data users must encrypt e-mail messages or attachments containing confidential or sensitive information, including client information, PHI, or personal identifying information to any party outside the Alabama Consolidated Email (ACE) system using encryption methodologies approved by the DMH Chief Information Officer or designee.
F. Staff will report suspected security violations or other breaches of confidentiality, and any violations of this or other DMH policies and procedures occurring during the use of network services in accordance with DMH's Incident Reporting Procedures.

Substance Usage

This policy establishes a tobacco/smoke-free environment for clients and staff; therefore, the use of tobacco products is prohibited at all times. The policy applies to clients, employees, staff, contractors, and visitors. Employees who use or possess any tobacco products in violation of this policy are subject to progressive discipline.

The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance or the possession of drug paraphernalia is prohibited at all times. The Department does not differentiate between drug users and persons who distribute or sell drugs. Any employee who gives or in any way transfers a controlled substance to another person or sells or manufactures a controlled substance or possesses drug paraphernalia while on the job or on Department premises will be subject to disciplinary action. If an employee is convicted of violating any criminal drug statute while at the workplace, he or she will be subject to discipline up to and including termination. Facilities are responsible for developing procedures to implement this policy and to obtain a drug-free workplace policy acknowledgement from each employee.

Initial Planning Meeting

The purpose of the initial planning meeting is to introduce the client and families to ADMH Autism Services.

During the initial planning meeting, the ICC will establish rapport with client and families, help families to identify support needs and review available support needs.

An initial planning meeting will be scheduled by the assigned ICC after the client is determined to be eligible for services.

Upon initial contact, the ICC will conduct the CANS (Child and Adolescent Needs and Strengths assessment) with the client/family and develop initial outcomes based on needs for the initial planning meeting.

Updated Individual Support Plan (ISP) process:

1) When a referral is sent to a Rehabilitative Services provider, the ICC will send the provider the *o*utcomes, goals and needs page. This page will be sent to the provider via s comm. Templates for the Outcomes and Goals page can be found in Agency Document Storage.

2) The Rehab provider will review *o*utcomes, goals and needs page, including the psychosocial and any other pertinent documents prior to the ISP team meeting.

3) A meeting with the client/family, ICC and Rehab provider will be scheduled and held. The Rehab provider will obtain a signature from the client or the signing designee using the Plan Signature page or their agency meeting/plan approval page. After the meeting, the ICC will submit a Rehab service authorization to the ICC supervisor for approval.

4) The Rehab provider will create and submit an Individual Support Plan, ISP, in Therap including objective/measurable step(s) from the goal(s) discussed in the team meeting.

5) The Rehab provider's supervisor (PASS 1) will review and approve the ISP in Therap.

6) The Rehab provider will Scomm the ICC when ISP is approved in Therap

7) ICC will review and acknowledge ISP in the Rehab provider's account.
If any issues are noted, the ICC will report the issue to their supervisor and the ICC supervisor will address with Rehab provider PASS 1 (Supervisor)

8. The Rehab provider will document status of the ISP in the case note including documentation of progress.

9. At the end of each month, progress of the objective/measurable step should be documented in case note as well as on the ISP data sheet. The data sheet should be uploaded to the ISP indicating the month and year using the external attachment.

See Rehabilitative Services Timelines section for more details.

Special Meeting Circumstances

There will be instances where providers need to hold special meetings. These meetings may address specific behaviors, events such as crises or transitions, specific providers, and may or may not require change to the care plan.

Safety Planning should be considered for all clients**.**

All clients should have a safety plan**.**

Specific care team members may be on 24-Hour Phone Access (Behavior Support, In-Home Therapy/Mental Health Support). Planning is framed as family/client responds to provide stability**.**

Meeting for crisis planning is intended to prevent need for out-of-home placement.

Transition Planning should be considered at specific stages of a client's life such as transitions from services, adolescence to adulthood, inpatient admission, relocation, new school, etc. Transitions from services should be addressed as goals are being met. Preparing for aging-out of services should be planned by age 14 and ongoing supports should be identified. Transition from adolescence to adulthood should be addressed beginning at age 14 until age 21. Medical, vocational, and therapeutic services and supports should be identified to provide warm handoff at transition. Other transitions (inpatient admission, relocation, new school) should address goals as they arise. These goals should be discussed at each planning meeting at minimum.

Partial Team Meetings may occur to discuss the addition of other services, a change in hours, goal revision or addition, discharge from given service, or a change in provider. Specific and applicable team members may meet to address these concerns. Amendments to care plan should be shared with entire team within 5 days.

Meetings without Addendums may occur to address non-compliance and attendance of client, specific provider concerns, family concerns, staffing issues, or major client updates. These items may not require an addendum to the client's treatment plan.

Safety Planning

The number one goal in safety planning is that the process and any resulting plans will help to reduce unsafe situations and the likelihood of harm. In order for this goal to be realized, the person/family must actually use the plan in the event of a potential issue or concern occurs. Therefore, it is important that the client/family and Rehab providers are familiar with the plans as well as can readily access the forms.

The safety planning process includes a two-sided document (***Safety Plan*** and ***Emergency Response Form***), ***Safety Assessment Guide*** and ***Safety Screener***. These documents should serve to create a bridge for the family, the informal support network, and the formal treatment networks while providing a better strategy for "next time events."

The ICC reviews the Safety Plan and Emergency Responder form, at least, every six (6) months to make sure it is still current and update as needed. If assistance is needed to help create these documents, use the *Safety Assessment Guide* for guidance.

The Safety Plan should:

- ✓ Be used by youth/families experiencing a first or infrequent crisis episode or who are addressing behaviors in the home/community that are unlikely to rise to the level of emergency services.
- ✓ Define setting, triggers and/or signs for when a potential situation occurs
- ✓ Have strategies and actions to help the client at home as well as in the community
- ✓ Be readily available in the home and in the family vehicle if possible.
- ✓ Be revisit the plan at least, every six (6) months by the ICC, client and family to insure it is still relevant and meeting their needs when situations occur.
- ✓ This will often be the one and only crisis planning tool that is used

How to help clients and families know ways to calm an escalating situation

- Be on alert for triggers and warning signs
- Try to reduce stressors by removing distracting elements, going to a less stressful place or providing a calming activity or object
- Remain calm, as the behavior is likely to trigger emotions in you
- Be patient
- Praise attempt to self-regulation
- Debrief the team on the safety plan and any other safety products that are in use so that everyone can be prepared and aware of what to do if needed.

How do you know it's time to get more help?

