State of Alaska
Department of Health and Social Services

Community-Based Youth Residential Behavioral Health Services Review Provider Manual

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SECTION 1: QUALIS HEALTH CARE MANAGEMENT PROGRAM OVERVIEW

Organizational Overview

Qualis Health's mission is to generate, apply, and disseminate knowledge to improve the quality of healthcare delivery and health outcomes. In executing Qualis Health's mission and striving toward Qualis Health's vision to be recognized for leadership, innovation, and excellence in improving the health of individuals and populations, Qualis Health is guided by the following set of core values:

- **Integrity and professionalism:** Qualis Health performs its work in an objective and unbiased manner and interacts with providers, Medicaid recipients, and program stakeholders in a respectful and professional manner. Qualis Health's employees receive comprehensive training and continuing education to ensure they are highly skilled and knowledgeable, and Qualis Health monitors their own performance as Qualis Health strives to assure accuracy and high technical quality in the review services Qualis Health provides.
- **Collaboration:** Qualis Health promotes collaborative relationships, both internally and externally. Qualis Health values diversity of opinion, background, and perspectives among Qualis Health's employees, clients, and collaborators. Qualis Health follows established processes and procedures that promote both collaboration and quality in the provision of review services, and Qualis Health collects and reports on relevant review data that can be used to identify opportunities to improve the delivery of healthcare and patient outcomes.
- **Stewardship:** Qualis Health conducts work knowing that the primary objective of clients is to maximize healthcare value by assuring high quality and cost effectiveness. Qualis Health seeks to apply technical and professional innovations that assist us in serving as good stewards of healthcare resources.

Purpose of Care Management

The purpose of Qualis Health's Care Management program for the State of Alaska Department of Health and Social Services is to provide utilization review and care coordination services. Qualis Health's services help ensure appropriate medical services are provided to Alaska Medicaid recipients at a reasonable cost and in accordance with state and federal regulations, statutes, and policies. Qualis Health has been providing care management services for Alaska Medicaid for more than 20 years.

Definition of Utilization Management

Qualis Health's care management programs use the following definition for utilization management (UM):

> Evaluation of the medical necessity, appropriateness, and efficiency in the use of behavioral healthcare services under the provisions of the applicable health benefits plan; evaluations are also known as "utilization review."

Utilization Management works to ensure:

- Appropriate use of behavioral healthcare services
- Efficiency or cost-effectiveness
- Quality of care

History of Medicaid Utilization Review and the Quality Improvement Organization (QIO) Program in Alaska

Medicaid, an entitlement program created by the federal government, is the primary program financing basic health and long-term care services for low-income Alaskans. The Alaska Department of Health and Social Services maintains the Medicaid core services for the State of Alaska. The Alaska Medicaid program provides both mandatory prior authorization review and optional care coordination facilitation services. Eligibility for Medicaid services is determined by medical necessity and the eligibility category of the recipient.

The federal government has expended significant dollars in developing and supporting the utilization review of inpatient hospital care. This type of review has been required by law for Medicare and state Medicaid programs since 1972.

Alaska Department of Health and Social Services has historically contracted with a peer review organization (PRO)—now called a quality improvement organization (QIO)—to review selected inpatient admissions for medical necessity and appropriateness. A QIO is an organization that meets federal requirements for utilization and quality control review and holds a Medicare contract with the Centers for Medicare & Medicaid Services (CMS).

Qualis Health, the CMS Medicare QIO for the state of Washington, has been an Alaska Medicaid contractor since 1985, performing utilization reviews and prior authorization services. Reviews are performed on admission, concurrent continued stay, or retrospective basis.

Qualis Health's Background and Experience

Qualis Health is a private, nonprofit healthcare QIO with 40 years of experience in providing utilization review, case management, and quality improvement services. Qualis Health is based in Seattle, Washington. Qualis Health also has regional offices in Birmingham, Alabama; Anchorage, Alaska; Irvine, California; Washington, DC; Boise, Idaho; Topeka, Kansas; and Albuquerque, New Mexico.

Established in 1974, Qualis Health started out as a professional standards review organization (PSRO) for Medicare in the state of Washington. As a PSRO for the first legislated Medicare quality review program, Qualis Health conducted retrospective

reviews of hospitalizations to determine whether they were medically necessary. Qualis Health's Medicare review activities expanded to Alaska in 1984.

Qualis Health began offering utilization review services to the Medicaid population in Washington State in 1975. In 1985, Qualis Health was awarded the utilization review contract with Alaska Medicaid. Qualis Health currently serves as a Medicaid contractor in Alabama, Alaska, the District of Columbia, Kansas, New Mexico, Washington, and Wyoming.

Qualis Health started offering utilization review services to private industry in 1979. Qualis Health has been a presence in the private-sector market in Alaska since 1984, when the first care management client was added.

Today, Qualis Health continues to serve all three sectors—Medicare, Medicaid, and private industry. Because Qualis Health is a third party that is not affiliated with any provider organizations nor with the insurance industry, the organization is able to objectively evaluate the medical necessity and quality of healthcare provided to the clients served.

For Medicaid and private-sector customers, Qualis Health offers a range of programs designed to control healthcare costs while improving the quality of healthcare delivered to consumers. These programs include traditional utilization management services, including psychiatric review services, such as pre-service admissions, concurrent, retrospective chart, and retrospective telephonic reviews; coding validation; and medical consultation.

In the late 1980s, Qualis Health launched nurse case management services for Medicaid and the private sector. Qualis Health's Medicaid case managers work with patients who have catastrophic illnesses and injuries. They also work with these patients' families, providers, physicians, and Alaska Medicaid to promote the right care at the right time and in the right setting. Qualis Health's case management program is nationally recognized for excellence and superior results.

Qualis Health's offices in Seattle and Anchorage have full accreditation from URAC for their Health Utilization Management and Case Management programs, demonstrating compliance with the highest industry standards for pre-service, concurrent, and retrospective reviews, and case management services. The URAC accreditation for Health Utilization Management assures providers, physicians, and patients that the review processes Qualis Health follows are fair and impartial, and that URAC standards for review timeframes, reviewer qualifications, appeal procedures, and confidentiality of information are met, thus resulting in high-quality services and objective review decisions.

Qualis Health's Professional Expertise

More than 200 Qualis Health professionals, including department leaders, medical directors, clinical reviewers, case managers, care coordinators, quality improvement specialists, biostatisticians, communications specialists, information technology specialists, and administrative support staff, work hard to serve the needs of various clients. In addition, Qualis Health has an extensive network of more than 300 physicians who serve as consultants to the organization and provide collaborative clinical peer review services. The network includes physicians representing all 24 of the specialty boards recognized by the American Board of Medical Specialties as well as dentists, chiropractors, naturopaths, and other complementary and alternative medicine practitioners.

Qualis Health's employees have well-established relationships with facilities and health plans, allowing for effective collaboration in healthcare evaluation and improvement. As part of a continuing effort to work in cooperation with the community, Qualis Health is actively pursuing new provider and physician partnerships.

SECTION 2: COMMUNICATIONS WITH QUALIS HEALTH

Introduction

Qualis Health's review process is flexible and is set up to handle review requests received via the internet, telephone, fax, and mail. Qualis Health offers secure web-based review capability using the internet to create a two-way link that can be used to exchange care management data, thus facilitating real-time, online approvals. This is the preferred method of review submission and provides immediate feedback regarding your review. Qualis Health also maintains toll-free, dedicated phone and fax numbers for Medicaid providers to use to request review services.

Qualis Health's regular business hours are 8:00 am to 5:00 pm Alaska Time, Monday through Friday, excluding scheduled holidays. (See Appendix F.) Qualis Health staff members are available to handle telephonic review requests received from 8:00 am to 5:00 pm on regular business days.

Contacting Qualis Health via the Internet

The Qualis Health Provider Portal (QHPP) is Qualis Health's web-based review system. Providers submitting web-based review requests will need to obtain a user ID and password to log in and access the QHPP. Trained providers can log in and directly enter information for their review request.

For more information, or to learn how to use the QHPP, please visit http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources.

For additional assistance, contact Qualis Health at (877) 200-9046, (907) 550-7620, or akbehavioralhealth@qualishealth.org.

Contacting Qualis Health by Mail

Requests for authorization may be submitted on the web via the QHPP (preferred method), fax, phone, or mail.

Requests submitted by mail to Qualis Health's Anchorage office should be sent to:

Qualis Health
Attn: AKBH Utilization Review Department
PO Box 243609
Anchorage, AK 99524-3609

Contacting Qualis Health by Phone

To reach Qualis Health's telephonic review services, call (877) 200-9046 (toll-free in Alaska) or (907) 550-7620 (locally in Anchorage). In the event your call is after business hours or an attendant is not available, your call will be directed to Qualis Health's 24-hour voice mail system.

During regular business hours, Qualis Health monitors the voice mail system, checking messages and ensuring callbacks are handled in a timely manner. Messages left after 5:00 pm on weekdays, on weekends, or on holidays are retrieved on the next business day and calls are returned by 11:00 am Alaska Time.

Contacting Qualis Health by Fax

Providers may send a fax to Qualis Health at (877) 200-9047. (The preferred method of submitting a review is electronically via the QHPP.) Faxed submissions must be legible and include all required demographic and clinical information that is found on the questionnaire forms and fax coversheet. (See Exhibits 3 and 4.) Completed questionnaires can be faxed to (877) 200-9047.

A fax cover sheet with a confidentiality disclaimer is highly recommended.

The following are suggestions for submitting your fax:

- No bold font
- No italics
- No underlining
- No all caps
- If possible, no special characters, e.g., * or = (quotes are OK)
- Sans serif fonts
- Normal spacing (i.e., looks like a normal document not written in a column that takes up a horizontal third of the page)
- Typed is preferred over handwritten

Please answer all questions in as much detail as possible.

Qualis Health's Communication of Review Determinations

The QHPP offers immediate feedback from Qualis Health concerning the request for review—pended awaiting review, certified, pended for further review, or additional information required. For requests submitted through the QHPP, an internet-based notification of the final determination and certification number is posted for the provider. Providers using the QHPP for their request submissions will not need to wait for a phone call or for the transmission of a fax or mailed document to learn of the final determination.

