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IN THE SUPREME COURT OF THE STATE OF ALASKA

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STATE OF ALASKA AND THE COMMISSIONER OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, Appellants, v. PLANNED PARENTHOOD OF THE GREAT NORTHWEST, Appellee.	)	Supreme Court No. **S-16123**

Trial Court Case No. **3AN-14-04711 CI**

APPEAL FROM THE SUPERIOR COURT,
THIRD JUDICIAL DISTRICT AT ANCHORAGE,
THE HONORABLE JOHN SUDDOCK, PRESIDING

BRIEF OF APPELLANTS STATE OF ALASKA AND THE COMMISSIONER OF DHSS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

OTHER CASES

ALASKA CONSTITUTION

ALASKA STATUTES

ALASKA REGULATIONS

FEDERAL LAWS

OTHER LAWS

OTHER SOURCES

AUTHORITIES PRINCIPALLY RELIED UPON

Alaska Law

Alaska Constitution, Article I, § 1

This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; that all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State.

AS 47.07.010. Purpose

It is declared by the legislature as a matter of public concern that the needy persons of this state who are eligible for medical care at public expense under this chapter should seek only uniform and high quality care that is appropriate to their condition and cost-effective to the state and receive that care, regardless of race, age, national origin, or economic standing. It is equally a matter of public concern that providers of services under this chapter should operate honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures while providing medical care to recipients. Accordingly, this chapter authorizes the department to apply for participation in the national medical assistance program as provided for under 42 U.S.C. 1396--1396p (Title XIX, Social Security Act).

AS 47.07.068. Payment for abortions

(a) The department may not pay for abortion services under this chapter unless the abortion services are for a medically necessary abortion or the pregnancy was the result of rape or incest. Payment may not be made for an elective abortion.

(b) In this section,

(1) "abortion" has the meaning given in AS 18.16.090;

(2) "elective abortion" means an abortion that is not a medically necessary abortion;

(3) "medically necessary abortion" means that, in a physician's objective and reasonable professional judgment after considering medically relevant factors, an abortion must be performed to avoid a threat of serious risk to the life or physical health of a woman from continuation of the woman's pregnancy;

(4) "serious risk to the life or physical health" includes, but is not limited to, a serious risk to the pregnant woman of

(A) death; or

(B) impairment of a major bodily function because of

(i) diabetes with acute metabolic derangement or severe end organ damage;

(ii) renal disease that requires dialysis treatment;

(iii) severe pre-eclampsia;

(iv) eclampsia;

(v) convulsions;

(vi) status epilepticus;

(vii) sickle cell anemia;

(viii) severe congenital or acquired heart disease, class IV;

(ix) pulmonary hypertension;

(x) malignancy if pregnancy would prevent or limit treatment;

(xi) kidney infection;

(xii) congestive heart failure;

(xiii) epilepsy;

(xiv) seizures;

(xv) coma;

(xvi) severe infection exacerbated by pregnancy;

(xvii) rupture of amniotic membranes;

(xviii) advanced cervical dilation of more than six centimeters at less than 22 weeks gestation;

(xix) cervical or cesarean section scar ectopic implantation;

(xx) any pregnancy not implanted in the uterine cavity;

(xxi) amniotic fluid embolus; or

(xxii) another physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy that places the woman in danger of death or major bodily impairment if an abortion is not performed.

7 AAC 105.100. Covered services.

The department will pay for a service only if that service

(1) is identified as a covered service in accordance with AS 47.07 and 7 AAC 105 - 7 AAC 160;

(2) is provided to an individual who is eligible for Medicaid under 7 AAC 100 on the date of service;

(3) is ordered or prescribed by a provider authorized to order or prescribe that service under applicable law;

(4) is provided by a person who is enrolled as a Medicaid provider or rendering provider under 7 AAC 105.210, or otherwise eligible to receive payment for services under 7 AAC 105 - 7 AAC 160;