- Aggression or self-injury become recurrent risks to self and others
- Unsafe behaviors, such as elopement and wandering cannot be contained
- A threat of suicide is made
- A family can no longer keep them safe with the current measures in place
- Law enforcement involvement increases or causes out of home placement such as hospitalization

ADMH Autism Services seeks to provide services in a safe and secure environment and is a non-restraint program. De-escalation and blocking techniques only are to be used for crisis intervention. Regarding crises moving forward, providers should be prevention minded. The team should meet and review the

treatment plan to revise or develop a crisis plan. The team may determine that additional services, supports, or resources are required to meet the client's need.

In the event any of these issues occur, a crisis plan may need to be created.

**Only In-Home/ Mental Health Support or Behavior Support provider staff can create a crisis plan.

If the person doesn't receive either of these services, a team meeting should be initiate to discuss the safety issues and any additional needed services and supports.

First Responder/Emergency Response Form

This form should be the second side to the Safety Plan and readily available to provide pertinent information to first respondents including Crisis Intervention Teams, Law Enforcement and or EMTs.

Safety Screener
A Safety Screener should be completed every six (6) months with each youth/family by the ICC. The purpose of the screener is to determine if there are any safety concerns that need to be address as well as provide the youth and families with appropriate strategies and resources that can possibly address the concern as well as identify goals in the Treatment Plan and

Safety Assessment Guide
The Safety Assessment Guide is a tool that can be used during safety planning that can help to ask the right questions and give examples of potential problems, triggers, warning signs, and interventions. This document does not have to be completed and is optional for use.

If the client has no formal plan for crisis, initial goals should include ensure/restore safety, resolve current situation/symptoms, and ameliorate contributing factors. Possible indicators of risk may include poor relationships,

Field Safety

ADMH Autism Services are provided in home and community-based settings; therefore, proper precautions are necessary to consider before entering home and/or meeting clients/families in the community. Items to consider:

1. Be Aware of Your Surroundings (know before you go): multiple exits, where to park, local resources, stand to side of door and wait to be let in, listen for pets, stay near the exit
2. Gas Up
3. Limit What You Carry: lock up before arrival, extra baggage slows you down, avoid carrying medications
4. Consider Clothing: be comfortable, keep heels low, avoid loose jewelry and clothing
5. Actions and Words: watch body language, listen to tone
6. The Buddy System: let someone know where you will be, easy access to emergency contact, involve the supervisor, alone is not the only option.
7. Follow your agency's policy and protocols for Covid-19 and other infectious diseases.

Hospital Admissions and Discharges

When a client enters an in-patient stay at a medical institution there should be contact made by the client's ICC and appropriate documentation should occur.

This contact should include information related to stabilization and limited discharge planning. ICC services are the only billable services while a client is admitted, and this is only allowable within 180 days of discharge from a medical institution.

Rehab providers under Autism Services are required to maintain a client's spot for at least 30 days from admission into the medical facility.

If the ICC is made aware of admission to inpatient care, the ICC should contact facility to identify self and gain information, if possible, with the use of a Release of Information form.

The ICC should document the client's admission within Therap as a case note. The ICC should then resume regular duties as assigned.

The ICC should plan with the treatment team for discharge and continuation of services.

The ICC is responsible for providing updates of client's status throughout stay to treatment team and providers.

Once discharged, the treatment team should call a meeting, address crisis planning if needed, and develop plan for prevention of future admission.

Transfer Process

When a client is going to be transferred between regions, export all notes and forward to the new ICC/region and update document storage.

Once the client case has been transferred to the new ICC, the previous ICC will no longer have access to the client's record.

If a client is receiving case management services from a different provider agency, a prior approval is required before Autism Services Intensive Care Coordination can begin for that client.

Prior to transferring regions, the TCM supervisor completes *Alabama Prior Review and Authorization Request Form 342* and *The Request for Interagency Prior to Authorization Transfer Form 385* forwards to the Autism Service Administrator, which is then submitted to Medicaid.

Transition Planning

Transition planning should be considered at specific stages of a client's life such as transitions from services, adolescence to adulthood, inpatient admission, relocation, or new school.

Transitions from services should be addressed as goals are being met. Preparing for aging-out of services should be planned by age 14 and ongoing supports should be identified.

Transition from adolescence to adulthood should be addressed beginning at age 14 until age 21. Medical, vocational, and therapeutic services and supports should be identified to provide warm handoff at transition.

Other Transitions (inpatient admission, relocation, new school) should address goals as they arise. These goals should be discussed at each planning meeting at minimum.

Discharge and Termination of Services

Discontinuation of services may occur by discharge or termination. Discharge/termination should be planned and/or addressed in advance, if possible. A team meeting should be held to discuss reasons for discharge/termination and possible solutions to avoid any interruption in service provision.

**If the individual/family fails to make appropriate changes needed, the termination process will continue.

If discharge/termination occurs, resources for future services should be provided to the client/family upon discharge.

The team will meet to discuss the issues related to the request for discharge or termination of services.

If the client is discharged from services, the TCM supervisor should follow up with the client/family 30 days and 90 days after discharge.

If the client/family wishes to re-enter services, they must start at the beginning of the enrollment process. A delay in re-activation of services may occur.

Discharge/termination of services should be documented in the individual's case note and the individual/ family should be informed in writing including the reason(s) for discharge.

Discharge
The following are possible reasons for discharge but not limited to:

- Family relocation
- Long-term placement
- Loss of Medicaid eligibility
- Transition/aging out of services
- Withdrawal of consent for services
- Loss of program eligibility
- Goals and needs met

- Decreased level of need

Termination

The following are possible reasons for termination but not limited to:

- Program non-compliance
- Lack of participation in services

Refusal to adhere to program requirements within 30 days following notification will result in termination.

Discharging and Readmission Clients in Therap

All providers should accurately maintain caseload listings in Therap.

To discharge a client, refer to the Therap User Guide:

https://help.therapservices.net/app/answers/detail/a_id/352/kw/discharge%20).

To readmit a client, refer to the Therap User Guide: Readmission of Clients in Therap

Denials and Appeals

Clients and/or families have the right to file an appeal as a response to denial of eligibility, service provision, extension of hours, etc.

Individuals who are denied eligibility, access to services, an extension of hours/units, etc. May file an appeal to the denial within 15 days of receiving denial.

The appeal process begins with a written request from the applicant. All appeals must be filed in writing within 15 days of the effective date noted on the denial letter including information that is requested to be considered for approval.

The written request for appeal should be sent to ADMH Autism Services: Appeals, P.O. Box 301410, Montgomery, Alabama 36130-1410.

The individual will receive a full review and the individual will receive a response within 30 days after receipt of the appeal.

Medicaid provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are denied the service(s) of their choice or the provider(s) of their choice; or (b) whose services are denied, suspended, reduced, or terminated.

Although Rehab providers do not make decisions regarding program eligibility, they still may not limit, suspend, or deny services without cause, particularly as an act of discrimination (see Provider Responsibilities). Clients should follow provider processes for appeals or service disputes, but such violations will be reported to the ICC and ADMH staff for follow-up action as needed.