For requests that are not submitted through the web-based review system, Qualis Health will communicate the determination and the Prior Authorization number (i.e., the certification number) to the provider via phone or fax. Qualis Health will send letter notifications for all non-certified reviews (adverse decisions) and partial denials within one business day after the determination is given. These notifications will be sent to the recipient and the facility within one business day of the date the decision is made. Notifications are available to the State of Alaska Division of Behavioral Health via Qualis Health's web-based system.

SECTION 3: COMPLIANCE WITH URAC'S UTILIZATION REVIEW STANDARDS

Frequently Asked Questions about Utilization Review Decisions

Qualis Health complies with URAC health utilization management (UM) standards when performing utilization reviews (UR). These standards provide a process for conducting a utilization review that is clinically sound and respects recipients' and providers' rights. URAC standards ensure that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process. Some frequently asked questions about the process of making utilization review decisions are answered in the following sections.

1. Who makes the utilization review decision?

URAC (formerly known as Utilization Review Accreditation Committee) Health Utilization Management Accreditation requires Qualis Health to use the following process to determine if a proposed medical treatment or service is medically necessary:

A licensed mental health professional reviews the clinical information provided using Alaska State Medicaid Program Medical Necessity Criteria and review protocols. If the clinical information provided does not meet current Alaska State Medicaid Program Medical Necessity Criteria and review protocols for residential and community-based services, or if, in the clinical reviewer's judgment, a physician should review the case, it is referred for this additional review.

2. What recourse is there when we disagree with a Qualis Health determination?

Qualis Health's written notice of non-certification decision contains instructions of initiating an appeal of the non-certification. Please see Section 11 for details on the appeal process. Your appeal letter will outline the steps that must be taken to request a second level of appeal with the State of Alaska Division of Behavioral Health.

3. How are review timelines determined?

The number of days allotted for each type of review for this Alaska Medicaid program is based on URAC Utilization Review Standards and on Alaska State Medicaid Program Medical Necessity Criteria and review protocols. Review timelines differ for different types of reviews.

When additional information is required to complete the review, the timeline is adjusted accordingly. When this occurs, it is the provider's responsibility to provide Qualis Health the additional information requested to complete the review. If the information is not received within 7 business days, the review will be completed with the information already received, putting the case at risk of a potential non-certification or technical denial.

In rare instances, Qualis Health may choose to exercise a single extension of up to 15 calendar days on non-urgent reviews when there are reasons beyond the control of the organization that require an extension. When this occurs, Qualis Health must inform the provider (by the date the notice the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision. All RBRS and Community-Based Residential Behavioral Health Service reviews are non-urgent reviews.

SECTION 4: HIPAA

Business Associate Standing

Qualis Health provides care management services on behalf of its clients and is considered a “Business Associate” of these clients under the Health Insurance Portability and Accountability Act (HIPAA) “Administrative Simplification” regulations governing patient health information. These regulations include the Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”) and the Security Standard (“Security Rule”).

National Provider Identification

Software program and web-based review system (Jiva) is currently accommodating Alaska Medicaid client and provider identification numbers in compliance with HIPAA. Covered entities under HIPAA are required to use National Provider Identifiers (NPIs) in standard transactions. Providers are responsible for obtaining their NPI from the National Provider System (NPS). The NPS is now contained within the National Plan and Provider Enumeration System (NPPES). This notice was published on May 30, 2007, in the Federal Register/Vol.72, No. 103, Pages 30011–30014, establishes the data that are available from the NPPES.

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SECTION 5: PROVIDER BILLING CONCERNS

Claim Discrepancies

Providers are encouraged to thoroughly examine discrepancies in claims for accuracy prior to contacting Qualis Health. The fiscal agent for the Alaska Department of Health and Social Services has a provider inquiry telephone line for this purpose. Providers may contact the fiscal agent at (800) 770-5650 (toll-free in Alaska) or (907) 644-6800.

Providers may call Qualis Health to investigate a discrepancy that has caused or has the potential to cause a claim to fail. Some examples of such discrepancies are as follows:

- The date(s) on the Qualis Health review does not match the certified admission or discharge date on the claim.
- Admitting or principal diagnosis codes on the Qualis Health review do not match the code(s) on the claim.
- Incorrect recipient Medicaid Identification number indicated on the Qualis Health review.
- The Prior Authorization number used for billing does not match the Prior Authorization number on the Qualis Health review. (**Note: Prior Authorization number must be noted on the claim.**)
- An amendment was attempted to be added to a current Service Authorization.

Contingency for Payment

Qualis Health certification indicates only that the service is medically necessary. **This certification (approval) does not guarantee payment for services rendered.** Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

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SECTION 6: ELIGIBILITY AND REVIEW LIMITS

Overview

The Alaska Medicaid Mental Health review program has been established to provide treatment providers a way to prior authorize medical necessity before or after services are rendered. The federal and state Medicaid program was established as a prior authorization system and is regulated by federal and state codes.

Provider Responsibility for Automated Voice Response

Providers are responsible for verifying recipient eligibility for prior authorization of admission or continued stay review. The following information is available to assist the provider in the Automated Voice Response process.

ID Cards

The Department of Health and Social Services, Division of Public Assistance, produces and distributes medical assistance identification cards. These verify that a recipient is eligible to receive services from the Alaska Department of Health and Social Services in a given month. Cards contain the eligible recipient's name, identification number, date of birth, eligibility month and year, and eligibility code. Please note that the Resource Code on the ID card will indicate if the recipient has a payment source in addition to Medicaid. Refer to your Provider's billing manual from Xerox, the State's fiscal agent, for further clarification.

Automated Voice Response System (AVRS)

The State's fiscal agent provides and maintains the Automated Voice Response System (AVRS) to help providers determine the eligibility of the recipients. The AVRS may be accessed by calling (800) 884-3223 7 days a week, 24 hours a day. Providers may receive Automated Voice Response by contacting the fiscal agent at (800) 770-5650 (toll-free in Alaska) or (907) 644-6800.

Review Limits

All services provided above and beyond the service limits will need to be approved in order to be reimbursed by Alaska's Medicaid Program.

There are limits to the scope of reviews that Qualis Health is authorized to perform in the Alaska State Medicaid Program:

1. No reviews are authorized for recipients over the age of 21, unless the recipient is already receiving treatment in the treating facility when the recipient turns 21 years old. When this is the case, coverage is available until the recipient's 22nd birthday.
2. No amendments will be allowed to service authorization.
3. Reviews must be completed within 12 months of services being delivered or 12 months after eligibility is established.

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SECTION 7: PROCESSES FOR SERVICE AUTHORIZATION REVIEW SUBMISSIONS

Purpose

Qualis Health has adopted a browser-based product that uses the internet to create a two-way link between healthcare providers and Qualis Health Utilization Management/Mental Health Review to facilitate the service authorization review process. Providers access this link via the Qualis Health Provider Portal (QHPP). The QHPP allows providers to submit service authorization requests to Qualis Health using a secure internet connection and is available to the provider 24 hours a day, seven days a week. Service Authorizations submitted during non-office hours will be processed as received on the next business day. (See Appendix G.)

Responsibility

Providers are responsible for submitting all Service Authorization requests as required by Alaska State Medicaid Program Medical Necessity Criteria and review protocols. Providers are responsible for submitting all requests for additional services through service authorizations to Qualis Health in a timely manner as required by the Alaska Department of Health and Social Services. Providers are also responsible for submitting service authorizations to Qualis Health for recipients who are covered by other Third Party Liability (TPL) resources for admission and continued stay if utilizing Alaska Medicaid as a form of reimbursement.

Requirements

Use of the QHPP requires internet access and establishment of provider logon information for each user. Training is conducted by Qualis Health via WebEx sessions. If you are interested in receiving training, please see Qualis Health's website at http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-education.

You may also contact Qualis Health by calling (800) 949-7536 ext. 2800 or by emailing akbehavioralhealth@qualishealth.org.

Process and Procedures

Submission

Once you have received QHPP training from Qualis Health, submit your review requests via the internet 24 hours per day at the following web address: https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin.

Operational hours for Qualis Health Alaska Medicaid Behavioral Health service authorizations are 8:00 am to 5:00 pm Alaska Time, Monday through Friday, except for designated holidays. (See Appendix F.)

Submission Methods

Qualis Health will accept review requests submitted by providers over the internet (preferred method), or via telephone, fax, or mail.

Submission Mode	Description
Internet (Qualis Health Provider Portal [QHPP])	**Internet is the preferred method of review.** Providers log in to the QHPP and directly enter information for review request. Contact akbehavioralhealth@qualishealth.org for information about signing up for the QHPP. Once you have your user ID and password, you can log in to the QHPP at https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin.
Fax	Providers may request reviews by faxing the request to Qualis Health's toll-free fax number, (877) 200-9047. Include a cover sheet regarding confidentiality and your admission information from the medical record.
Phone	Providers may request reviews by calling Qualis Health at (877) 200-9046 (toll-free) or (907) 550-7620. Providers who call after hours or on holidays or weekends will be prompted to leave a message or call back on the next business day.
Mail	Mail requests to Qualis Health's Anchorage office. Qualis Health Attn: Utilization Review Department PO Box 243609 Anchorage, AK 99524-3609

Calls to the above phone numbers will connect to a Qualis Health representative. In the event that no one is immediately available, callers may leave a message in the confidential voice mail system. Instructions are clearly stated for accessing the electronic voice mailboxes, which are monitored so that calls may be returned in a timely and efficient manner.

Required Service Authorization Documentation

Provider will complete the questionnaire for all youth in residential settings including Residential Behavioral Rehabilitation Services, Clinic services and rehabilitations services. Use the most recent questionnaire to prepare for the questions that will be asked in the review process. Please see Exhibits 3 and 4 for the **Service Authorization Questionnaires**. Additional information listed in Sections 8 and 9 and Appendices E and H is also needed for each service authorization request.