(5) is medically necessary as determined by criteria established under 7 AAC 105 - 7 AAC 160 or by the standards of practice applicable to the provider;

(6) has received prior authorization from the department, if prior authorization is required under 7 AAC 105 - 7 AAC 160; and

(7) is not specifically excluded as a noncovered service under 7 AAC 105 - 7 AAC 160

7 AAC 105.110. Noncovered services.

Unless otherwise provided in 7 AAC 105 - 7 AAC 160, the department will not pay for a service that is

(1) not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system, as determined upon review by the department;

(2) not properly prescribed or medically necessary in accordance with criteria established under 7 AAC 105 - 7 AAC 160 or by standards of practice applicable to the prescribing provider;

(3) incurred for an evaluative or periodic checkup, examination, or immunization

(A) that is in connection with the participation, enrollment, attendance, or accomplishment of a program or activity unrelated to the recipient's physical or mental health or rehabilitation; or

(B) unless it is

(i) for a mammogram;

(ii) part of an EPSDT screening; or

(iii) required by the department for the purpose of determining eligibility for Medicaid;

(4) for or in connection with cosmetic therapy or plastic or cosmetic surgery, including rhinoplasty, nasal reconstruction, excision of keloids, augmentation mammoplasty, silicone or silastic implants, facioplasty, osteoplasty (prognathism and micronathism), dermabrasion, skin grafts, and lipectomy; however, coverage is available if required for the following corrective actions if performed within the normal course of treatment or otherwise beginning no later than one year after birth or the event that caused the need for the corrective action:

(A) repair of an injury;

(B) improvement of the functioning of a malformed body member;

(C) correction of a visible disfigurement that would materially affect the recipient's acceptance in society;

(5) a nonmedical charge imposed by a recipient's friend or relative;

(6) for a person who is in the custody of federal, state, or local law enforcement, including a juvenile in a detention or correctional facility, except as an inpatient in a medical institution;

(7) for an experimental or investigational service, including one

(A) that is in a phase I or II clinical trial as defined in the United States Department of Health and Human Services, National Institutes of Health, Glossary of Terms for Human Subjects Protection and Inclusion Issues, adopted by reference in 7 AAC 160.900;

(B) for which inadequate available clinical or preclinical data exists to provide a reasonable expectation that the proposed service is at least as safe and effective as one not under experiment or investigation;

(C) for which an expert has issued an opinion that additional information is needed to assess the safety or efficacy of the proposed service;

(D) for which final approval from the appropriate governmental body has not been granted for the specific indications for which the use of the service is being proposed; however, if a drug has received final approval from the United States Food and Drug Administration (FDA) for any indication, final approval is not required for the specific indication for which use is being proposed if

(i) the prescription or order was issued by a licensed health care provider within the scope of the provider's license;

(ii) prior authorization was obtained from the department if required under 7 AAC 105 - 7 AAC 160; or

(iii) the condition being treated with the drug is not otherwise excluded as a use of the drug; or

(E) whose use is not in accordance with customary standards of medical practice;

(8) for missed appointments; however, the provider may charge the recipient;

(9) for interpreter services;

(10) for infertility services;

(11) for impotence therapy and services;

(12) for treatment, therapy, surgery, or other procedures related to gender reassignment;

(13) for sterilization for recipients under 21 years of age and hysterectomies performed solely for sterilization purposes;

(14) for nonsurgical weight reduction or maintenance treatment programs and products;

(15) for nonmedical fitness maintenance centers and services;

(16) for educational services or supplies that are separately identifiable in

(A) the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS), adopted by reference in 7 AAC 160.900; or

(B) Alternative Link's ABC Coding Manual for Integrative Healthcare, adopted by reference in 7 AAC 160.900;

(17) an alternative therapy or other service including acupuncture, homeopathic or naturopathic remedy, or Ayurvedic medicine;

(18) an outpatient drug for which payment under the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services' drug rebate program established in 42 U.S.C. 1396r-8 is not available;

(19) for which the recipient does not meet the eligibility requirements for that service under 7 AAC 100; or

(20) after the recipient's date of death.