Reference:
AL Medicaid Administrative Code: 560-X-3-.03 Fair Hearing Procedures for Recipients and Providers.
2017 Alabama Intensive Home-Based Behavioral Services Settlement Agreement

Grievances and Complaints

All complaints and grievances are accepted, reviewed, and investigated ensuring that no person is retaliated against or denied services for filing a complaint or grievance.

Complaint is defined as allegations made by clients, families, guardians, associations, or agencies concerning the delivery or receipt of services which may violate rules and policy, or adversely affect a client's health and well-being.

Grievance is defined as a problem, perceived by the client to involve unfair treatment violation of client rights accorded by law, ADMH policy, or established practice.

ADMH Autism Services providers should follow their agency's policy when a complaint or grievance has been filed against staff or agency.

The client and/or family should contact their ICC to discuss the concern. The ICC can assist with directing the client and/or family to the policies and contact person with the specific provider agency to resolve the issue.

If the concern is related to an issue with the ICC, the family should contact the ICC agency and follow the agency's protocol regarding reporting of concerns.

If the issue is not resolved at the provider agency level, the client and/or family should contact the TCM Supervisor or he Regional Autism Coordinator within their region.

The individual and/or family also has the option to contact ADMH Advocacy Services (800-367-0955) at any time.

The State Autism Coordinator will assign the complaint investigation to ADMH Compliance Officer. The ADMH advocacy staff will also be notified of the complaint and assist with the investigation as needed.

Reference:
AL Medicaid Administrative Code: 560-X-3-.03 Fair Hearing Procedures for Recipients and Providers.
2017 Alabama Intensive Home-Based Services Settlement Agreement

Compliance

ADMH Autism Services Providers will be held to standards for delivering quality services to individuals and families. To ensure compliance to these standards and regulations, providers must deliver services to clients according to plans, assure client well-being and satisfaction of treatment, and comply with state and federal regulatory requirements.

Examples of noncompliance and/or violations of policies, regulations, guidelines include but is not limited to:

- Incidents of actual or threatened physical, emotional, or sexual harm or exploitation
- Incidents of harassment or discrimination towards clients, family members, or other service supports
- Absence of plan to address dangerous behaviors of consumers or lack of training and direction for staff members working with individual
- Staff member who mistreats or neglects clients has not been subject to corrective action or can continue to work with or be in the presence of clients
- Inadequate oversight and involvement in provision of supports and services
- Unethical and inappropriate dual relationship that impedes the progression of treatment
- Failure to actively participate in meetings and appointments to develop treatment plans
- Service supports and treatments goals fail to teach clients needed skills to participate in their communities actively and effectively.
- Individuals are provided limited opportunities to make own choices about various aspects of life.
- Individual's rights are violated and inappropriately restricted
- Submitting false claims or misrepresenting treatment through insufficient documentation
- Failure to follow policies and rules regarding HIPAA, confidentiality and/or privacy.
- Access to needed services is not arranged, facilitated, or completed in a timely fashion

If the provider is found to be noncompliant to policies, standards and regulations; the provider will be subject to corrective action including termination of provider contract.

Rights Protection Compliance

All providers responsible for providing treatment and care of recipients of Autism Services are required to do so in such a manner as not to violate the rights of recipients. Every provider who has observed or who has knowledge of an incident which violates the rights of recipients has a responsibility to report such incidents to their supervisor and others as required by state and federal laws. If the incident is not resolved internally, a report should be made by the provider to Advocacy or ADMH Autism Services. All staff are responsible to cooperate with any investigations by Advocacy and/or ADMH Autism Services.

ADMH Autism Services shall investigate alleged violations of recipient's rights and shall have unlimited and unimpeded access to that individual's records including copies thereof and related staff records. Cases of suspected individual abuse, mistreatment or other serious incidents shall follow the incident management procedures by ADMH Autism Services.

Medicaid's Civil Rights Compliance
Providers must adhere to the Civil Rights Compliance policy under Medicaid. This form and policy can be found in the ADMH Autism Services Provider Agency Application or on Alabama Medicaid's website at https://medicaid.alabama.gov/CONTENT/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx.

Agency Reviews
Autism Services will utilize site visits and chart reviews to ensure compliance with Medicaid and ADMH standards, policies and procedures as well as ensuring a standard of care is established during the service delivery.

Site Visits
An initial site visit will be scheduled with the agency by the Compliance Officer when the performance provider application has been approved and all required documentation has received. The visit may be in-person but may be conducted virtually in special circumstances with the approval of the State Autism Coordinator.

The site review will consist of but not limited to:

- review of protection of client rights
- dignity and respect
- protection from abuse, neglect, mistreatment, and exploitation
- safety and incident reporting
- HIPAA and personal security
- staff resources and development
- physical location information

A request for site visit will be sent to the agency.

The Compliance Officer will complete the site visit within 10 working days from the request.

A site visit review will be coordinated with the Provider agency representative, Compliance Officer and AS Planning and Quality Assurance Specialist to review findings from the visit.

A site visit report will be forwarded to the to the Quality Assurance committee for review within 5 working days of the review for approval.

The provider may be required to provide a "plan of correction" within 15 working days of receipt of the report if needed.

The approved initial site visit report will be accepted, and the provider will receive an approved credential letter of operation.

A follow-up visit may be conducted within 3 months of the visit to ensure that any identified issues have been resolved.

Every year or two years, a provider will receive a new site visit based upon the number of years approved during the previous site visit. The process for credential renewal is the same as the initial visit.

An agency that is still determined to be out of compliance at that point may be subject to contract cessation or other actions at the recommendation of the Quality Assurance committee. The ADMH and the State Autism Coordinator will make the final decision.

Onsite visits, thereafter, may occur announced or unannounced as appropriate or requested by State Autism Coordinator.

Reasons for onsite visits may include training, technical assistance, maintenance of compliance with ADMH and Medicaid regulations and guidelines, response to complaints, incident investigations, or direction from legal authorities.

Providers can prepare for visits by referencing "Site Visit Checklist" on the ADMH Autism Services website at https://mh.alabama.gov/autism-services/

Chart Reviews

Every year, case management and rehabilitation service providers will receive a chart review.

The chart review will be conducted online within Therap by the Compliance Officer.

Clients and families will also be contacted to answer questions about service delivery.

A selected number of charts will be reviewed at random. A minimum of 10% and a maximum of 20% of records will be reviewed based upon the number individuals served by the agency.

Reviews may be announced or unannounced.

The purpose of the chart review is to ensure compliance of service provision, proper documentation, service satisfaction, and adherence of Medicaid and State regulations.