Document the following information in the Communication (Notes) field:

- Contact name and phone number of the person providing the service authorization information
- Type of service authorization being submitted (e.g., RBRS, Clinic service, or rehabilitation services)
- Actual admit date and projected discharge date
- Verification of the recipient's Medicaid eligibility

Medical Necessity Screening

Once the information for the specific review period has been received, Qualis Health's clinical reviewer will assess the medical information using Alaska State Medicaid Program Medical Necessity Criteria and review protocols to determine whether the condition of the recipient meets the Severity of Illness and Intensity of Service requirements for the level of care and the type and number of days of services requested. If the Alaska State Medicaid Program Medical Necessity Criteria and review protocols are met, the Qualis Health clinical reviewer will issue a Prior Authorization number and the review will be certified. For additional information on medical necessity information required for determinations, see Appendices B, C and D.

Request for Additional Information

If the information on the initial form is insufficient, Qualis Health will request additional information based on the guidelines established by the Alaska Department of Health and Social Services and will send a pend service authorization notice requesting additional information via the QHPP or phone. The provider will have 7 working days to provide the additional documentation and will submit the requested information electronically. If the additional information is sufficient, a service authorization approval will be sent to provider. If the information is **not** sufficient or **not** provided, Qualis health will send a partial denial or denial notice. (See Exhibits 3 and 4.)

The Alaska Department of Health and Social Services will not reimburse providers for services that have been non-certified by Qualis Health or by a second-level provider appeal by the State.

Questionnaires

Questionnaires and checklists within the QHPP are associated with specific behavioral health medical necessity review requirements. Use the updated questionnaires for your review process. (See Exhibits 3 and 4.) Both questionnaires are also available online via https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin.

Questionnaire templates within the QHPP provide many selection drop-down lists that save time in the review process and do not require many client demographic elements, as the information is present in the system.

The QHPP user guide may be accessed at http://www.qualishealth.org/sites/default/files/QHPP-User-Guide.pdf.

Process and Procedures for Level 2–4 Inpatient Residential Care Beds (Daily Rate Beds)

Providers will submit Service Authorizations electronically to Qualis health. Providers will fill out the questionnaire with the requested information. This can be accomplished by utilizing the QHPP (preferred method), or by calling/faxing the toll-free number during normal business hours. A Qualis Health representative will review the detailed message that can be left on the electronic voice mail system. In order for Qualis Health to prioritize callbacks appropriately, the pertinent information must be given when leaving a message. This includes:

- Your name
- Your telephone number, including area code, beeper number, or extension
- Recipient name (with the correct spelling)
- Recipient ID number (Medicaid)
- Recipient date of birth
- Facility name

Leaving the information in the electronic voice mail system does not complete the review process nor does it automatically certify the review. All other requirements of the review process must also be completed. Qualis Health will return your call and assist you with completing the review process.

The care and treatment of the recipient should never be delayed in order to obtain Qualis Health certification.

Submit the service authorization (SA) for the days requested, but no more than 30 days for level 2 and 90 days for level 3–4.

Admission and Continued Stay Reviews Level 2

Level 2 reviews are submitted for 30-day timeframes. Enter the requested information into the QHPP. The requested information will include:

- Treatment plan date
- Dates requested for the SA
- Diagnosis codes using ICD-10 or the most current codes
- Medical necessity questions
    - Describe the symptoms related to an acute mental, behavioral or emotional disorder (e.g., depressed mood).
    - Describe any aggression to others or self-harm. Give dates and specific examples of occurrences in the past 30 days.
    - Describe how discharge would exacerbate a relapse or deterioration of the recipient’s condition or a safety risk if the recipient was to return home.
    - Discharge transition/plan. Give detailed information about provider of services when discharged.
    - Further description from the Psychological ICD-10 Diagnosis Code(s)

When travel is required to a level 2 facility, prior authorization with the fiscal agent will give a 7 days approval to allow for travel to occur. The following review will be for the additional 21 days of the review timeframe.

Admission Reviews Level 3–4

Level 3–4 reviews are submitted every 90 days. Enter the requested information into the QHPP. The requested information will include:

- Recipient custody status
- Treatment plan date
- Dates requested for the SA
- Diagnosis codes using ICD-10 or the most current codes
- Medical necessity questions
    - Describe the symptoms related to an acute mental, behavioral or emotional disorder (e.g., depressed mood).
    - Describe any aggression to others or self-harm. Give dates and specific examples of occurrences in the past 30 days. What time period did the aggression, SI or self-harm occur? Describe any inappropriate maladaptive sexual behavior and when they occurred.
    - Describe, if applicable, how the recipient is not able to maintain his/her activities of daily living.
    - If a co-occurring condition describes how the condition impacts the inability to be in a less restrictive level of care at this time.
    - Describe any destruction in the home, school or community within the last 6 months.
    - Describe how discharge would exacerbate a relapse or deterioration of the recipient's condition.
    - Discharge/transition plan (provide specific providers and services needed such a foster home, clinic services and who or what agency will be providing the services).
    - Further description from the Psychological ICD-10 Diagnosis Code(s)

Continued Stay (Concurrent) Reviews Level 3–4

Level 3–4 continued stay reviews are submitted every 90 days. Enter the requested information into the QHPP. The requested information will include:

- Recipient custody status
- Treatment plan date
- Dates requested for the SA
- Diagnosis codes using ICD-10 or the most current codes
- Medical necessity questions
    - Describe the recipient's maladaptive behavior within the last 6 weeks (provide specific dates and examples).

  - Describe the recipient's functional status within the last 6 weeks (provide specific behaviors and dates of behaviors).
  - Describe how discharge would exacerbate a relapse or deterioration of the youth's condition. (Why does the recipient need to stay in this level of care?)
  - Discharge/transition plan (provide specific providers and services needed such a foster home, clinic services and who or what agency will be providing the services).
  - Further description from the Psychological ICD-10 Diagnosis Code(s)

Clinic Services

The service limit for clinic services is 10 hours per fiscal year.

- 90832 Individual psychotherapy
- 90853 Group psychotherapy
- 90847 Family psychotherapy with recipient present
- 90846 Family psychotherapy without recipient present

Process and Procedures for Additional Behavioral Health Clinic Services

Clinic services may be requested for 90–135 days. The preference, if billing for residential beds, is to request clinic services every 90 days.

Clinic services include:

- Individual Psychotherapy
- Group Psychotherapy
- Family Psychotherapy with recipient present
- Family Psychotherapy without the recipient present

Enter the requested information into the QHPP as a Residential Group Home Services Review. The requested information will include:

- Treatment plan date
- Dates requested for the SA
- Diagnosis codes using ICD-10 or the most current codes
- Medical necessity questions
  - Maladaptive behaviors in the last 90–135 days
  - Functional status within the last 90–135 days
  - Reason recipient is unable to maintain without these services
  - Further description from the Psychological ICD-10 Diagnosis Code(s)

Process and Procedures for Level 3–4 Residential Community/ Fee-for-Service

Fee-for-service requests beyond the service limit can be requested for 90–135 days and are for the next treatment plan period.

Enter the requested information into the QHPP. The requested information will include:

- Custody Status of recipient
- Treatment plan date
- Dates requested for the SA
- Diagnosis codes using ICD-10 or the most current codes
- Initial review medical necessity questions
    - Describe the symptoms related to an acute mental, behavioral or emotional disorder (e.g., depressed mood).
    - Describe any aggression to others or self-harm. Give dates and specific examples of occurrences in the past 30 days. What time period did the aggression, SI or self-harm occur? Describe any inappropriate maladaptive sexual behaviors and when they occurred.
    - Describe, if applicable, how the recipient is not able to maintain his/her activities of daily living.
    - If a co-occurring condition describes how the condition impacts the inability to be in a less restrictive level of care at this time.
    - Describe any destruction in the home, school, or community within the last 6 months.
    - Describe how discharge would exacerbate a relapse or deterioration of the recipient's condition.
- Continued stay medical necessity questions
    - Describe the recipient's maladaptive behavior within the last 6 weeks (provide specific dates and examples).
    - Describe the recipient's functional status within the last 6 weeks (provide specific behaviors and dates of behaviors).
    - Describe how discharge would exacerbate a relapse or deterioration of the youth's condition. (Why does the recipient need to stay in this level of care?)
    - Discharge/transition plan (provide specific providers and services needed such a foster home, clinic services and who or what agency will be providing the services).
    - Further description from the Psychological ICD-10 Diagnosis Code(s)

If requesting more than 12 hours per day, enter the following information into the QHPP:

- Summary of the most current assessment detailing the needs of the recipient receiving services
- Most current treatment plan goals and objectives which support the service request for over 12 hours per day to address the identified treatment needs
- Summary of 5 progress notes documenting the services that are to be provided to or on the behalf of the recipient. These are the progress notes of RSS or Therapeutic behavioral health services that support the request for over 12 hours per day.

This additional information should describe:

- How recent the behaviors were. List the specific behaviors being exhibited. (See example in Exhibit 5.)
- Whether or not these behaviors are continuing

Service Limits for Rehabilitation Services

See Exhibit 2 for list of services and limits.

Chart Requests

Qualis Health may request the chart of a recipient to verify quality of care or accuracy of the information provided. The chart request may be made telephonically, through the QHPP, or in writing.

SECTION 8: SERVICE AUTHORIZATIONS

Purpose

The purpose of a service authorization review is to determine if the services are medically necessary and appropriate. The Alaska Medicaid Behavioral Health review program has been established to provide treatment providers a way to authorize services rendered. The federal and state Medicaid program was established as a service authorization system and is regulated by federal and state codes. Providers are required to submit reviews in a timely manner.

Responsibility

Providers are responsible for obtaining the service authorization review from Qualis Health. Qualis Health will accept information for service authorizations from providers providing the services. The clinical reviewer will receive all of the relevant clinical information to satisfy Alaska State Medicaid Program Medical Necessity Criteria and review protocols before the service authorization review will be authorized.

Requirements

All services, including the daily rate, rehabilitation services, clinic services and those provided over the service limit, require a service authorization by Qualis Health in order to be reimbursed by Alaska Department of Health and Social Services.

The service authorization must document the medical necessity for daily rate, rehabilitation services, clinic services and those provided over the service limit.

The provider may submit the service authorization review request to Qualis Health via the QHPP (preferred method), phone, fax, or mail. (See Sections 7 and 8.)

