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ATTENTION: ALTERNATIVE BILLING CONCEPTS (ABC) CODES FOR BEHAVIORAL HEALTH SERVICES TO END AS OF 12/31/2009

Alaska Medical Assistance will transition from use of Alternative Billing Concepts (ABC) procedure codes. Revising the Behavioral Health billing codes from ABC codes to national standard codes has been a goal of the department for some time. This change will minimize problems providers encounter when billing other third parties or when programming systems to national standards. Because service limits are specified in calendar year limits, changing the code set at the beginning of the year should improve the providers' ability to manage PA requests and track service limit usage. Due to the delay in implementing the new MMIS, the department has recently determined that Affiliated Computer Services, Inc. (ACS) could proceed with implementing the changes in the current system at this time.

Effective with dates of service on and after January 1, 2010, claims and prior authorization requests for services rendered in 2010 must be reported using national standard codes.

The "old" ABC codes can only be used for billing claims for services rendered **on or before** December 31, 2009. The "new" national codes must be used for billing claims for services rendered **on or after** January 1, 2010.

The "new" prior authorization (PA) request form will be required for services provided on or after January 1, 2010 that exceed program service limits. ACS will assist providers with cross-walking the old ABC codes to the new national codes for any 2010 PA requests received on the old PA request form and received by ACS on or before December 15, 2009.

The enclosed packet contains the following information:

- A cover letter
- A crosswalk comparing the old ABC codes and the new national replacement codes
- A list of questions and answers for your reference regarding this code set transition effort
- New Prior Authorization (PA) request forms containing the new national codes
    - NOTE: These forms can be completed and saved using computer word processing software.

For your convenience, the enclosed crosswalk includes all the services covered by the Medicaid program for your provider type, whether the codes and descriptions have changed or not. These crosswalks replace the applicable procedure code tables in Section I of billing manuals for affected provider types as follows:

- Tables I-4 and I-5 for community mental health clinic providers
- Table I-7 for substance abuse providers
- Tables I-4 and I-5 for mental health physician clinic providers

Please contact the ACS Provider Inquiry Unit at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska) if you need additional clarification regarding the information provided in this flyer, or have general inquiries regarding the Alaska Medicaid Program. Provider Inquiry staff is available to assist you Monday – Friday, 8:00 a.m. – 5:00 p.m.

QUESTIONS AND ANSWERS FOR BEHAVIORAL HEALTH PROVIDERS

Affiliated Computer Services (ACS), in conjunction with the Department of Health and Social Services, has developed these questions and answers to assist providers in filing claims and prior authorization requests with Alaska Medical Assistance. It is hoped that this information will be useful to providers as they transition from the use of current Alternative Billing Concepts (ABC) codes to national codes.

Question: Why is this change being implemented now?
Answer: Revising the Behavioral Health billing codes from ABC codes to national standard codes has been a goal of the department for some time. This change will minimize problems providers encounter when billing other third parties or when programming systems to national standards. Because service limits are specified in calendar year limits, changing the code set at the beginning of a calendar year should improve providers' ability to manage prior authorization requests and track service usage and limits. Due to the delay in implementing the new Medicaid Management Information System (MMIS), the department has recently determined that ACS could proceed with implementing the changes in the current system at this time.

Question: How are these behavioral health code cross-walks used?
Answer: The code crosswalks correlate the ABC codes with replacement national codes. Providers will continue to bill using ABC codes for dates of service on or before December 31, 2009 and will use the replacement national code for services provided on or after January 1, 2010.

Question: Which national code sources were used to choose the replacement codes for the alternative billing codes that are reflected in the crosswalks?
Answer: Replacement codes were chosen from comparable services included within the national coding systems: the American Medical Association's Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS).

Question: Is there a "one-to-one" correlation between the ABC codes and the replacement national code?
Answer: Not always. Double-check the code and description columns of the new replacement national codes for accuracy when filing your claim. Some new national codes require the use of modifiers to describe the services.

Question: Have the time increments associated with the services changed?
Answer: For a few services, the time increment for the national replacement code is different. Ensure that you bill the correct number of units to identify the quantity of services actually rendered. Note that the time increment associated with family and group psychotherapy coded using codes 90847, 90849 and/or 90853 without a procedure code modifier has changed. When these codes are billed without modifiers for billing services rendered before 12/31/2009, the unit of time is 30 minutes; however, the time increment associated with these unmodified codes as of January 1, 2010 will be one hour. Providers will need to pay special attention to ensure the appropriate codes and/or modifiers are billed as well as the appropriate number of units of service when billing codes 90847, 90849, and 90853.