Chart reviews will include but not limited to the review of 1) GERs, 2) agency investigations, 3) treatment plans, 4) case notes, 5) and other records such as assessments and applications for enrollment. Required information for individual records include, but not limited to, name of recipient, dates of service, name of provider agency and person providing services, nature, extent, or units of services provided, and place of service.

Providers may reference "Chart Review Checklist" on the ADMH Autism Services website at https://mh.alabama.gov/autism-services/ for information regarding record reviews.

The Compliance Officer will notify the agency that a chart review will be conducted, request any information needed and explain the chart review process to the agency representative.

A chart review meeting will be scheduled after the completion of the review with the agency and AS Quality Assurance staff to discuss any findings.

The completed chart review with findings report will be forwarded to the agency within 5 days of the meeting.

The agency will be required to provide a "plan of correction" within 15 working days of receipt of the report if needed.

A follow-up review may be conducted within 3 months of the visit to ensure that any identified issues have been resolved.

INCIDENT MANAGEMENT

Each Autism Services credentialed provider shall develop and implement written policy and procedures to support compliance with the incident reporting requirements of ADMH. This policy should outline what constitutes and incident, reporting notifications and timelines as well as a monitoring mechanism. This process should be a timely and appropriate review of incidents and data by the organization to take preventive and/or corrective actions to ensure the safety and protect the interests of the individuals and their families. This policy does not supersede or replace any other statutory requirements for reporting to the Alabama Department of Human Resources, Department of Public Health, OSHA, Law Enforcement Agencies, or other designated agencies as required by law.

As of November 1, 2019, the Alabama Department of Mental Health, Office of Autism Services, approved the implementation of THERAP as the ADMH approved electronic incident reporting system. THERAP is a web-based application that allows for the electronic submission of incident reports. All credentialed ADMH Autism Services providers (internal and external) are required to use this system for incident reporting and will be provided training on the system. Incidents are to be reported and uploaded in a timely manner and remain confidential throughout the entire process.

DEFINITIONS:

Incident/Event: Defined as any event that could or has caused harm to any individual be it physical harm, psychological harm or even extended discomfort to manipulate that individual. It also includes but is not limited to, damage to property be it personal or state owned and any form of exploitation involving a client or their family.

General Event Reports (GER): Documentation form used to record, document, and follow up on an incident/event.

GER Resolutions (GERR): The process in Therap to record, document and complete any GER that requires investigation.

Incident Prevention and Management System: Defined as a systematic system to record/document, analyze and otherwise evaluate incidents that occur to try and develop correctives measures to prevent reoccurrence.

The following are considered reportable incidents: medical emergencies including moderate injuries, severe injuries, choking, seizures, falls, unscheduled hospital admissions, medication errors, AWOL/Missing person, death, behavioral issues, natural disasters, fire, allegations of abuse, neglect, mistreatment, or exploitation, physical assault, sexual assault, manual restraint, mechanical restraint, chemical restraint, and other occurrences which require the notification of Police, or DHR.

PROCEDURES:

1. The provider will have and implement an IPMS to enhance safeguards for clients of ADMH Autism Services, their families, and all that are involved.

2. The provider shall provide notifications and documentation of all incidents within the timeframes outlined on the Incident Mapping document and will fully cooperate with all follow-ups to reported

incidents. Failure to do so may result in disciplinary action(s), cessation of contract and possible civil and/or criminal actions dependent upon the circumstances.

3. The provider will input and approve each GER/incident in the online THERAP application.

4. All approved GERs will be reviewed by an Autism Compliance Officer with any needed resolutions forwarded to the Quality Assurance Committee or AS Coordinator if immediate attention is warranted.

5. If possible, the provider should designate a different person to create and a different person to approve GERs. This will improve the authenticity of the incident as well as improve the agency monitoring of incidents.

6. Each contracted provider shall develop and implement a mechanism to report incident data, identify trends, and take preventative actions to improve individual's safety during service delivery.

7. Autism Services will complete daily, monthly, and quarterly reviews of incidents to ensure safety and to protect the interests of the individuals and their families.

***** Any suspicion of abuse, neglect, mistreatment, and/or exploitation should follow the Mandated Reporter procedures for reporting in addition to GER reporting.**

To get full definitions of reportable incidents, timelines, notification instructions; go to Autism Services Incident Mapping:

https://www.therapservices.net/resources/alabama/ADMH-Autism_Incident_Mapping_Document_191211.pdf

For user guides on GERs, please visit:
https://help.therapservices.net/app/products/detail/p/125/~/general-event-reports-ger

For GER Resolutions, visit:

https://help.therapservices.net/app/products/detail/p/53/~/ger-resolution

Reference

Alabama Administrative Code 580-5-30

Alabama Department of Mental Health Policy 19.5 Incident Management

Laws, Regulations, and Ethical Considerations

Health Insurance Portability and Accountability Act (HIPAA) - HIPAA regulates disclosure and use of an individual's health records and establishes privacy and security on those records. HIPAA also secures insurance coverage mobility if a person changes jobs. The HIPAA Privacy Rule prohibits health plans and other covered entities from disclosing any information about the patient without his consent, unless it's for payment, treatment, or operations. This federal law takes precedence over any less restrictive state legislation but allows Alabama and other states to enact laws that provide stronger privacy protection for health records.

HIPAA applies to health plans, business associates (people who work for the entity and require access to protected health info), health care clearinghouses, and most health care providers. HIPAA protects all health information a covered entity transmits in any way (oral, paper, or electronic), including the following: the individual's mental condition, the stipulated condition of individual's health care, or payment information given at any time for the individual's health care.

Americans with Disabilities Act (ADA) - The ADA protects the rights of people who have a physical or mental impairment that substantially limits their ability to perform one or more major life activities, such as breathing, walking, reading, thinking, seeing, hearing, or working. It does not apply to people whose impairment is unsubstantial, such as someone who is slightly nearsighted or someone who is mildly allergic to pollen. However, it does apply to people whose disability is substantial but can be moderated or mitigated, such as someone with diabetes that can normally be controlled with medication or someone who uses leg braces to walk, as well as to people who are temporarily substantially limited in their ability to perform a major life activity.

Title II of the ADA applies to all State and local governments and all departments, agencies, special purpose districts, and other instrumentalities of State or local government (“public entities”). It applies to all programs, services, or activities of public entities, from adoption services to zoning regulation. Title II entities that contract with other entities to provide public services (such as non-profit organizations that operate drug treatment programs) also have an obligation to ensure that their contractors do not discriminate against people with disabilities.