7 AAC 105.130. Services requiring prior authorization.

(a) Except as otherwise provided in 7 AAC 105 - 7 AAC 160, the department will not pay for the following services unless the department has given prior authorization for the service:

(1) nonemergency, medically necessary transportation and accommodation services;

(2) a specific health care service for which prior authorization is specifically required under 7 AAC 105 - 7 AAC 160;

(3) a service that exceeds an annual or periodic service limitation established in 7 AAC 105 - 7 AAC 160;

(4) an item of durable medical equipment, supplies, or hearing items identified in 7 AAC 105 - 7 AAC 160 as requiring prior authorization;

(5) respiratory therapy;

(6) home health care services under 7 AAC 125.300 - 7 AAC 125.399;

(7) home infusion therapy services;

(8) private-duty nursing services;

(9) hospice care services;

(10) magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), single-photon emission computerized tomography (SPECT), and positron emission tomography (PET);

(11) an inpatient or outpatient procedure or diagnosis, regardless of the length of stay, identified in the English description of diagnoses and procedures in the Select Diagnoses and Procedures Pre-certification List, adopted by reference in 7 AAC 160.900;

(12) an inpatient hospital continued stay that exceeds an applicable limitation in 7 AAC 140.320 on length of hospitalization;

(13) a prescription drug identified on the Alaska Medicaid Prior-authorized Medications List, adopted by reference in 7 AAC 160.900;

(14) an inpatient psychiatric hospital admission in accordance with 7 AAC 140.360;

(15) a residential psychiatric treatment center admission or continued stay in accordance with 7 AAC 140.405;

(16) an administrative-wait or swing-bed stay at a general acute care hospital;

(17) a long-term care facility admission or continued stay;

(18) home and community-based waiver services under 7 AAC 130;

(19) personal care services under 7 AAC 125.010 - 7 AAC 125.199;

(20) behavioral health services identified in 7 AAC 135 as requiring prior authorization.

(b) Except as provided in 7 AAC 140.320, failure to obtain the required prior authorization may result in nonpayment, regardless of the eligibility of the recipient or the appropriateness of the services.

(c) For prior authorization, factors that the department will consider include the service's medical necessity, clinical effectiveness, cost-effectiveness, and likelihood of adverse effects, as well as service-specific requirements in 7 AAC 105 - 7 AAC 160. The department may place minimum or maximum quantities allowed of a specific service, may require other services before the recipient receives the requested service, or may require prior authorization for other services, as necessary

(1) for the protection of the public health, safety, and welfare;

(2) to prevent waste, fraud, and abuse of the Medicaid program; or

(3) to maintain the financial integrity of the department and the Medicaid program.

(d) The department may pay for a service under (a) of this section without prior authorization if prior authorization was not possible before the service was provided or a claim for payment is being processed after the service was provided following determination of a recipient's retroactive eligibility under 7 AAC 100.072.

7 AAC 110.153. Orthodontic services.

(a) The department will pay for orthodontic services for recipients under 21 years of age, if the services are for

(1) limited orthodontic treatment of the primary dentition for a malocclusion that does not involve the entire dentition; a prior authorization submitted by the orthodontist is required for limited orthodontic treatment of the primary dentition and must include

(A) a description of the condition;

(B) a description of the orthodontic appliance;

(C) a scored Handicapping Labiolingual Deviation (HLD) Index Report, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic films;

(F) intraoral and extraoral photographs;

(G) other pertinent medical or dental information to support the requested orthodontic treatment, including required extractions or orthognathic surgery;

(2) interceptive orthodontic treatment of the primary or transitional dentition to redirect ectopically erupting teeth, correct isolated dental crossbite or recover minor space loss where overall space for erupting teeth is adequate; a prior authorization submitted by the orthodontist is required for interceptive orthodontics and must include

(A) a description of the condition;

(B) a description of the orthodontic appliance;