Question: Will the modifiers "1M" and "1H" change when the alternative billing codes change?
Answer: Modifiers "1M" and "1H" will no longer be valid modifiers. The new modifiers that will be used by Alaska Medical Assistance are "U6" to indicate a quarter hour unit (15 minutes) and "U7" to indicate a half hour unit (30 minutes). In addition, the modifiers HR (representing family/couple) and HQ (representing group) will also be accepted.

Question: Have the service limitations and prior authorization requirements changed?
Answer: No, the service limitations and prior authorization requirements have not changed. Please ensure that prior authorization requests include the correct number of units and the correct codes on the appropriate prior authorization request form. Double-check the date of service, the old and new code descriptions, and the time increments associated with them. Also, please remember that prior authorization units must be requested and entered into the MMIS in the lowest time unit increment possible so in some cases, every procedure code/modifier combination will not be present on the PA request form but every procedure code/modifier combination can be used for billing claims.

Question: Will Third Party Liability (TPL) Avoidance for mental health rehabilitation services be continued for the new codes?
Answer: Yes, it is understood that most other insurance carriers do not cover mental health rehabilitation services, therefore, the Alaska MMIS will continue to ensure that editing related to billing third party insurance will be bypassed for all claim lines for which a mental health rehabilitation service is billed--whether the service is billed using ABC codes in calendar year 2009 or new national standard codes in calendar year 2010.

SUBSTANCE ABUSE REHABILITATIVE SERVICES CROSSWALK

Table I-7(a) CPT[1] Procedure Codes: Substance Abuse Rehabilitative Services							
Procedure Code for DOS thru 12/31/09	**Modifier thru 12/31/09**	**Procedure Code Description for Coded Service**	**Reimbursement Rate for Coded Service**	**Procedure Code Effective 01/01/10**	**Modifier Effective 01/01/10**	**Procedure Code Description for Coded Service**	**Reimbursement Rate Effective 01/01/10**
80100	none	Drug screen, qualitate/multi *[Multiple Drug]*	Medicare Fee Schedule (1 Unit = 1 drug screen)	80100	none	Drug screen, qualitate/multi *[Multiple Drug]*	Medicare Fee Schedule (1 Unit = 1 drug screen)
90862	none	Medication management	$75.00/Visit (1 Unit = 1 Visit)	90862	none	Medication management	$75.00/Visit (1 Unit = 1 Visit)

Note: For complete definitions and guidelines for the above services, please refer to *2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care,* as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at *http://www.hipaa.samhsa.gov/hipaacodes2.htm.*

[1] CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

SUBSTANCE ABUSE REHABILITATIVE SERVICES CROSSWALK

Table I-7(b) HCPCS Procedure Codes: Substance Abuse Rehabilitation Services
(Replaces Table I-7(b). HCPCS and ABC[1] Procedure Codes: Substance Abuse Rehabilitation Services)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
CDADK	none	Individual substance abuse therapy, per 15 minutes ***[Individual substance abuse counseling]*** Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling	$17.00/15 Minutes (1 Unit =15 Minutes)	**H2035**	none	Alcohol and/or drug treatment program, per hour ***[Individual substance abuse counseling]*** Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling	**$68.00/One Hour (1 Unit = 1 Hour)**
				H2035	**U6** (15-minute modifier)		**$17.00/15 Minutes (1 Unit =15 Minutes)**
H0001		Alcohol and/or drug assessment ***[Assessment/Diagnosis by substance abuse counselor]*** Maximum of 2 per consecutive 12-month period	$100.00/Session (1 Unit = 1 Session)	H0001	none	Alcohol and/or drug assessment ***[Assessment/Diagnosis by substance abuse counselor]*** Maximum of 2 per consecutive 12-month period	$100.00/Session (1 Unit =1 Session)
H0002		Behavioral health screening to determine eligibility for admission to treatment program ***[Medical Intake physical for non-methadone recipient]***	$300.00/Visit (1 Unit = 1 Visit)	H0002	none	Behavioral health screening to determine eligibility for admission to treatment program ***[Medical Intake physical for non-methadone recipient]***	$300.00/Visit (1 Unit = 1 Visit)
H0002	HF	Behavioral health screening to determine eligibility for admission to treatment program ***[Medical evaluation for admission into methadone treatment]***	$397.71/Visit (1 Unit = 1 Visit)	H0002	HF	Behavioral health screening to determine eligibility for admission to treatment program ***[Medical evaluation for admission into methadone treatment]***	$397.71/Visit (1 Unit = 1 Visit)

[1] ABC codes are copyright protected by Alternative Link, Inc., 2009, all rights reserved. Previous editions copyrighted 1999-2004.