Olmstead Decision - Under Title II of the ADA, the Olmstead Decision of 1999 requires states to place persons with mental disabilities in community settings rather than in institutions when the state’s treatment professionals have determined that: (1) community placement is appropriate, (2) the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and (3) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

New Freedom Initiative – The New Freedom Initiative is a comprehensive plan to ensure all Americans have the opportunity to learn and expand education, engage in productive work, access assistive and universally designed technologies, make own choices about daily lives, and participate fully in community life.

Individuals with Disabilities Education Act (IDEA) - In exchange for federal funding, IDEA requires states to provide a free appropriate public education (FAPE) in the least restrictive environment (LRE). The statute also contains detailed due process provisions to ensure the provision of FAPE. Originally enacted

in 1975, the Act responded to increased awareness of the need to educate children with disabilities and to judicial decisions requiring states to provide an education for children with disabilities if they provide an education for children without disabilities.

Mandated Reporting of Suspected Abuse and Neglect - Alabama law requires the following institutions and persons to report known or suspected child abuse and neglect of individuals under the age of 18 to the Alabama Department of Human Resource: all hospitals, clinics, sanitariums, doctors, physicians, surgeons, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, physical therapists, nurses, public and private K-12 employees, school teachers and officials, peace officers, law enforcement officials, pharmacists, social workers, day care workers or employees, mental health professionals, employees of public and private institutions of postsecondary and higher education, members of clergy as defined by Rule 505 of Alabama Rules of evidence (except for information gained solely in a confidential communication) which includes "any duly ordained, licensed, or commissioned minister, pastor, priest, rabbi, or practitioner of any bona fide established church or religious organization," or any other person called upon to render aid or medical assistance to any child when such child is known or suspected to be abused or neglected. (Code of Alabama 1975, Sections 26-14-1 through 26—14-13)

It is the responsibility of DMH employees and its contractors to treat all recipients with dignity and respect, to ensure that all recipients receive appropriate care and treatment, and to provide all recipients with protection from abuse and neglect, mistreatment or exploitation. Employees found in violation of this policy shall be subject to disciplinary actions.

Employees who fail to report incidents of recipient abuse, neglect, mistreatment, or exploitation or employees who withhold information regarding abuse, neglect, etc. during an investigation, or employees who withhold information regarding recipient abuse when questioned during an investigation regarding recipient abuse, neglect, etc. shall be subject to disciplinary actions ranging from a minimum of written reprimand to termination.

Duty to Warn states there shall be no monetary liability on the part of, and no cause of action shall arise against a licensed professional counselor or associate licensed counselor in failing to warn of and protect from a client who has communicated to the licensed professional counselor or associate licensed counselor a serious threat of physical violence against a reasonably identifiable victim or victims. If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the licensed professional counselor or associate licensed counselor making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency. No monetary liability and no cause of action may arise against a licensed professional counselor or associate licensed counselor who breaches confidentiality or privileged communication in the discharge of their duty as specified.

Informed Consent - Informed consent is described by the American Medical Association as "a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo specific medical treatment." Communication should involve details of the diagnosis, the proposed treatment, the risks and benefits of the proposed treatment, alternative treatments and their risks and benefits, and the risks and benefits of delaying or forgoing all treatment. Patients' informed consent also involves doctors answering patients' questions to help the patient make an informed decision about whether to undergo or refuse treatment. Patient's consent is voluntary.

Home and Community Based Settings (HCBS) - The Home and Community Based Settings (HCBS) Standards are designed to improve HCBS programs by ensuring the quality of Home and Community Based Services, provide rights protections for participants, maximize opportunities for individuals to have full access to the benefits of community living and ensure individuals can receive services in the most integrated setting. HCBS programs serve a variety of targeted populations, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Family Educational Rights and Privacy Act (FERPA)

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students." Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies. Parents or eligible students have the right to request that a school correct record which they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information. Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31): School officials with legitimate educational interest, other schools to which a student is transferring, specified officials for audit or evaluation purposes, appropriate parties in connection with financial aid to a student, organizations conducting certain studies for or on behalf of the school, accrediting organizations, to comply with a judicial order or lawfully issued subpoena, appropriate officials in cases of health and safety emergencies, and state and local authorities, within a juvenile justice system, pursuant to specific State law. Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school.

Rehabilitation Act

An act to replace the vocational rehabilitation act, to extend and revise the authorization of grants to states for vocational rehabilitation services, with special emphasis on services to those with the most severe handicaps, to expand special federal responsibilities and research and training programs with respect to handicapped individuals, to establish special responsibilities in the secretary of health, education, and welfare for coordination of all programs with respect to handicapped individuals within the department of health, education, and welfare, and for other purposes.

Cultural Competency

Cultural Competence is the ability to effectively work with individuals from other cultures, contains congruent behaviors, attitudes, and policies, produces mindful adaptation of services to support client in his/her cultural context, and promotes better outcomes for clients. Providers are encouraged to make adaptations to service delivery or model, be courteous and respectful of differences, modify family involvement expectations, be mindful of practices when scheduling services, accommodate language barriers, and maintain compliance with ethical guidelines.

Professionalism

Unprofessional behavior by staff members or contracted provider agency staff, whether manifested actively or passively, can adversely affect individual care.

Staff that are determined to have exhibited unprofessional behavior can be subject to an investigation which can lead to corrective actions and/or evaluation of the continuation of the provider agency's contract.

Staff refers to all persons, including ADMH staff, contracted provider staff and any personnel at DMH facilities, whether by employment or through contract.

Acceptable behavior is behavior that is honest, courteous, fosters a culture of excellence, maintains morale and contributes to staff retention with the ultimate goal of safe and effective patient care. Inappropriate behavior means conduct that is unwarranted and is reasonably interpreted to be demeaning, offensive and/or counterproductive.

For the purposes of this policy inappropriate behavior triggers an action limited to education/counseling by the supervisor/designee. However, persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior".

Examples of inappropriate behavior include, but are not limited to, the following:
- Belittling or berating statements.
- Name calling.
- Deliberate lack of cooperation without good cause.
- Intentionally degrading or demeaning comments regarding individuals and their families or other support staff.

Disruptive behavior is a style of verbal or non-verbal interaction manifested actively or passively with other staff members, family members or patients that directly, indirectly or potentially interferes with patient care. Disruptive behavior includes conduct that interferes with one's ability to work with other members of the treatment care team. Disruptive behavior can require the initiation of an investigation which can lead to progressive disciplinary actions and/or evaluation of the continuation of the provider agency's contract.

Examples of disruptive behavior include, but are not limited to, the following:
- Physically threatening language directed at anyone;
- Physical contact with another individual that is threatening or intimidating.
- Throwing instruments, charts or other things.
- Threats of violence or retribution.

• Sexual harassment
• Other forms of harassment including, but not limited to, persistent inappropriate behavior.