(C) a scored Handicapping Labiolingual Deviation (HLD) Index Report, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic films;

(F) intraoral and extraoral photographs;

(G) other pertinent medical or dental information to support the requested orthodontic treatment, including required extractions or orthognathic surgery;

(3) comprehensive orthodontic procedures for treatment of cleft palate, in conjunction with orthognathic surgery for a class III skeletal malocclusion, medical necessity due to functional impairment and a score of 26 or greater on the Handicapping Labiolingual Deviation (HLD) Index Report completed by an orthodontist; a prior authorization submitted by the orthodontist is required for comprehensive orthodontic treatment and must include

(A) a description of the condition including medical information to determine functional impairment;

(B) a description of the orthodontic appliance;

(C) a scored Handicapping Labiolingual Deviation (HLD) Index Report, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic films;

(F) intraoral and extraoral photographs;

(G) study models, if requested in the process of reviewing the prior authorization.

(b) The department will not pay for orthodontic services for recipients 21 years of age or older.

7 AAC 110.280. Nutrition services for pregnant women.

(a) The department will pay for outpatient nutrition services provided to a recipient who is

(1) pregnant;

(2) consistent with the criteria in (b) of this section, determined to be at high risk nutritionally by

(A) a physician, an advanced nurse practitioner, or a physician assistant who may order those services within the scope of the practitioner's license or certification; or

(B) a licensed dietitian or nutritionist employed by a hospital or the state's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) under 42 U.S.C. 1786.

(b) A pregnant recipient is at high risk nutritionally if the recipient

(1) has a chronic or metabolic disease;

(2) has a disease or condition that requires a prescribed therapeutic diet;

(3) was underweight before conception;

(4) has inadequate or excessive weight gain during pregnancy;

(5) has a history of substance abuse;

(6) has a history of low birth-weight infants;

(7) has multiple fetuses;

(8) has anemia;

(9) has intrauterine growth retardation; or

(10) is less than 16 years of age.

(c) The department will pay for the following nutrition services provided to a pregnant woman who meets the requirements of (a) and (b) of this section:

(1) one initial assessment in a calendar year;

(2) up to 12 hours of services in a calendar year for counseling and follow-up care after the initial assessment;

(3) more than 12 hours of service in a calendar year if those hours are

(A) medically justified and prescribed by a physician, an advanced nurse practitioner, or a physician assistant who may order those services within the scope of the practitioner's license; and

(B) given prior authorization by the department.

7 AAC 130.205. Eligibility for home and community-based waiver services.

(a) The department will pay for home and community-based waiver services provided in accordance with the applicable requirements of this chapter to an individual that is

(1) eligible for coverage under AS 47.07.020, 7 AAC 100.002, and (d) of this section; and

(2) enrolled in accordance with 7 AAC 130.219.

(b) Home and community-based waiver services are not available to an individual

(1) while the individual is an inpatient of a nursing facility, a hospital, or an ICF/IID, except for screening under 7 AAC 130.211 or assessment under 7 AAC 130.213; or

(2) if the individual's services, supports, devices, or supplies may be provided for entirely by services under 7 AAC 105 - 7 AAC 160 without the services specified under this chapter.

(c) A recipient enrolled in the home and community-based waiver services program is eligible to receive other Medicaid services for which the recipient is otherwise eligible.

(d) For the department to determine whether an applicant is eligible to receive home and community-based waiver services under this section, the applicant must be found eligible for one of the following recipient categories:

(1) children with complex medical conditions; to qualify for this recipient category, the applicant must

(A) be under 22 years of age;

(B) have a medical condition that would require care in a general acute care hospital or a nursing facility for more than 30 days per year if the applicant did not receive home and community-based waiver services;

(C) has a severe, chronic physical condition that results in a prolonged dependency on medical care or technology to maintain health and well-being;

(D) experiences periods of acute exacerbation or life-threatening conditions;

(E) need extraordinary supervision and observation;

(F) either need frequent or life-saving administration of specialized treatment or be dependent on mechanical support devices; and