Table I-7(b) HCPCS Procedure Codes: Substance Abuse Rehabilitation Services

(Replaces Table I-7(b). HCPCS and ABC[1] Procedure Codes: Substance Abuse Rehabilitation Services)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
H0005	none	Alcohol and/or drug services; group counseling by a clinician ***[Group substance abuse counseling]*** Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling	$9.00/15 Minutes (1 Unit = 15 Minutes)	H0005	none	Alcohol and/or drug services; group counseling *by a clinician* ***[Group substance abuse counseling]*** Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling	$9.00/15 Minutes (1 Unit = 15 Minutes)
H0006	none	Alcohol and/or drug services; case management ***[Care Coordination]*** Each reimbursable contact must be at least 20 minutes in length and is limited to maximum of 8 hours in any consecutive 6-month period	$16.00/15 Minutes (1 Unit = 15 Minutes)	H0006	none	Alcohol and/or drug services; case management ***[Care Coordination]*** Each reimbursable contact must be at least 20 minutes in length and is limited to maximum of 8 hours in any consecutive 6-month period	$16.00/15 Minutes (1 Unit = 15 Minutes)
H0013	none	Alcohol and/or drug services; **acute detoxification** *(residential addiction program outpatient)* Stay must not be less than a 24 hour period and there can be no more than 12 admissions in consecutive 12-month period.	$300.00/Day (1 Unit = 1 Day)	H0013	none	Alcohol and/or drug services; **acute detoxification** *(residential addiction program outpatient)* Stay must not be less than a 24 hour period and there can be no more than 12 admissions in consecutive 12-month period.	$300.00/Day (1 Unit = 1 Day)

Table I-7(b) HCPCS Procedure Codes: Substance Abuse Rehabilitation Services

(Replaces Table I-7(b). HCPCS and ABC[1] Procedure Codes: Substance Abuse Rehabilitation Services)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
H0015	none	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individual treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education. *[**Intensive outpatient** includes individual, family and group counseling, care coordination and rehabilitation treatment services]* Minimum 3 days or evenings/week, 8 to 12 hours or 32 to 48 units a week; not to exceed 8 consecutive weeks per consecutive 12-month period.	$17.00/15 Minutes (1 Unit = 15 Minutes)	H0015	none	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individual treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education. *[**Intensive outpatient** includes individual, family and group counseling, care coordination and rehabilitation treatment services]* Minimum 3 days or evenings/week, 8 to 12 hours or 32 to 48 units a week; not to exceed 8 consecutive weeks per consecutive 12-month period.	$17.00/15 Minutes (1 Unit = 15 Minutes)
H0020	none	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) *[Must be conducted by a physician, advanced nurse practitioner, physician's assistant, registered nurse or licensed practical nurse.]*	$12.50/Visit (1 Unit = 1 Visit)	H0020	none	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) *[Must be conducted by a physician, advanced nurse practitioner, physician's assistant, registered nurse or licensed practical nurse.]*	$12.50/Visit (1 Unit = 1 Visit)

Table I-7(b) HCPCS Procedure Codes: Substance Abuse Rehabilitation Services

(Replaces Table I-7(b). HCPCS and ABC[1] Procedure Codes: Substance Abuse Rehabilitation Services)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
H0022	none	Alcohol and/or drug intervention service [***Intermediate Service*** *includes individual, family and group counseling, care coordination, rehabilitation, and treatment services in a residential setting]* Maximum of 20 hours or 80 units per week; 8 weeks or 640 units per consecutive 12-month period	$17.00/15 Minutes (1 Unit = 15 Minutes)	H0022	none	Alcohol and/or drug intervention service [***Intermediate Service*** *includes individual, family and group counseling, care coordination, rehabilitation, and treatment services in a residential setting]* Maximum of 20 hours or 80 units per week; 8 weeks or 640 units per consecutive 12-month period	$17.00/15 Minutes (1 Unit = 15 Minutes)
T1006	none	Alcohol and/or substance abuse services; family/couple counseling *[**Family substance abuse counseling**]* Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling	$17.00/15 Minutes (1 Unit = 15 Minutes)	T1006	none	Alcohol and/or substance abuse services; family/couple counseling *[**Family substance abuse counseling**]* Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling	$17.00/15 Minute (1 Unit = 15 Minutes)
T1007	none	Alcohol and/or substance abuse services; treatment plan development and/or modification *[**Treatment plan review** for methadone recipient]*	$75.00/Session (1 Unit = 1 Session)	T1007	none	Alcohol and/or substance abuse services; treatment plan development and/or modification *[**Treatment plan review** for methadone recipient]*	$75.00/Session (1 Unit = 1 Session)