Boundaries and Dual Relationships

ADMH Autism Services is committed to creating a safe, respectful environment that is focused on the needs of the client. Relationships with ADMH Autism Services staff and contracted provider agency staff is intended to set limits and clearly define a safe, therapeutic connection, putting the needs of the client first. Professional boundaries shall be maintained at all times between clients, ADMH Autism Services staff and contracted provider staff.

Dual relationships develop when a provider has a second relationship with his or her client outside the traditional provider-client relationship.

Providers are encouraged to take precaution and establish boundaries when these types of relationships arise when delivering services.

Providers should consult with other professionals such as a supervisor and educate themselves on ways to navigate or avoid entering these types of relationships. Although there are clear and valid concerns (exploitation, preferential treatment, victimization, negative side effects, undo expectations for provider, and possible legal action), dual relationships are not inherently bad, can be successfully navigated when unavoidable, and may even increase trust and therapeutic relationship building.

- **Social dual relationship**—the therapist is also a friend
- **Professional dual relationship**—the therapist doubles as someone's work colleague or collaborator
- **Business dual relationship**—the therapist is also involved with someone in a business capacity
- **Communal dual relationship**—both therapist and client are members of a small community will likely run into each other or be involved in the same activities outside of the office
- **Institutional dual relationship**—the therapist serves as counselor and other roles within a particular institution, such as a prison, hospital, or in the military
- **Forensic dual relationship**—the therapist is a counselor as well as a witness in legal trials or hearings involving his or her client
- **Supervisory dual relationship**—the therapist is also responsible for overseeing and supervising the client's development as a professional therapist, as often occurs in educational settings
- **Digital, online, or Internet dual relationship**—the therapist is connected with the client on social media sites such as Facebook, Twitter, and LinkedIn
- **Sexual dual relationship**—the therapist and client are engaged in a sexual relationship

System of Care Principles

ADMH Autism Services operates as a "System of Care". A "System of Care" is a spectrum of effective, community-based services and supports for children/youth and their families with or at risk for mental health or other challenges. Services and supports are organized into a coordinated network that build meaningful partnerships and address cultural and linguistic needs. The focus is to help affected children/youth function better at home, in school, in the community, and throughout life.

Core Values include:

- **Family Driven and Youth Guided** - Strengths and needs of child, family determine type and mix of services and supports
- **Community-based** - Locus of services and system management within a supportive and adaptive infrastructure of processes and relationships at community level
- **Competent agencies and services reflect cultural, racial, ethnic and linguistic differences of those served** - Facilitates access to and use of appropriate supports

Twelve Guiding Principles include:

1. Ensure availability and access to broad, flexible array of effective, evidenced-informed, and community-based services/supports that address physical, emotional, social, and educational needs
2. Provide individualized services based on potential and needs, guided by strengths-based wraparound planning, with child and family as partners in development
3. Deliver services and supports in least restrictive and most-normative clinically appropriate environment
4. Ensure child and family are full partners in planning and delivery of services, to include policies and procedures that govern care for all in their communities
5. Ensure cross-system collaboration (to include agencies, programs, funding sources, and administration) to support system-level management, coordination, and integrated care
6. Provide care management to ensure multiple services are delivered in a coordinated and therapeutic manner that allows movement through the system with changing needs
7. Provide developmentally appropriate mental health services/supports that promote optimal social and emotional outcomes in the home and community
8. Provide developmentally appropriate services/supports to facilitate transition to adulthood and adult-service system
9. Utilize mental health promotion, prevention, early identification and intervention to improve long-term outcomes, specifically activities for youth/adolescents
10. Incorporate continuous accountability measures to track, monitor, and manage system's meeting care goals and fidelity to philosophy, as well as quality, effectiveness, and outcomes at every level
11. Protect the rights of and promote effective advocacy efforts for children, youth, and families
12. Provide non-discriminatory services that are sensitive and responsive to such differences (e.g. race, gender expression, SES, geography, religion, language)

Ten Principles of Wraparound include:

1. **Family and Youth Voice and Choice**
   Family and youth perspectives are encouraged and prioritized during all phases of the service planning process. Planning is based upon the family members' perspectives, and the team strives to provide options and choices so that the plan reflects family values and preferences.
2. **Team Based**
   The team consists of individuals chosen by the youth and family. These individuals can come from a formal network such as service providers, as well as informal team members including family, friends and community relationships.
3. **Natural Supports**
   The youth, family and other team members actively seek out and encourage the full participation of individuals chosen from the informal network to be a part of the youth and family's natural support system, such as family, friends and community relationships. These natural supports are fully involved in the activities and interventions of the plan, as it pertains to the tasks they are

able to help with. The relationship between the youth and family and their natural supports must be reciprocal.

4. **Collaboration**
   Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single plan. The plan reflects a blending of the perspectives, mandates and resources of the team members. The plan guides and coordinates the work of each team member as all work towards achieving the goals set by the youth and family.
5. **Community-based**
   The team seeks to implement services and supportive strategies in the most inclusive and most accessible settings. The team will work to maintain the youth in the least restrictive setting possible, promoting the safe integration of the youth into family, home and community life.
6. **Culturally Competent**
   The planning process demonstrates respect for the values, preferences, beliefs, culture and identity of the youth and family. The plan is built upon the lifestyle of the youth and family, reflects their strengths and includes activities that make sense and are attainable.
7. **Individualized**
   To achieve the goals in the plan, the team develops and implements a set of strategies, supports and services specifically geared to the youth and family.
8. **Strengths Based**
   The planning process and plan is built upon, and enhances the capabilities, knowledge, skills and assets of the youth and family, their community and other team members.
9. **Persistence / Unconditional Care**
   Despite challenges and possible setbacks, the team persists in working toward the goals included in the plan until the team reaches an agreement that a formal planning process is no longer required. Giving up is not an option.
10. **Outcome Based**
    The team connects the goals and strategies of the plan to indicators of success that can be observed and measured. The team monitors progress and revises the plan accordingly.

Client Eligibility, Rights and Responsibilities

Client Eligibility

Individuals enrolled into ADMH Autism Services can meet eligibility criteria within one of two Target Groups: Target 3 (Disabled Children) or Target 10 (Disabled Children with ASD).

Individuals will be enrolled in either Target Group to receive intensive care coordination and will be assigned an intensive care coordinator accordingly.

Diagnostic and Assessments

Per Alabama Medicaid, ADMH can only accept an autism diagnosis provided by a licensed clinical psychologist or a licensed physician. A provisional diagnosis cannot be accepted.

Licensed physicians will be expected to fully complete the Autism Diagnostic Tool for Healthcare Providers. This tool walks physicians through the DSM-5 diagnostic criteria for Autism Spectrum Disorder, to include considering rule out considerations, previous testing/assessments, and confirmation that the diagnosis is not better explained by another condition. A signature by the licensed physician or licensed clinical psychologist is also required on the tool.