(G) require, as determined under 7 AAC 130.215, a level of care provided in a nursing facility;

(2) adults with physical and developmental disabilities; to qualify for this recipient category the applicant must

(A) be 21 years of age or older;

(B) meet the criteria specified in AS 47.80.900(6); and

(C) require, as determined under 7 AAC 130.215, a level of care provided in a nursing facility;

(3) individuals with intellectual and developmental disabilities; to qualify for this recipient category the applicant must

(A) meet the criteria specified in 7 AAC 140.600(c) and (d); and

(B) require, as determined under 7 AAC 130.215, a level of care provided in an ICF/IID;

(4) older adults or adults with physical disabilities; to qualify for this recipient category the applicant must require, as determined under 7 AAC 130.215, a level of care provided in a nursing facility and must be

(A) 65 years of age or older; or

(B) 21 years of age or older and have a physical disability.

7 AAC 130.213. Assessment and reassessment.

(a) If a screening under 7 AAC 130.211 and supportive diagnostic documentation reasonably indicate the need for services described in 7 AAC 130.211(a), the department will conduct an assessment of the applicant's physical, emotional, and cognitive functioning to determine the

(1) recipient category under 7 AAC 130.205(d) for which the applicant is eligible; and

(2) level of care under 7 AAC 130.215 that the applicant requires.

(b) If an assessment indicates that an applicant meets the level-of-care requirement under 7 AAC 130.215, the department will send notice to the care coordinator for development of a plan of care in accordance with 7 AA C 130.217.

(c) To request a reassessment of a recipient's continuing need for home and community-based waiver services, the recipient must submit a new application with current information in accordance with 7 AAC 130.207 not later than 90 days before the expiration of the period covered by the preceding level-of-care approval A new application is required in order to continue to receive home and community-based services after the expiration of the previous period.

(d) If the new application indicates a need for continuing services, the department, not later than one year after the date of the previous assessment, will reassess a recipient to determine if the recipient continues to meet the eligibility requirements of 7 AAC 130.205(d) and level-of-care requirement under 7 AAC 130.215. After the reassessment, the department will notify the recipient, the recipient's representative, and the recipient's

care coordinator of that determination. However, the department will perform an earlier reassessment if the department determines it necessary due to a material change related to the health, safety, and welfare of the recipient.

(e) Repealed 7/1/2015.

(f) If the department finds, based on the reassessment under this section, that the recipient no longer requires the level of care described in 7 AAC 130.215, the department will

(1) forward the reassessment for review by an independent qualified health care professional in accordance with AS 47.07.045(b) and 7 AAC 130.219(e)(4); and

(2) notify the recipient and the recipient's care coordinator of the referral and extension of the notification timeframe under 7 AAC 130.207(c)(3).

(g) If the department determines that translation services for a non-English speaking applicant or interpretation services for a deaf applicant are necessary for an assessment or reassessment under this section, the department will secure and pay for those services.

7 AAC 135.010. Scope of Medicaid behavioral health services.

(a) The department will pay for a behavioral health service under 7 AAC 135.010 - 7 AAC 135.290 if

(1) the recipient meets the criteria for services under 7 AAC 135.020;

(2) the provider meets the criteria for payment under 7 AAC 135.030;

(3) the service is identified as a treatment need in

(A) a professional behavioral health assessment under 7 AAC 135.110 or a reassessment conducted while the recipient is receiving behavioral health services; and

(B) a behavioral health treatment plan;

(4) screening and brief intervention services are provided in accordance with 7 AAC 135.240;

(5) the department has given prior authorization for the service under 7 AAC 105.130 and 7 AAC 135.040;

(6) the service is medically necessary and clinically appropriate;

(7) the service is provided as active treatment;

(8) the service, if it is a behavioral health clinic service, is provided under the general direction of a physician;

(9) the service is provided by a member of the provider's staff who is performing that service as a regular duty within the scope of that staff member's knowledge, experience, and education; and

(10) the clinical record requirements of 7 AAC 105.230 and 7 AAC 135.130 are met.