Information Needed for the Review

Qualis Health representatives will collect all information required for clinical reviews. Please see Exhibits 3 and 4 for the service authorization questionnaires.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (ICD-10 code)
- Facility name, address and phone number
- Facility Medicaid provider number
- Type of review requested
- Admit date
- Living situation
- Anticipated discharge date

Timeframes for Submission of Service Authorization Reviews

Reviews must be completed within 12 months of services being delivered or 12 months after eligibility is established.

Timeframes for Pended Reviews

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via web-based review system and/or phone. The provider has no more than 7 business days to submit the requested information before Qualis Health will proceed with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review.

Medical Necessity Review Process

During the service authorization review, Qualis Health's clinical reviewer will review the service authorization request and evaluate the medical necessity. If the Alaska State Medicaid Program Medical Necessity Criteria and review protocols are met, the Qualis Health clinical reviewer will issue a Service Authorization number and approval notice via the QHPP. The review will be certified (authorized for payment) and approval transferred to the fiscal agent.

SECTION 9: CONTINUED STAY (CONCURRENT) UTILIZATION REVIEWS

Purpose

The purpose of the continued stay review process is to evaluate whether the patient requires an extension of services and meets medical necessity. During the continued stay review, the Qualis Health clinical reviewer evaluates what services have already been provided to the patient and the plan for continuing treatment. Providers should submit reviews in a timely manner.

A continued stay (concurrent) review takes place during the time in which a recipient is receiving treatment in a residential care facility.

Responsibility

Providers are responsible for obtaining certification for continued stays from Qualis Health. The clinical reviewer will receive all of the appropriate detailed clinical information for the requested review period to satisfy Alaska State Medicaid Program Medical Necessity Criteria and review protocols before the continued stay review will be certified. Provider is responsible for assuring that the information submitted in the review is accurate for the timeframe of the review and documented in medical record of chart.

Process and Procedures

The provider will submit the continued stay review request to Qualis Health via the QHPP (preferred method), phone, fax, or mail. Please refer to Sections 7 and 8 for methods of and processes for submission.

Information Needed for the Review

The **continued stay review service authorization** collects the basic information needed by Qualis Health representatives to complete the review. See Exhibits 3 and 4 for the service authorization continued stay review questions.

The clinical reviewer will review the submitted clinical information and evaluate the necessity of admission, appropriateness of service, and continued need for placement at the current level of care. During the review, the information submitted will be considered:

- Current acuity or behavioral issues that support the need for continued care at the current level of care
- Appropriateness of diagnostics, therapies, procedures, and other services
- Length of stay
- Discharge planning progress and needs

If the submitted documentation supports the Alaska State Medicaid Program Medical Necessity Criteria and review protocols, the clinical reviewer will approve the service authorization.

Service Authorization Review Process

Once the information for the review has been received, the Qualis Health clinical reviewer will assess the documentation submitted using Alaska State Medicaid Program Medical Necessity Criteria and review protocols to determine whether the condition of the recipient meets criteria for the level of care and the type of services requested. If the Alaska State Medicaid Program Medical Necessity Criteria and review protocols are met, the review will be certified (authorized for payment). Refer to the process and procedures outlined in Section 8.

Once the provider has initiated a continued stay review with Qualis Health, the review process will continue until one of the following occurs:

- The recipient is discharged, upon which the facility will place the actual discharge date and updated discharge information in web-based review system or contact Qualis Health to provide the discharge information.
- Continued stay (concurrent) review is non-certified by Qualis Health.
- The recipient loses Medicaid eligibility.

Timeframes for Pended Reviews

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via the QHPP and/or phone. The provider has no more than 7 business days to submit the requested information before Qualis Health will proceed with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review.

SECTION 10: REPORTING SERIOUS OCCURRENCES AND EVENTS

It is the provider's responsibility to report all serious occurrences and sentinel events to the State and other authorities as indicated below.

Reporting Requirements of Providers from the State of Alaska, Department of Health and Social Services, Division of Behavioral Health

- Any death must be reported to the State of Alaska Division of Behavioral Health staff no later than the close of business the next business day after the resident's death.
- Any incident which requires investigation by an investigating body is to be reported to the State of Alaska Division of Behavioral Health staff no later than the close of business the next business day.
- Providers are to report these occurrences to any of the State of Alaska Division of Behavioral Health staff at (907) 269-3600.

Alaska Behavioral Health's Clarification of Providers' Reporting Requirements

It is also the provider's responsibility to report all serious occurrences as indicated below.

Medical (which requires medical care administered by a licensed practitioner)

- Incidents that require outside medical attention
- Burns
- Lacerations requiring medical attention
- Bone fractures or breaks
- Substantial hematoma
- Injuries to internal organ, whether self-inflicted or by someone else

AWOL (absent without leave)

- If gone overnight
- If anything significant occurred during the AWOL
- Police intervention
- Use of substances
- Suspected abuse

Sexual Acting Out/Physical Aggression

- Any activity or occurrence which must be reported to state Child Protective Service agencies
- Any time an Alaskan youth is the victim or the offender
- Suicidal attempt or serious suicidal gesture

Providers are to report serious (sentinel) events and occurrences using the form that can be accessed through the link in Exhibit 6. The is the same form that must be used to report to Certification and Licensing. Report these occurrences to the State of Alaska Division of Behavioral Health staff members at Sonya.Schrimpf@direct.dhss.akhie.com; Irina.Cline@direct.dhss.akhie.com; Paul.Mordini@direct.dhss.akhie.com, or via fax at (907) 269-8166. The form is to be filled out completely when submitted to the State of Alaska Division of Behavioral Health.

The incident form can also be submitted to OCS or DJJ if the youth is in the custody of the state.

SECTION 11: UTILIZATION REVIEW APPEALS

Overview

Qualis Health offers an appeal process in all cases involving an adverse determination. When a review determination is to non-certify a review request, Qualis Health will generate written notification of the adverse decision within one business day of the date the decision is made. Qualis Health's non-certification notification will include rights for an appeal review.

If the recipient has been getting a service paid by Alaska Department of Health and Social Services that is stopped, suspended, or reduced by an action Qualis Health takes, the recipient may ask that the service be continued. If the recipient wants to have the service continued while awaiting a hearing decision, he/she should ask for a continuation of the service within 10 days of the date of the action to stop, suspend, or reduce the service. If the recipient asks for the service to be continued and the hearing decision determines that the Alaska Department of Health and Social Services was correct to stop, suspend, or reduce the service, the State may require the recipient to repay the cost of the services provided. (Regulatory References: 42 CFR 431.230(b) and 7 AAC 49.200)

First-Level Appeal Rights for Providers

A first-level appeal process is available to providers when a provider does not agree with the initial determination by Qualis Health. The provider may submit a request for a first level of appeal to Qualis Health and request an additional review of the clinical submission and any additional information. The provider may request an appeal any time within 180 days of the date at the top of the denial letter. An appeal may be requested by calling (877) 200-9047 or by writing to:

Qualis Health
Attn: Care Management Department
PO Box 243609
Anchorage, AK 99524-3609

Second-Level Appeal Rights for Providers

A second-level appeal process is available to providers through the Alaska Department of Health and Social Services. A provider may request a second-level appeal when they are not satisfied with the results of the decision by Qualis Health. A second-level appeal must be requested in writing and postmarked within 60 days of the date of the decision by Qualis Health. A telephone call does not serve as notification that a second-level appeal is being requested.

Providers should submit second-level appeals to:

Division of Behavioral Health
Claims Appeal Section
3601 C Street, Suite 878
Anchorage, AK 99503

Include a copy of the Qualis Health first-level decision and supporting documentation considered relevant with the written appeal request.

Providers will be notified in writing of the final decision by the Alaska Department of Health and Social Services. If the recipient has been getting a service paid by the Alaska Department of Health and Social Services that is stopped, suspended, or reduced by an action Qualis Health takes, the recipient may ask that the service be continued. If the recipient wants to have the service continued during the time awaiting an appeal decision, he/she should ask for a continuation of the service within 10 days of the date of the action to stop, suspend, or to reduce the service. If the recipient asks for the service to be continued and the appeal decision determines that the Alaska Department of Health and Social Services was correct to stop, suspend, or reduce the service, the state may require the recipient to repay the cost of the services provided. (Regulatory References: 42 CFR 431.230(b), 42 CFR 431.231(a), 7 AAC 49.190 and 7 AAC 49.200)

APPENDIX A: GLOSSARY OF DEFINITIONS, REGULATIONS AND ACRONYMS

Definitions and Regulations

Active Treatment

Active treatment refers to the planning, delivery, and monitoring of a dynamic set of inter-related, effective, culturally appropriate, and individualized behavioral health services designed to meet the behavioral health service needs of the recipient. Active treatment includes the use of specific and clear intervention strategies that target those behaviors identified in the diagnostic evaluation, **individualized** POC, and designed to improve functioning, reduce or eliminate negative symptoms, demonstrate ongoing measurable progress, and enhance the quality of the recipient's life. Qualified team must provide active treatment to a recipient and his/her legal guardian(s).

Attestation

Attestation is the act of showing or evidence showing that something is true.

Clinical Records

A provider of psychiatric services shall maintain a clinical record of services provided to a recipient. A clinical record must include:

- Diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.
- The results of required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings.
- An individualized Plan of Care (POC)
- Updated Plan of Care (POC) reviews
- **Individualized** discharge plan to include specific discharge information. Documentation of active discharge planning at time of admission and continually updated to include contacts made, disposition of the contact, efforts to collaborate and coordinate with referring agency, receiving agency, receiving school (to include special education), barriers identified, and any other information effecting discharge planning. The clinical record must document the parent/legal guardian's active engagement in the discharge process and the facility's efforts to contact and engage the parent/guardian in the process when there is no or limited participation.
- Progress notes that document the service provided, the date of the service, duration of service, active interventions provided, the recipient's response to the intervention, and the recipient's progress toward identified treatment goals and objectives. The provider of the service must sign each progress note and include his/her professional credentials.