Psychological reports are accepted from licensed clinical psychologists, which should include assessment and testing observations and results, rule-out considerations, and clinical diagnosis of Autism Spectrum Disorder per the DSM-5 criteria.

Admission Criteria

Child/youth between the ages of birth and twenty years old, has an autism spectrum disorder diagnosis, and is enrolled in Medicaid.

Child/youth that has more intensive needs that require multidisciplinary intervention and monitoring designed to address challenging behaviors and/or needs in the home and community settings.

Re-determination Criteria

The child/youth is continuing to make progress toward treatment goals and there is reasonable expectation of progress at this level of care and this level of care is required to prevent worsening of the child/youth's condition.

Exclusionary Criteria

- The needs identified in the referral to ICC does not meet admission criteria as stated above.
- The needs identified in the referral to ICC are not directly related to an ASD diagnosis.
- The person(s) with authority to consent to medical treatment for the child/youth does not voluntarily consent to participate in ICC.
- The child/youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of the referral and is unable to return to a family home environment or community setting with community-based supports.

Case management services are comprehensive services that assist eligible individuals in gaining access to needed medical, social, educational and other services. Targeted Case Management (TCM) services assist specific eligible recipients, or targeted individuals, to access other services.

Medicaid recipients may receive TCM services in more than one Target Group, or case management services from another program if Medicaid determines this would not present a duplication of services.

Once individual is deemed eligible, the ICC will be assigned and expected to follow timeline shown in the "Service Descriptions: Intensive Care Coordination" section.

Treatment care team meetings should evaluate goal progression, review assessment results and re-determine eligibility annually to determine if client needs to be transitioned from one Target Group to the other or discharged from services.

Client Rights

1. Exercise one's rights as a U.S. citizen
2. Access a full array of appropriate services
3. Inclusion in the community
4. Live, work, learn, recreate alongside individuals without disabilities
5. Be presumed competent until adjudicated otherwise
6. Social interaction with individuals of both sexes
7. Vote and participate in political processes in accordance with state and federal laws
8. Exercise religion freely
9. Confidentiality of medical, legal, financial, and personal documents and records
10. Possess and own property, real and personal
11. Privacy and dignity
12. Privacy of and reasonable access to communications, visitors, mail, and calls
13. Receive only prescribed medications, drugs, and treatments in accordance with established medical standards of care
14. Use of restraints, physical or chemical, only in accordance with established medical, educational, and social standards of care and taking into account the health and safety of the individual
15. Free and appropriate education as mandated by state and federal laws
16. Freedom from neglect, abuse, or exploitation
17. Make decisions affecting one's own life
18. Access general community and neighborhood services
19. Use of services in safe and humane environments
20. Consistently receive human respect and dignity as an individual
21. Exercise all rights without retaliation or punishment
22. Access medical (to include hearing services), dental, and vision care
23. Freedom from any physical, sexual, or psychological abuse, exploitation, coercion, reprisal, intimidation, or neglect
24. Being fully informed about services, as an individual by way of appropriate language, means, and setting to ensure understanding of information
25. Be informed on how to access advocacy services, ombudsmen, and rights protection services at the program/provider, ADMH, DHR, and federal levels without fear of accessing such services
26. Adequate food and shelter in residency programs run or certified by state regulatory agencies
27. Enforce the aforementioned and other protected rights of individuals through appropriate administrative hearings, to include a competent court of law

Client and Family Responsibilities

1. Comply with all rules and regulations of Medicaid and ADMH Autism Services
2. Complete assessments, documentation, surveys, etc. in a timely manner
3. Attend collaboratively scheduled appointments
4. Actively participate in planning and service activities
5. Engage in open communication
6. Mutually respect service and support staff
7. Notify ICC of any changes to Medicaid, contact information, medication, or treatment, outside of services or supports, and legal matters (custody, conservatorship, advance directives, etc.) Comply with requirements and recommendations in the Client and Family Handbook.
8. Clients/families are allowed no more than three unexcused absences or no-shows within 6 months
9. After five absences (in 6-month period) due to sickness, documentation from a healthcare provider is required.
10. After five absences, the ICC should make a phone call to the individual and send letter to them to determine reasoning of absence.
11. If no response, the ICC and treatment team will meet to discuss possibly terminating services.
12. Client and families are expected to respond in a timely manner to correspondence and be available for scheduled visits. Failure to respond could delay services.

Self-Determination

Self-determination gives individuals with disabilities the opportunities and rights as all people. Founding principles include freedom of choice, authority over self and life, respectful support, responsibility to others, and confirmation of others. Self-determination gives individuals with disabilities the right to make one's on choices and decisions based on his or her preferences and interests, self-monitor and regulate, direct service and support utilization, obtain needed services, choose goals and work toward them in a self-directed manner, participate in and contribute to one's community, and act and advocate on one's own behalf.

Due Process

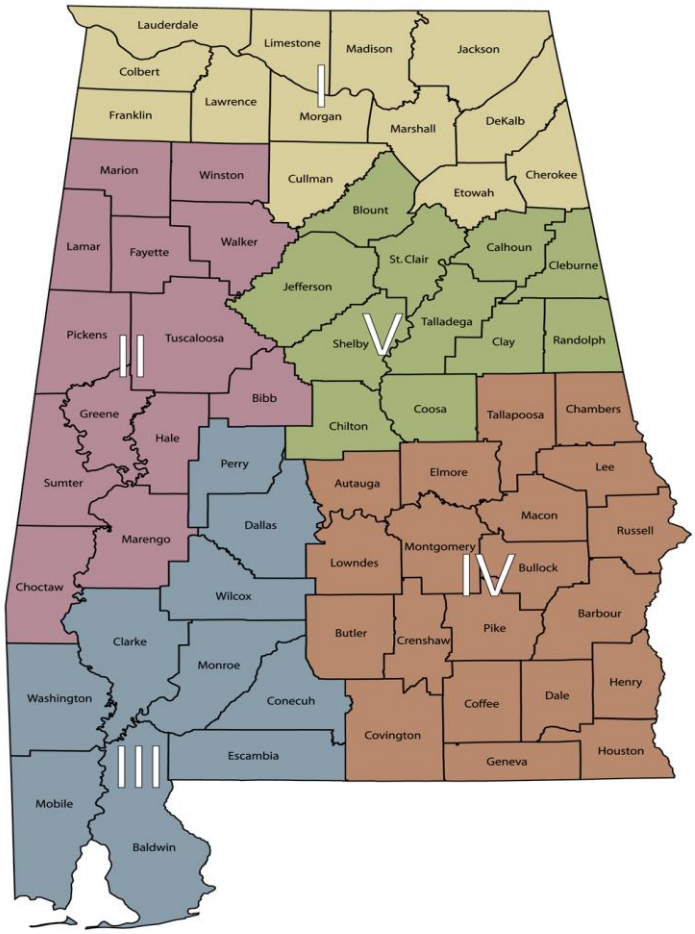
Due Process is a course of proceedings, not necessarily legal proceedings, carried out in accordance with established rules and regulations for safeguarding a person's rights.