(b) The department will pay for the following behavioral health clinic services provided in accordance with this chapter by

(1) a mental health professional clinician, a physician licensed as required under 7 AAC 110.400, a physician assistant licensed as required under 7 AAC 110.455, or an advanced nurse practitioner licensed and certified as required under 7 AAC 110.100, if the provider is working within the scope of the provider's education, training, and experience:

(A) the following professional behavioral health assessments conducted in accordance with 7 AAC 135.110:

(i) a mental health intake assessment;

(ii) an integrated mental health and substance use intake assessment;

(iii) psychological testing and evaluation;

(B) psychotherapy conducted in accordance with 7 AAC 135.150;

(C) short-term crisis intervention services conducted in accordance with 7 AAC 135.160;

(2) a physician licensed as required under 7 AAC 110.400, a physician assistant licensed as required under 7 AAC 110.455, or an advanced nurse practitioner licensed and certified as required under 7 AAC 110.100, if the provider is working within the scope of the provider's education, training, and experience, if the provider has prescriptive authority, and if the provider is enrolled under 7 AAC 120.100(c) as a dispensing provider:

(A) the following professional behavioral health assessments conducted in accordance with 7 AAC 135.110:

(i) a psychiatric assessment interview;

(ii) an interactive psychiatric assessment using equipment and devices;

(B) pharmacologic management services conducted in accordance with 7 AAC 135.140.

(c) The department will pay for the following behavioral health rehabilitation services in accordance with this chapter if the service is provided by a member of the provider's staff who is performing that service as a regular duty within the scope of that staff member's knowledge, experience, and education:

(1) behavioral health screening under 7 AAC 135.100;

(2) a substance use intake assessment under 7 AAC 135.110(c);

(3) case management under 7 AAC 135.180;

(4) detoxification services under 7 AAC 135.190;

(5) comprehensive community support services for adults under 7 AAC 135.200;

(6) therapeutic behavioral health services for children under 7 AAC 135.220;

(7) recipient support services under 7 AAC 135.230;

(8) medication administration services under 7 AAC 135.260;

(9) behavioral health treatment plan review and development, including a client status review under 7 AAC 135.100;

(10) medical evaluation;

(11) methadone or antabuse administration;

(12) behavioral health treatment plan review for a recipient in a methadone treatment program;

(13) day treatment services for children under 7 AAC 135.250;

(14) daily behavioral rehabilitation services under 7 AAC 135.270;

(15) residential substance use treatment services under 7 AAC 135.280;

(16) short-term crisis stabilization services under 7 AAC 135.170;

(17) facilitation of a telemedicine session under 7 AAC 135.290.

(d) The department will not pay for any of the following services as a Medicaid covered service under this chapter:

(1) outpatient mental health services provided by a hospital or psychiatric facility, unless the outpatient program is a mental health physician clinic that is enrolled in accordance with 7 AAC 105.210;

(2) experimental therapy;

(3) telephone consultation or coordination with another service provider other than case management;

(4) preparation of reports as a separate service;

(5) narcosynthesis;

(6) socializing;

(7) recreation therapy;

(8) primal therapy;

(9) rage reduction or holding therapy;

(10) marathon group therapy;

(11) megavitamin therapy;

(12) pastoral counseling;

(13) explanation of an examination to a family member or other responsible individual that is provided outside of a family therapy session;

(14) therapy or evaluation if the documentation required by 7 AAC 105.230, 7 AAC 135.120, and 7 AAC 135.130 is inadequate or is absent from the recipient's clinical record or behavioral health treatment plan;

(15) room and board costs as a part of a behavioral health clinic service or rehabilitation service;

(16) transportation or travel time as a part of a behavioral health clinic service or rehabilitation service, except as provided under 7 AAC 135.180.