- AND: Contacts with State of Alaska representatives of custody youth
    - Level 2: Every 30 days
    - Level 3–4 RBRS beds: Every 90 days
    - Level 3–4 fee-for-service beds: Every 90–135 days

Community Residential Services

Community behavioral health services provided to a recipient who resides in a foster home or residential setting that is licensed under 7 AAC 50.005–7 AAC 50.790 or 7 AAC 56 if those services are provided in accordance with 7 AAC 135.020(b) to a child recipient who is experiencing a severe emotional disturbance for the purposed outlined in 7 ACC 135.270 as follows:

Daily Behavioral Rehabilitation Services

(a) The department will pay a community behavioral health services provider for daily behavioral rehabilitation services provided to a recipient who resides in a foster home or residential setting that is licensed under 7 AAC 50.005–7 AAC 50.790 or 7 AAC 56 if those services are provided in accordance with 7 AAC 135.020(b) to a recipient who is a child experiencing a severe emotional disturbance, and for the purpose of

(1) improving the recipient's overall functioning and reducing the likelihood of

(A) the recipient's failure in a school setting;

(B) longer term separation from the recipient's family; or

(C) referral of the recipient to more restrictive institutional care;

(2) promoting the recipient's wellness, recovery, and resiliency;

(3) helping the recipient

(A) develop or improve specific age-appropriate social behavior;

(B) develop or improve self-management skills that will support overall success;

(C) make better behavioral choices within the recipient's family, school, and community;

(4) assisting the recipient in developing strategies for transitioning into adulthood, including planning for continued education or employment.

(b) To qualify as a daily behavioral rehabilitation service, the service must provide safety, structure, supervision, and at least two of the following types of active treatment each day:

(1) teaching of life skills designed to restore the recipient's functioning;

(2) counseling focused on functional improvement, recovery, and relapse prevention;

(3) encouraging and coaching.

(c) The department will not pay for the daily supervisory activities provided in a licensed foster home or licensed residential setting that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance.

(d) The department will not pay a community behavioral health services provider for any other behavioral health service provided by the recipient's foster parent on the same day, including residential behavioral rehabilitation services under 7 AAC 135.800.

Directing Clinician 7 AAC 135.990

"Directing clinician" means a substance use disorder counselor or a mental health professional clinician who, by virtue of that individual's education, training, and experience, and with respect to the recipient's behavioral health treatment plan, (A) develops or oversees the development of the plan; (B) periodically reviews and revises the plan as needed; (C) signs the plan each time a change is made to the plan; and (D) monitors and directs the delivery of all services identified in the plan.

Medical Necessity Requirements Summary

A medically necessary behavioral active treatment health service is designed to:

- Assess the nature and extent of the psychiatric disorder and its impact upon the recipient’s ability to meet the demands of daily living, social, occupation, or educational functioning.
- Diagnose the psychiatric disorder
- Treat the psychiatric disorder
- Provide rehabilitation for the psychiatric disorder
- Prevent the relapse or deterioration of the recipient’s condition due to the psychiatric disorder

In making a determination as to whether the proposed services are medically necessary, the Qualis Health reviewer will consider the following:

- The recipient’s diagnosis and level of functioning
- The risk of harm from the recipient to self or other individuals

Mental Health Professional Clinician 7 AAC 160.990(b)(49)(A)

An individual who is working for an enrolled community behavioral health services provider; is performing community behavioral health services that are within that individual's field of expertise; is not working in a capacity that requires the individual to be licensed under AS 08; and has a master's degree or more advanced degree in psychology, counseling, child guidance, community mental health, marriage and family therapy, social work, or nursing.

- 7 AAC 160.990(b)(49)(A) describes a mental health professional clinician who is not required to be licensed.
- 7 AAC 160.990(b)(49)(B–F) describes mental health professional clinicians who are licensed.
- Mental health professional clinicians can be either licensed or not licensed.

Recipient Support Services 7 AAC 135.230

(a) The department will pay a community behavioral health services provider for a recipient support service if that service
  (1) is medically necessary under (b) of this section;
  (2) if provided during sleep hours, meets the requirements of (c) of this section; and
  (3) if provided during waking hours, meets the requirements of (d) of this section.

(b) The department will consider a recipient support service to be medically necessary only if
  (1) the current need for that service is identified through a professional behavioral health assessment under 7 AAC 135.110 that
    (A) documents the recipient's history of high-risk behavior or the rationale for heightened vigilance; and
    (B) recommends the frequency and location where the service should be provided; and
  (2) the recipient's behavioral health treatment plan clearly identifies
    (A) the recipient's target symptoms; and
    (B) how the staff of the community behavioral health services provider is expected to respond to and resolve a recipient's high-risk behavior.

(c) When recipient support services are provided to a recipient during the recipient's sleep hours, the individual rendering the service must be awake and able to hear or observe the recipient's behavior and, if that behavior puts the recipient or others at risk, respond to prevent harm to the recipient or others.

(d) If recipient support services are provided to a recipient during the recipient's waking hours, the individual rendering the service must be present and able to observe the recipient's behavior and, if that behavior puts the recipient or others at risk, respond to prevent harm to the recipient or others.

(e) The following elements of recipient support services are considered active treatment:
  (1) structure;
  (2) support;
  (3) sight or sound supervision.

(f) Recipient support services may be provided at

(1) the recipient's residence;

(2) the recipient's workplace;

(3) the recipient's school; or

(4) any other appropriate community setting specified in the behavioral health treatment plan.

(g) The department will pay a community behavioral health services provider for recipient support services provided to more than one recipient by the same staff during the same session if

(1) each recipient lives in the same household; and

(2) the service is provided to each recipient in accordance with this section.

(h) Recipient support services do not include the daily supervisory activities that

(1) a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance; or

(2) are normally provided by or within an assisted living facility, congregate housing facility, or group home for an adult

Rehabilitative Services

Special healthcare **services** that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. **Rehabilitation services** help people return to daily life and live in a normal or near-normal way.

Residential Behavioral Rehabilitation Services (RBRS)

- The purpose of RBRS is to remediate specific dysfunctions which have been explicitly identified in an assessment and individualized written treatment plan that is regularly reviewed and updated.
- RBRS also build the strengths and resiliency of children/youth and families. RBRS are provided to children/youth in residential settings to treat debilitating psychosocial, emotional, and behavioral disorders.
- RBRS provide intervention, stabilization, and development of appropriate coping skills upon the recommendation of a mental health professional within the scope of their practice as prescribed by applicable law.
- RBRS are “client-centered” and are provided within the residential care system individually, in groups, and in the family.
- Services must include the recipient’s biological, adoptive, foster, or identified family unless this is clinically inappropriate or a post-discharge placement has not been identified.
- RBRS continue post-discharge to ensure a successful transition back into a community setting.

Residential Care, Children and Youth (RCCY)

Organization of providers who provide services to youth in a residential setting

Service Authorization (SA) 7 AAC 135.040

- Request for services above the service limit
- RBRS
    - Level 2: Every 30 days
    - Level 3–4: Every 90 days
- Clinic services: Every 90–135 days
- Community Rehabilitative Services: Every 90–135 days

Service Limits 7 AAC 135.040

See Exhibit 2.

Severe Emotional Disturbance 7 AAC 135.065

(a) A child experiencing a severe emotional disturbance is an individual under 21 years of age who currently has or at any time during the past year has had a diagnosable mental, emotional, or behavioral disorder of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, adopted by reference in 7 AAC 160.900, the International Classification of Diseases, adopted by reference in 7 AAC 160.900, or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R), adopted by reference in 7 AAC 160.900, and that

(1) has resulted in a severe functional impairment that significantly interferes with the child's ability to participate in one or more life domains at a developmentally appropriate level and within a culturally appropriate context; or

(2) has resulted in the individual exhibiting one or more of the following:

(A) Persistent symptoms of distress or diminished affect that do not readily respond to encouragement, reassurance, or instructional control;

(B) impeded development or inappropriate attachment as a result of exposure to traumatic life events or impaired relationships;

(C) pervasive behavior that is disruptive, aggressive, or risk-taking and that places the individual at serious risk of physical harm to self or to another person or results in serious property damage;

(D) consistent inability to participate appropriately in a community setting, including family, school, work, or child care;

(E) imminent risk for out-of-home placement;

(F) imminent risk for being placed in the custody of the department under AS 47.12.120 or as a result of exposure to maltreatment under AS 47.10.011;

(G) Current hospitalization or the imminent risk of hospitalization.

(b) In addition to the impairments described in (a)(1) and (2) of this section, for individuals with cognitive impairments or organic brain syndrome, there must be documented evidence showing that the individual has the ability to benefit from rehabilitative services that would enable the individual to self-regulate behavior, modulate emotional reactivity, and improve developmentally appropriate functioning in major life domains.

Treatment Plan 7 AAC 135.120 and 7 AAC 50.330

- Due to be written, signed, and implemented within **15 days of admission** (7 AAC 50.330(a))
- Reviewed every three months except level 2 (7 AAC 50.330(e))
- Level 2: Every 30 days
- Level 3–4 RBRS beds: Every 90 days
- Level 3–4 Community Behavioral Health beds: Every 90–135 days

Acronyms

AAC: Alaska Administrative Code

CFR: Code of Federal Regulations

CMS: Centers for Medicare & Medicaid Services

CPT: Physicians' Current Procedural Terminology (Codes)

DBH: Division of Behavioral Health (of DHSS)

D/C: Discharge

DD: Developmentally Disabled

DHSS: Department of Health and Social Services

DOB: Date of Birth

DSDS: Division of Senior and Disability Services (of DHSS)

DSM: Diagnostic and Statistical Manual of Psychiatric Disorders

IDD: Intellectual and Developmental Disability

IIT: Inpatient Interdisciplinary Team/Treatment Team

DJJ: Division of Juvenile Justice (of DHSS)

HIPAA: Health Insurance Portability and Accountability Act

ICD-10: International Classification of Diseases (10th Edition)

IDD: Individual with Developmental Disability

LOA: Leave of Absence

LOC: Level of Care

LOS: Length of Stay

OCS: Office of Children's Services (of DHSS)

PA: Prior Authorization

POC: Plan of Care

QHPP: Qualis Health Provider Portal (web-based review system)

QIO: Quality Improvement Organization

RCCY: Residential Care, Children and Youth

SA: Service Authorization

SI: Severity of illness

SED: Severe Emotional Disturbance

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982

APPENDIX B: ALASKA STATE MEDICAID PROGRAM LEVEL 2 GROUP HOME MEDICAL NECESSITY CRITERIA

Admission

Must have at least one of these:

- Is there documentation of an acute mental, emotional or behavioral disorder?
- Is there a safety risk for the recipient or others?
- Is there documentation of a family crisis which needs to be stabilized?
- Will the recipient deteriorate further if not in placement?