Recipients and their responsible party will be provided specific information prior to a right being restricted, or as soon as possible thereafter, and will be advised of the process involved, and shall also be informed of what the recipient can do to have the right restored. Recipients and others acting on their behalf will have the right to file a complaint concerning the restriction of a recipient's rights. The recipient's ability to exercise a right will be based upon the individual needs, skills, and abilities of the recipient as determined by the treatment care team.

When a right has been restricted, the treatment care team shall review and document, at least quarterly, the continuing need for the restriction. Treatment or care deemed appropriate by the treatment care team for removal of the restriction shall also be provided. A

recipient's rights will be restored when the team determines that criteria has been met to justify restoration and this will be documented in the individual's record.

Department of Mental Health
Autism Services



Region I Autism Services - Kelly Goff, Regional Autism Coordinator
Region II Autism Services - Andrea McCoy, Regional Autism Coordinator
Region III Autism Services -Santedra Jackson, Regional Autism Coordinator
Region IV Autism Services -, Mashanna Starks, Regional Autism Coordinator
Region V Autism Services - Cody Farmer, Regional Autism Coordinator

ADMH and Community Contacts

ADMH Autism Services	www.mh.alabama.gov	1-800-499-1816
Autism Society of Alabama	www.autism-alabama.org	877-4-AUTISM
Autism Resource Foundation	www.theautismresourcefoundation.org	256-975-0411
Making Connections ASD Networking group	www.makingconnectionsasd.org	256-541-1542
Alabama Lifespan Respite		866-RESTALA
DHR BCBA Services	Sabrina.franks@dhr.alabama.gov	
Emotional Distress		988
Safety Net Campaign	www.projectlifesaver.org	877-580-LIFE
Alabama Disability Advocacy Program (ADAP)	www.adap.ua.edu	205-348-4928
Help Me Grow		211

Autism ID Card – County Health Department form and directions available on Autism Society of Alabama https://www.autism-alabama.org/navigatingautism/

Regional Autism Network

Region I – University of Alabama in Huntsville	uahran@uah.edu	256-824-5700
Region II – University of Alabama	ua-ran@ua.edu	205-348-3131
Region III – University of South Alabama	usaran@health.southalabama.edu	251-410-4533
Region IV – Auburn University	auran@auburn.edu	334-844-2004
Region V – University of Alabama at Birmingham	uabran@uab.edu	205-934-1112

Commonly Used ADMH Acronyms and Abbreviations

ADA	Americans with Disabilities Act
ADAP	Alabama Disabilities Advocacy Program
ADMH	Alabama Department of Mental Health
ADRS	Alabama Department of Rehabilitation Services
ALSDE	Alabama State Department of Education
AMA	Alabama Medicaid Agency
ASA	Autism Society of Alabama
ASD	Autism Spectrum Disorder
BCBA	Board Certified Behavior Analyst
CANS	Child and Adolescent Needs and Strengths
CASS	Certified Autism Support Specialist
CTCM	Contracted Targeted Case Management
DHR	Department of Human Resources
DSM	Diagnostic and Statistical Manual
DYS	Department of Youth Services
FERPA	Family Educational Rights and Privacy Act
GER	General Event Report
HCBS	Home and Community Based Settings
HIPAA	Health Insurance Portability and Accountability Act
I/DD	Intellectual and/or developmental disability
ICC/TCM	Intensive Care Coordinator/Targeted Case Management
ICD	International Statistical Classification of Diseases and Related Health Problems
IDEA	Individuals with Disabilities Education Act
IDF	Individual Data Form
IEP	Individualized Education Plan
ISP	Individualized Support Plan
MHSA	Mental Health Substance Abuse
PASS	Professional Autism Services Specialist
PHI	Protected Health Information
RAC	Regional Autism Coordinator
RAN	Regional Autism Network
RBT	Registered Behavior Technicians
ROI	Release of Information
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness

Language Interpretive Services

Language Interpretative Services are available through Propio. Attached are the instructions on how to access and some general information:

Language Interpretative Services are available through Propio. Attached are the instructions on how to access and some general information:

Name AL Dept of MH Contracted Providers
Client ID: Code 11934
Client ID only needed with pre-scheduled calls or to confirm your account

1. To access Interpreter, dial: 205-851-1118
2. Select target language
3. Provide required information:
- Region/location
- Caller first and last name and spelling
- Name of Client and birthdate
- Name/relationship to client person being called

Back-up Service Line: 1-866-386-1284
To be used if primary number is unavailable

Client Support Line: 1-888-528-6692

propio

Complete language list at:
LanguageCodes.info

Top Language Auto Attendant	
Spanish	1
Arabic	2
French	3
Nepali	4
Somali	5
Kinyarwanda	6
Swahili	7
All Other Languages	8

Telephonic Interpreting Services

AL Dept of MH Contracted Providers
Audio and Video Remote Interpreting

propio ONE

1. Launch the Propio ONE app: ONE
   Or
   Launch the desktop browser/PC (Chrome):
   https://one.propio-ls.com/

2. Log in — Enter User Code: Code hkXXVQ
   Click LOG IN

3. Language — Search for or scroll to the language.
   Click the audio icon to connect to an audio only interpreter.
   Click the video icon to connect to a video interpreter.

Be prepared to provide billing information as requested by your internal management.

Appendix

Alabama Department of Mental Health

Autism Services

CHANGE OF STAFF FORM

This form is only required when staff is leaving your agency and is an approved performing provider of Autism Services.

Staff Name:

_____

Effective Date:

_____

X _____

Print Supervisor NameSupervisor Signature

Therap Help and Support

Therap is happy to be working with providers in Alabama! The Department of Mental Health Office of Autism Services has mandated the use of Therap for documentation throughout the State of Alabama.

Please see the **ADMH-Autism Incident Mapping Document** for instructions on how to complete a General Event Report in Therap in line with state standards.

Support Home Page: https://support.therapservices.net/

- **Provider Admin Resources**
- **Training Videos**
- **Recorded Webinars**
- **Conference Information**

Alabama Autism State Page: https://help.therapservices.net/app/alabama-autism-providers

- **Alabama Autism State Page**
- **Rehabilitation Providers User Guides**
- **TCM Providers User Guides**
- **Applications and Features**
- **Admin Password Reset Request**
- **Therap Team**
- **System Workflow**

For any additional assistance or support, please contact alsupport@therapservices.net.