7 AAC 135.020. Recipient eligibility for Medicaid behavioral health services.

(a) The department will pay for behavioral health clinic services for the following individuals only:

(1) a child experiencing an emotional disturbance;

(2) a child experiencing a severe emotional disturbance;

(3) an adult experiencing an emotional disturbance;

(4) an adult experiencing a serious mental illness.

(b) The department will pay for behavioral health rehabilitation services for the following individuals only:

(1) an individual experiencing a substance use disorder characterized by

(A) a maladaptive pattern of substance use; or

(B) cognitive, behavioral, or physiological symptoms indicating that the individual will continue to use a substance despite significant substance-related problems associated with its use;

(2) a child experiencing a severe emotional disturbance;

(3) except as provided in (d) of this section, an adult experiencing a serious mental illness.

(c) If, during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services, that provider shall refer the recipient to a provider that provides behavioral health rehabilitation services in the community.

(d) A child experiencing a severe emotional disturbance may be provided comprehensive community support services under 7 AAC 135.200, in place of therapeutic behavioral health services for children under 7 AAC 135.220, if that recipient

(1) is at least 18 years of age and under 21 years of age; and

(2) except for age, falls within the definition of an adult experiencing a serious mental illness.

7 AAC 135.990. Definitions.

In this chapter, unless the context requires otherwise,

(1) "active treatment"

(A) means that the individual who renders the services actively engages the recipient and provides pre-planned specific interventions, supports, or other actions that assist the recipient in achieving the goals written in the behavioral health treatment plan;

(B) includes recipient support services;

(2) "adjunctive treatment" means a treatment that is associated with another treatment in a subordinate or auxiliary capacity;

(3) "adult experiencing an emotional disturbance" means an individual 21 years of age or older who is experiencing a non-persistent mental, emotional, or behavioral disorder that

(A) is identified and diagnosed during a professional behavioral health assessment under 7 AAC 135.110; and

(B) is not the result of intellectual, physical, or sensory deficits;

(4) "behavioral health clinic services" means services provided under 7 AAC 135.010(b);

(5) "behavioral health rehabilitation services" means services provided under 7 AAC 135.010(c);

(6) "behavioral health screening" means administering and interpreting the Alaska Screening Tool, adopted by reference in 7 AAC 160.990, at the point of entry to a behavioral health program to determine the appropriate assessments needed to identify the recipient's treatment needs;

(7) "behavioral health treatment plan" means

(A) a written individualized treatment plan that details

(i) the goals, objectives, services, and interventions selected to address a recipient's behavioral health needs identified by a professional behavioral health assessment under 7 AAC 135.110; and

(ii) with respect to selected services and interventions, their frequency and duration; or

(B) a short-term crisis intervention plan under 7 AAC 135.160, or short-term crisis stabilization plan under 7 AAC 135.170;

(8) "case management" means assistance to the recipient and the recipient's family in accessing and coordinating high-quality needed services, including

(A) medical, psychiatric, and mental health services;

(B) substance use treatment;

(C) educational, vocational, and social supports; and

(D) community-based services, related assessments, and post-discharge follow-up activities;

(9) "child experiencing an emotional disturbance" means an individual under 21 years of age who is experiencing a non-persistent mental, emotional, or behavioral disorder that

(A) is identified and diagnosed during a professional behavioral health assessment under 7 AAC 135.110; and

(B) is not the result of intellectual, physical, or sensory deficits;

(10) "client status review" means an evaluation under 7 AAC 135.100 to measure a recipient's quality of life at the time of intake and at subsequent intervals during treatment or recovery;

(11) "co-occurring disorder" means a diagnosable substance use disorder and a diagnosable mental health disorder that the recipient experiences at the same time;

(12) "detoxification services" means those services under 7 AAC 135.190 provided by a community behavioral health services provider;

(13) "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;

(14) "general direction" means, in a community behavioral health services provider, a physician provides general program and clinical consultative services when needed;

(15) "Medicaid behavioral health services" means the behavioral health clinic services identified in 7 AAC 135.010(b) and the behavioral health rehabilitation services identified in 7 AAC 135.010(c);