Continued Stay

- Is there a continuation of behaviors which are consistent with admission criteria?
- Are there additional assessments which need to be completed?
- Is recipient waiting for the appropriate level of care to be available?
- Continued placement will not harm the recipient.

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APPENDIX C: ALASKA STATE MEDICAID PROGRAM LEVEL 3 GROUP HOME MEDICAL NECESSITY CRITERIA

Admission

Must meet 2 of the following for each group.

Functional Group

- Aggressive/assaultive behavior to peers or adults within the last six months not accounted for by another diagnosis or due to the effects of a substance or medical condition. Examples include: biting, kicking, pinching, bullying, cruelty to animals, destruction of property, or threatening behavior.
- Property destruction in the home, school, or community within the last six months.
- Suicidal statements, without a plan or stated intent to follow through.
- Has been abusive to self within the previous two months as evidenced by cutting the skin, pulling out hair, picking, scratching, or rubbing the skin to create sores or scars or burning or branding the skin.
- Running behavior that puts the client at substantial risk.
- Increased anxiety as evidenced by not being able to perform up to developmental expectations for the past three months (not due to developmental issues).
- Depressed, irritable or manic mood for at least six months as evidenced by anxiety, depressed/irritable mood, and withdrawal from normal activities or family.
- Neglects to take responsibility for daily hygiene and needs direct assistance/direction to complete activities of daily living (not due to developmental issues).
- Not able to maintain appropriate sexual boundaries for the past year as evidenced by inappropriate sexual play with inanimate objects, explicit sexual comments, sexual contact or penetration toward peers or adults/caregivers.
- Criminal behaviors including the intolerance of adult authority or stealing from family, friends, and stores, which may or may not result in legal charges.

Environmental Group (in home, school, or community within the last six months)

- Serious stressors in “family system” due to frequent moves, numerous disruptions, severe conflict, or issues of abuse or divorce.
- Inability to meet physical needs.
- Criminal behaviors by parents or family members occurring within the family or neighborhood.
- Exposure to alcohol abuse or use of illegal substances in the “family setting” or “community network.”
- Exposure to domestic violence in the “family setting.”
- Family or caregivers unable or unwilling to participate in services for the client.
- Other family problems such as emotional instability, neglect, abuse, or absence.

Response to Services Group (at the least restrictive level of care in home, school or community)

- Under stress, the client has shown significant vulnerability to external stressors.
- Decompensates when under pressure due to family issues, turmoil in day-to-day living environment including educational setting.
- Unable to maintain changes during transitions even with intensive supports.

Co-occurrence Group

- Has a co-occurring condition which does not allow maintenance in a less restrictive level of care such as: substance abuse disorder, medical condition, developmental disability, traumatic brain injury, Fetal Alcohol Syndrome, etc.
- Has exhibited behavior consistent with admission criteria within the past six weeks; or
- Has exhibited new symptoms or behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals;
- Treatment plan has objectives appropriate for level 3 related to improving behavioral and social/emotional functioning;
- Client is participating in the treatment process;
- Family is participating in the treatment process;
- Vigorous efforts are being made to affect a timely discharge to another level of care; AND
- Continued placement is more likely to be beneficial to the client than to be harmful; OR
- The client does not meet the above criteria; BUT:
    - Has clearly defined treatment goals necessary for discharge which can be completed in 30 days and no lower level of care can accomplish the goals; OR
    - Discharge to lower level of care available within 30 days and continued care will avoid an additional transition.

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APPENDIX D: ALASKA STATE MEDICAID PROGRAM LEVEL 4 GROUP HOME MEDICAL NECESSITY CRITERIA

Admission

Must meet 2 from the Functional Group and at least 2 from the other groups.

Functional Group

- Aggressive/assaultive behavior to peers or adults within the last three months grossly out of proportion to any precipitating psychosocial stressors, not accounted for by another diagnosis or due to the effect of a substance or medical condition. Examples include: punching a wall, throwing or smashing items, frequent and/or uncontrollable tantrums of yelling and screaming, aggressive impulses that resulted in seriously assaultive acts; and/or
- Threats to harm others with the means to do so.
- Substantial property destruction within the last three months grossly out of proportion to precipitating psychosocial stressors, not accounted for by another diagnosis or a substance or medical condition in the home, community, or school and/or charges were filed.
- Suicidal gestures or statements, without a plan or stated intent to follow through.
- Abusive to self in previous four weeks as evidenced by cutting the skin, pulling out hair, picking, scratching, rubbing the skin to create sores or scars, burning, or branding the skin.
- Running behavior that puts the client at substantial risk in previous two months.
- Increased anxiety as evidenced by not being able to perform up to developmental expectations for the past three months (not due to developmental issues).
- Depressed, irritable or manic mood for at least two months, as evidenced by: changes in appetite or eating pattern, unexplained weight loss, anger outbursts with increased frequency or intensity, excessive guilt, excessive preoccupation with death, diminished ability to concentrate or make a decision, feelings of hopelessness, helplessness or worthlessness, or no longer engages with friends or family.
- Not able to maintain appropriate sexual boundaries for the past four months (longer if the child/youth has been in a restrictive setting) as evidenced by: inappropriate sexual play with inanimate objects, sexual comments, sexual contact such as rubbing or touching others, inducing others to touch offenders private parts, penetration such as digital, penile or with an object, and/or adjudicated sexual offense.

Environmental Group (in home, school, or community)

- Serious stressors in “family system” due to frequent moves, numerous disruptions, severe conflict or issues of abuse or divorce.
- Inability to meet physical needs.
- Criminal behaviors by parents or family members occurring within the family or neighborhood.
- Exposure to alcohol abuse or use of illegal substances in the “family setting” or “community network.”
- Exposure to domestic violence in the “family setting.”
- Family or caregivers unable or unwilling to participate in services for the client.
- Other family problems such as emotional instability, neglect, abuse, or absence.

Co-occurrence Group

Has a co-occurring condition which does not allow maintenance in a less restrictive level of care such as: substance abuse disorder, medical condition, developmental disability, traumatic brain injury, Fetal Alcohol Syndrome, etc.

Continued Care

1. Has exhibited behavior consistent with admission criteria within the past six weeks, or
2. History, clinical presentation and progress strongly suggests that discharge to lower level of care presents a high likelihood of deterioration, high risk behavior and the inability to make progress on goals;
3. Treatment plan has objectives appropriate for level 4 related to improving behavioral and social/emotional functioning;
4. Client is participating in the treatment process;
5. Family is participating in the treatment process;
6. Vigorous efforts are being made to affect a timely discharge to another level of care; AND
7. Continued placement is more likely to be beneficial to the client than to be harmful; OR
8. The client does not meet the above criteria BUT:
    a. Has clearly defined treatment goals necessary for discharge which can be completed in 30 days and no lower level of care can accomplish the goals; OR
    b. Discharge to a lower level of care available within 30 days and continued care will avoid additional transition.

APPENDIX E: ALASKA MEDICAID MENTAL HEALTH REVIEW TIMEFRAMES FOR REVIEW SUBMISSIONS

Submitting Requests for Prior Authorization Reviews

If a review is submitted **before** these timeframes, the review will be pended and the provider will be requested to submit updated clinical information within these timeframes.

Admissions (when required for Medical Necessity Review)

On the day of admission, or up to two days before. (When travel is an issue, call as necessary before the date of admission and submit up to 5 calendar days in advance.)

Continued Stay Reviews

Submit the review on the assigned “Next Review Date,” or up to three days before the “Next Review Date.”

Pended Reviews

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via the QHPP and/or phone. The provider has no more than 7 business days to submit the requested information before Qualis Health will proceed with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review. Additional information may be submitted via the QHPP for your convenience.

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APPENDIX F: CONTACT INFORMATION AND HOLIDAY SCHEDULE

Qualis Health

Business Hours

Monday through Friday
8:00 am to 5:00 pm Alaska Time

Holiday Schedule

New Year's Day, Martin Luther King Jr. Day, Presidents' Day, Seward's Day, Memorial Day, Independence Day, Labor Day, Veterans' Day, Thanksgiving Day, Christmas Day

Anchorage Office

PO Box 243609
Anchorage, Alaska 99524

Phone: (877) 200-9046
(907) 550-7620

Fax: (877) 200-9047

Betty Robards, MS, LPA
Director, Alaska Medicaid Behavioral Health Services
(800) 949-7536 ext. 7626
(907) 550-7626
bettyr@qualishealth.org

Website

http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health

Qualis Health Provider Portal

https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin

Support: akbehavioralhealth@qualishealth.org
(877) 200-9046

State of Alaska

Alaska Department of Health and Social Services
Division of Behavioral Health
3601 C Street, Suite 878
Anchorage, AK 99503

Phone: (907) 269-3600

Fax: (907) 269-8166

Website

http://dhss.alaska.gov/dbh

Alaska Administrative Code

http://www.akleg.gov/basis/aac.asp

Staff

Terry Hamm
Medical Assistant Admin IV
DHSS/DBH/Manager Medicaid Provider Assistance Services
(907) 269-7826
Terry.Hamm@alaska.gov

Judy Helgeson
DHSS/DBH/Medicaid Provider Assistance Services
(907) 269-3697
Judith.Helgeson@alaska.gov

Tim Brown
DHSS/DBH/Medicaid Provider Assistance Services
(907) 269-0021
Timothy.Brown@alaska.gov

APPENDIX G: CONTACT INFORMATION FOR TRAVEL, FISCAL AGENT AND REVIEWS

Travel Authorizations Through Fiscal Agent

When traveling, provider is responsible for calling the numbers below.

Phone	(800) 770-5650 (toll-free in Alaska) (907) 644-6800 Weekdays 8:00 am–4:00 pm Saturday 8:00 am–5:00 pm Sunday 8:00 am–12:00 pm Hours are Alaska Time
Fax	(907) 644-8131 24-hour access
Mail Claims to	Fiscal Agent/Travel Authorizations PO Box 240769 Anchorage, AK 99524-0769

Claims Status, Electronic Media Claims (EMC) and Billing Procedures Through Fiscal Agent

Phone (toll-free in Alaska)	(800) 770-5650 8:00 am–5:00 pm Alaska Time
Phone	(907) 644-6800 8:00 am–3:30 pm Alaska Time
Fax	(907) 644-8126 24-hour access
Mail Claims to	Fiscal Agent/Travel Authorizations PO Box 240769 Anchorage, AK 99524-0769

Prior Authorization and Continued Stay Reviews and Qualis Health

Preferred method is the Qualis Health Provider Portal, available 24 hours per day.

Qualis Health Provider Portal (QHPP)	https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
QHPP Support	(907) 550-7620 8:00 am–5:00 pm Alaska Time akbehavioralhealth@qualishealth.org
Phone	(877) 200-9046 (toll-free in Alaska) (907) 550-7620 8:00 am–5:00 pm Alaska Time
Fax Documentation to	(877) 200-9047 24-hour access
Mail Documentation to	Qualis Health PO Box 243609 Anchorage, AK 99524-3609

Qualis Health Provider Relations - Anchorage Office

Phone	(877) 200-9046 (toll-free in Alaska) (907) 550-7620
Betty M. Robards, MS, LPA Director, Alaska Medicaid Behavioral Health Services	(800) 949-7536 ext. 7626 (907) 550-7626 bettyr@qualishealth.org
Fax	(877) 200-9047
Mail	Qualis Health PO Box 243609 Anchorage, AK 99524-3609

Eligibility Status

Phone (Automated Voice Response System)	(800) 884-3223 24-hour access
Phone	(800) 770-5650 (toll-free in Alaska) (907) 644-6800 8:00 am–5:00 pm Alaska Time
Fax	(907) 644-8126 24-hour access

APPENDIX H: LIST OF EXHIBITS

Exhibit 1: Z Codes Allowed for Level 2 Billing
Exhibit 2: Service Limits
Exhibit 3: Example Continued Stay Review Questionnaire Level 2
Exhibit 4: Example Continued Stay Review Questionnaire Level 3–4
Exhibit 5: Examples of Specific Phrasing to Use in Reviews
Exhibit 6: Children's Residential Incident Report
Exhibit 7: Reporting Units or Minutes for Fiscal Agent

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Exhibit 1: Z Codes Allowed for Level 2 Billing

F Codes for Behavioral Health Services are typically required. However, Level 2 Group Homes provides emergency care and the following set of Z Codes is allowed for payment and review processing.

Exceptions for Level 2 Group Homes (Allowable Codes)

Z62.29	Upbringing away from parents
Z62.820	Parent-child relational problems
Z63.4	Uncomplicated bereavement
Z59.0	Homelessness
Z65.8	Other problems related to psychosocial circumstances
Z69.010	Encounter for mental health services for victim of parental child abuse, neglect, psychological abuse, sexual abuse
Z69.020	Encounter for mental health services for victim of non-parental child abuse, neglect, psychological abuse, sexual abuse
Z91.49	Other personal history of psychological trauma
Z91.5	Personal history of self-harm

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Exhibit 2: Service Limits

Clinic Services	Code	Service Limit (Per Fiscal Year)
Psychotherapy, 30 min. w/ patient or family member	90832	Individual + group + family therapy not to exceed 10 hours/year
Group psychotherapy	90853	Individual + group + family therapy not to exceed 10 hours/year
Family psytx w/ patient	90847	Individual + group + family therapy not to exceed 10 hours/year
Family psytx w/o patient	90846	Individual + group + family therapy not to exceed 10 hours/year
Multiple family group psytx	90849	Individual + group + family therapy not to exceed 10 hours/year
Psychiatric diagnostic evaluation	90791	Not to exceed 4 assessments/year
Psycho testing by psych/phys	96101	Not to exceed 6 hours/year
Neuropsych tst by psych/phys	96118	Not to exceed 12 hours/year
MH assessment by non-MD (MH intake assessment)	H0031	1 assessment every 6 months
Integrated MH & SA assessment - BH assessment	H0031	1 assessment every 6 months
Crisis intervention services	S9484	Not to exceed 22 hours/year

Rehabilitation Services, Adult and Child	Code	Service Limit (Per Fiscal Year)
Alcohol and/or drug use assessment	H0001	1 assessment/year
Crisis stabilization services	H2011	Not to exceed 22 hours/year
Case management	T1016	Not to exceed 180 hours/year
* No more than 1 hour/week in direct supervision of service provision		

Rehabilitation Services, Child Only	Code	Service Limit (Per Fiscal Year)
Ther behav svc Individual	H2019	Ther behav hlth services + peer support services not to exceed 100 hours/year
Ther behav svc Group	H2019 HQ	Not to exceed 140 hours/year
Ther behav svc Family with patient present	H2019 HR	Ther behav svc + Self-help/peer svc not to exceed 180 hours/year
Ther behav svc Family without patient present	H2019 HS	Ther behav svc + Self-help/peer svc not to exceed 180 hours/year
Self-help/peer svc Individual - family w/ patient present	H0038	In conjunction with individual, family and individual comp comm support services; 100 hrs child; 240 hrs adult
Self-help/peer svc Individual - family w/o patient present	H0038	In conjunction with individual, family and individual comprehensive comm support services; 100 hrs child; 240 hrs adult
BH day treatment	H2012	No more than 6 hrs/day; 180 hours/year
Daily Behav Rehabilitation Services	H0018	1 billable service per day

Rehabilitation Services, Adult Only	Code	Service Limit (Per Fiscal Year)
Individual comprehensive comm support services and peer support services	H2015	240 hours/year
Group comprehensive comm support services	H2015 HQ	140 hours/year

Recipient Support Services (RSS), Adult and Child	Code	Service Limit (Per Fiscal Year)
Psysoc rehab svc	H2017	4 hours/day

Exhibit 3: Example Continued Stay Review Questionnaire Level 2

1. Recipient Custody Status – Select one
   - ☐ Tribal
   - ☐ Non-custody
   - ☐ JJ - Juvenile Justice
   - ☐ OCS - Office of Children's Services
   - ☐ Please enter date of last treatment plan completed:
2. Describe the symptoms related to an acute mental, behavioral or emotional disorder (such as depressed mood):

3. Describe any aggression to others or self-harm. Give dates and specific examples of occurrences in the past 30 days:

4. Describe how discharge would exacerbate a relapse or deterioration of the recipient's condition or a safety risk if the recipient was to return home:

5. Discharge plan/transition; give detailed information about provider of services when discharged:

6. Anticipated Discharge Date:

ATTESTATION: Please read and affirm/acknowledge each of the four statements by marking an x in the box.

As the assigned directing clinician, I attest to compliance with 7 AAC 135.800(a)(4)(A) and (B) for the above named recipient and hereby:

- ☐ Affirm the assessment of the recipient's symptomatology, current level of functionality is documented in the recipient's clinical record and the treatment plan services, units, and duration requested are medically necessary and consistent with the recipient's level of impairment.
- ☐ Affirm that, for a recipient who is a child, the clinical record documents the required participation and input of the child's treatment team.
- ☐ Acknowledge the services are subject to post-payment review of medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules; and
- ☐ Acknowledge that approval of this authorization request does not guarantee payment.

By submitting the Directing Clinician Name, that clinician is attesting as stated above

Directing Clinician's Name:

Directing Clinician's phone number:

Directing Clinician's e-mail:

The directing clinician is (please select one):

- ☐ A mental health professional clinician as defined in 7 AAC 160.990(b)(49)
- ☐ A physician licensed as required under 7 AAC 110.400 or described in 7 AAC 105.200(c)
- ☐ A psychologist who is licensed as required under 7 AAC 110.550 or described in 7 AAC 105.200(c)
- ☐ A Psychological Associate who is licensed under AS 08.86, described in 7 AAC 105.200(c), or in the jurisdiction where services are provided, and who renders the services in association with a licensed psychologist within the scope of practice identified in 12 AAC 60.185
- ☐ A clinical social worker who is licensed under AS 08.95 or described in 7 AAC 105.200(c)
- ☐ A physician assistant who is licensed as required under 7 AAC 110.455 or described in 7 AAC 105.200(c)
- ☐ An advanced nurse practitioner who is licensed and certified as required under 7 AAC 110.100 or described in 7 AAC 105.200(c)
- ☐ A psychiatric nursing clinical specialist who is licensed under AS 08.68, described in 7 AAC 105.200(c), or in the jurisdiction where services are provided
- ☐ A marital and family therapist who is licensed under AS 08.63, described in 7 AAC 105.200(c), or in the jurisdiction with requirements substantially similar to the requirements of AS 08.63 where services are provided, and who works in the therapist's field of expertise under the direct supervision of a psychiatrist
- ☐ A professional counselor who is licensed under AS 08.29, described in 7 AAC 105.200(c), or in the jurisdiction with requirements substantially similar to the requirements of AS 08.29 where services are provided, and who works in the therapist's field of expertise under the direct supervision of a psychiatrist

Note: If you are not submitting is information via the Qualis Health Provider Portal, you will need to attach the required fax coversheet. Please contact Qualis Health for current coversheet.

Exhibit 4: Example Continued Stay Review Questionnaire Level 3–4

1. Recipient Custody Status – Select one
   - ☐ Tribal
   - ☐ Non-custody
   - ☐ JJ - Juvenile Justice
   - ☐ OCS - Office of Children's Services
2. Please enter date of last treatment plan completed:

3. Is this an Admission (Initial) review (If yes, answer questions below. If No, go to question 4)
   a. Describe the symptoms related to an acute mental, behavioral or emotional disorder (such as, depressed mood):

   b. Describe any aggression to others or self-harm. Give dates and specific examples of occurrences in the past 30 days. What time period did the aggression, SI or self-harm occur. Describe any inappropriate maladaptive sexual behavior and when they occurred:

   c. Describe if applicable, how the recipient is not able to maintain his/her activities of daily living:

   d. If a co-occurring condition describes how the condition impacts the inability to be in a less restrictive level of care at this time:

   e. Describe any destruction in the home, school or community within the last 6 months:

   f. Describe how discharge would exacerbate a relapse or deterioration of the recipient's condition:

4. Please answer these questions for Continued Stay Request (skip this section if above admission questions were completed):
    a. Describe the recipient's maladaptive behavior within the last 6 weeks (provide specific dates and examples):

    b. Describe the recipient's functional status within the last 6 weeks (provide specific behaviors and dates of behaviors):

    c. Describe how discharge would exacerbate a relapse or deterioration of the youth's condition. (Why does the recipient need to stay in this level of care?):

5. Discharge/transition plan (provide specific providers and services needed such a foster home, clinic services and who or what agency will be providing the services:

6. Anticipated discharge date:

7. Please enter further description from the Psychological ICD-10 Diagnosis Code(s):

8. Are you requesting more than 12 hours per day? If No, skip to attestation section. If yes, please provider the following clinical information:
    a. Summary of the most current assessment detailing the needs of the recipient receiving services (include specific behaviors, frequency, dates, and whether or not these behaviors are continuing or not:

    b. Most current Treatment plan goals and objectives which support the service request for over 12 hours per day to address the identified treatment needs:

    c. Summary of 5 progress notes documenting the services which are to be provided to or on the behalf of the recipient. These are the progress notes of RSS or Therapeutic behavioral health Services which support the request for over 12 hours per day:

ATTESTATION: Please read and affirm/acknowledge each of the four statements by marking an x in the box.

As the assigned directing clinician, I attest to compliance with 7 AAC 135.800(a)(4)(A) and (B) for the above named recipient and hereby:

- ☐ Affirm the assessment of the recipient's symptomatology, current level of functionality is documented in the recipient's clinical record and the treatment plan services, units, and duration requested are medically necessary and consistent with the recipient's level of impairment.

- ☐ Affirm that, for a recipient who is a child, the clinical record documents the required participation and input of the child's treatment team.
- ☐ Acknowledge the services are subject to post-payment review of medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules; and
- ☐ Acknowledge that approval of this authorization request does not guarantee payment.

By submitting the Directing Clinician Name, that clinician is attesting as stated above

Directing Clinician's Name:

Directing Clinician's phone number:

Directing Clinician's e-mail:

The directing clinician is (please select one):

- ☐ A mental health professional clinician as defined in 7 AAC 160.990 (b)(49)
- ☐ A physician licensed as required under 7 AAC 110.400 or described in 7 AAC 105.200(c)
- ☐ A psychologist who is licensed as required under 7 AAC 110.550 or described in 7 AAC 105.200(c)
- ☐ A Psychological Associate who is licensed under AS 08.86, described in 7 AAC 105.200(c), or in the jurisdiction where services are provided, and who renders the services in association with a licensed psychologist within the scope of practice identified in 12 AAC 60.185
- ☐ A clinical social worker who is licensed under AS 08.95 or described in 7 AAC 105.200(c)
- ☐ A physician assistant who is licensed as required under 7 AAC 110.455 or described in 7 AAC 105.200(c)
- ☐ An advanced nurse practitioner who is licensed and certified as required under 7 AAC 110.100 or described in 7 AAC 105.200(c)
- ☐ A psychiatric nursing clinical specialist who is licensed under AS 08.68, described in 7 AAC 105.200(c), or in the jurisdiction where services are provided
- ☐ A marital and family therapist who is licensed under AS 08.63, described in 7 AAC 105.200(c), or in the jurisdiction with requirements substantially similar to the requirements of AS 08.63 where services are provided, and who works in the therapist's field of expertise under the direct supervision of a psychiatrist
- ☐ A professional counselor who is licensed under AS 08.29, described in 7 AAC 105.200(c), or in the jurisdiction with requirements substantially similar to the requirements of AS 08.29 where services are provided, and who works in the therapist's field of expertise under the direct supervision of a psychiatrist

Note: If you are not submitting is information via the Qualis Health Provider Portal, you will need to attach the required fax coversheet. Please contact Qualis Health for current coversheet.

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Exhibit 5: Examples of Specific Phrasing to Use in Reviews

Use These	Not These
Crying when told no, Excessive clinging	Cries frequently, Angry outbursts
Hypervigilance, Excessive fear, worry	Nervous, Afraid
Daredevil behavior, Fire setting in last week	Risky behaviors, Hx setting fires
Runaway less than 24 hours (48 hrs, X # days)	Runs
Self-injurious behavior, Hallucinations in last week (Specifically describe)	Hurts themselves, Sees things
Drop in school grades (A to D in last 6 weeks)	Not doing well in school
School time outs, 1x wk, Absent 3 days in last 5	Misses school
Suicidal / Homicidal ideation with / without plan	Wants to hurt self
Detention @ least 2x in last 5 days, Suspended & note reason, when occurred	Made to stay after school
Impulsive, Property destruction, Threw the TV	Acts without thinking
Absent 5 days from work in last month	Misses work
Arrest / Specific illegal activity in last month	Legal troubles
Socially withdrawn in last month	Stays to themselves, Loner

Examples of Specific Time and Frequency

Use These	Not These
In the last month	Has a history of…
3x week for last 6 months or Since the last treatment plan review	Recently
In the last 48 hrs	Frequently, Often
In the last week	Seldom

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Exhibit 6: Children's Residential Incident Report

Download this form from Qualis Health's website: http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources

Children's Residential Incident Report Department of Health and Social Services			
Organization Information		**Form Completed By**	
Agency Name		Name of Reporter	
Facility Name		Title	
Administrator		Agency	
Facility Address		Phone Number	
Telephone and Fax		Signature (if faxed)	
Contact for Incident		Date Form Filled Out	
Recipient Information		Date Form Submitted	
Name		**Notifications**	
Medicaid Number		☐ Parent, Legal Guardian or Representative	
DOB		☐ Adult Protective Services (within own state)	
Gender		☐ Behavioral Health	
Admission Date		☐ RCCY Program Coordinator	
Incident Information		☐ Division of Juvenile Justice (State Office)	
Date		☐ Probation Officer	
Time		☐ Cental Office Program Coordinator	
Location		☐ Office of Children's Services	

Type of Incident (check all which apply)	☐ Social Worker
Report Immediately (within 24 hours) Check Box	☐ Psychiatric Nurse
☐ Death (including accidental death)	☐ Residential Licensing
☐ Suicide	☐ Public Health Licensing Unit (in own state)
☐ Attempt or Threat	☐ Law Enforcement Agency
☐ Requiring an increase in observation	☐ Person/Agency:
☐ Severe Distress or Depression	☐ Other:
☐ Allegation of Sexual Abuse	**Type of Incident Continued** (check all which apply)
☐ Perpetrator	☐ Internal Investigation
☐ Victim	☐ Fire or Other Disaster
☐ Harm to Self or Others (requiring medical care administered by a licensed practitioner)	☐ Pregnancy Estimated Due Date:
☐ Non-emergency Medical Care Requiring Parent / Guardian Consent	☐ Admission of a Runaway Child
☐ Serious injury/illness requiring attention by medical personnel	☐ Elopement
☐ Serious injury/illness requiring attention by in-house medical	☐ Unapproved Absence over 10 hours
☐ Use of seclusion or restraint	☐ Law Enforcement Contact / Probation Violation / Criminal Conduct
☐ Medication Error requiring medical attention	☐ Unplanned Change in Administration or Facility
☐ Knowledge or suspicion of abuse, neglect, misappropriation of funds or property of recipients of services	
☐ Knowledge that any employee, volunteer or household member has been convicted or charged with an offence under AS 47.05	
☐ Other:	

Staff Involved in Incident		**Witnesses**	
Name	Contact Info	Name	Contact Info

Summary of Incident	
Describe circumstances or events leading up to incident	
Describe actions taken in response to incident	
Describe follow-up plans	

Incident Analysis	
Factors contributing to incident	
Actions necessary/taken to prevent similar future incident and person responsible for implementation	

Exhibit 7: Reporting Units or Minutes for Fiscal Agent

Clinic Services	Code	Modifier	Unit	Submit in Units or Minutes
Psy dx eval (Psychiatric diagnostic evaluation)	90791		1 assess	Units
Psytx office 20–30 Minutes				
(Psychotherapy, 30 Minutes w/ pt or family mem)	90832		30 Minutes	Minutes
MH assess by non-MD (MH intake assessment)	H0031		1 assess	Units
Integrated MH & SA assessment (BH assessment)	H0031	HH	1 assess	Units
Psycho testing by psych/phys	96101	U6	15 Minutes	Minutes
Neuropsych tst by psych/phys	96118	U6	15 Minutes	Minutes
Crisis interven svc	S9484	U6	15 Minutes	Minutes
Group psychotherapy	90853		30 Minutes	Minutes
Family psytx w/ patient	90847		30 Minutes	Minutes
Family psytx w/o patient	90846		30 Minutes	Minutes
Multiple family group psytx	90849		30 Minutes	Minutes

Rehabilitation Services, Adult and Child	Code	Modifier	Unit	Submit in Units or Minutes
Alcohol and/or drug use assess	H0001		1 assess	Units
Crisis interven svc (Crisis stabilization)	H2011		15 Minutes	Minutes
Self-help/peer svc (Individual)	H0038		15 Minutes	Minutes
Case management	T1016		15 Minutes	Minutes

Rehabilitation Services, Child Only	Code	Modifier	Unit	Submit in Units or Minutes
Ther behav svc (Individual)	H2019		15 Minutes	Minutes
Ther behav svc (Group)	H2019	HQ	15 Minutes	Minutes
Ther behav svc (Family with patient present)	H2019	HR	15 Minutes	Minutes
Ther behav svc (Family without patient present)	H2019	HS	15 Minutes	Minutes
Self-help/peer svc (Family with patient present)	H0038	HR	15 Minutes	Minutes
Self-help/peer svc (Family without patient present)	H0038	HS	15 Minutes	Minutes
BH day treatment	H2012		1 hour	Minutes
Daily Behavioral Rehabilitation Services	H0018		1 unit (day)	1 Unit

Rehabilitation Services, Adult Only	Code	Modifier	Unit	Submit in Units or Minutes
Comp comm supp svc (Individual)	H2015		15 Minutes	Minutes
Comp comm supp svc (Group)	H2015	HQ	15 Minutes	Minutes

Recipient Support Services (RSS), Adult and Child	Code	Modifier	Unit	Submit in Units or Minutes
Psysoc rehab svc	H2017		15 Minutes	Minutes