Table I-7(b) HCPCS Procedure Codes: Substance Abuse Rehabilitation Services

(Replaces Table I-7(b). HCPCS and ABC[1] Procedure Codes: Substance Abuse Rehabilitation Services)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
T1012	none	Alcohol and/or substance abuse services; skills development [***Rehabilitation Treatment]*** Maximum of 10 hours or 40 units per week; 40 hours or 160 units per consecutive 12-month period	$17.00/15 Minutes (1 Unit = 15 Minutes)	T1012	none	Alcohol and/or substance abuse services; skills development ***[Rehabilitation Treatment]*** Maximum of 10 hours or 40 units per week; 40 hours or 160 units per consecutive 12-month period	$17.00/15 Minutes (1 Unit = 15 Minutes)

Note: For complete definitions and guidelines for the above services, please refer to *2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care,* as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at *http://www.hipaa.samhsa.gov/hipaacodes2.htm.*

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New Prior Authorization Form Instructions

The Prior Authorization forms were created as a Word document to offer providers the ability to download, fill in, and save on office computers, however; due to various security settings on individual computer systems, some providers may experience difficulty. It is hoped that the following step-by-step instructions will be of assistance to providers using the new form.

Go to http://medicaidalaska.com/providers/forms.shtml.

Scroll down the page and choose the appropriate form under the heading OTHER forms.

Save as a Word document to your Desktop.

Open the document file.

Go to the TOOLS on your tool bar and select OPTIONS.

Click on the SECURITY TAB and select MACRO SECURITY.

Select the MEDIUM security and select OK.

Close the document.

Reopen the document and **enable the macros, then** you should be able to type in the fields. Save the completed form.

SUBSTANCE ABUSE TREATMENT SERVICES
PRIOR AUTHORIZATION REQUEST

Effective 01/01/2010

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Provider Information

1. Request Date
2. Provider Name
3. Provider ID No.
4. Contact Name and Address
   (decision will be returned to this address)
5. Phone No.
6. Fax No.
7. E-Mail Address

Recipient Information

8. Recipient Name
9. Date of Birth
10. Recipient ID No.
11. Gender: ☐ Male ☐ Female
12. Recipient Address

☐ a. Private Home ☐ b. Foster Home
☐ c. Office of Children's Services Rehabilitation Home
☐ d. Transitional/Supported Living Home
☐ e. Residential Substance Abuse Treatment Center
☐ f. Homeless/Shelter ☐ g. Other-Explain:

13. ☐ **New Request** Requested Dates: From: Thru:
14. ☐ **Update to existing PA** a. Update From: Thru: b. PA No.

(Required for PA updates only.)

Alcohol and/or Drug (Substance Abuse) Program or Treatment Services

Services	Code	Modifier	Unit	15. Units Req.		Rate	16. $ Req.
Drug screen, qualitate/multi *[Multiple drug]*	80100		1 screening		+		
Medication management	90862		1 visit		X	$75.00	
Alcohol/drug/substance abuse treatment/ program/service…							
• Individual substance abuse counseling	H2035	U6	15 min		X	$17.00	
• Assessment *[and diagnosis by substance abuse counselor]*	H0001		1 session		X	$100.00	
• Group counseling by a clinician	H0005		15 min		X	$9.00	
• Case management *[care coordination]*	H0006		15 min		X	$16.00	
• Acute detoxification *[residential addiction program, outpatient]*	H0013		1 day		X	$300.00	
• Intensive outpatient…	H0015		15 min		X	$17.00	
• Intervention service *[intermediate service]*	H0022		15 min		X	$17.00	
• Family/Couple counseling *[family counseling]*	T1006		15 min		X	$17.00	
• Skills development *[rehabilitation treatment services]*	T1012		15 min		X	$17.00	
					17. Total $ Requested		

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

[+]Per Medicare fee schedule.

Revised 12/08/09

SUBSTANCE ABUSE
PRIOR AUTHORIZATION REQUEST

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

Provider Information

Request Date
Provider Name
Provider ID No.
Contact Name
Contact Phone No.

Recipient Information

Recipient Name
Recipient ID No.

18. Client meets American Society of Addiction Medicine (ASAM) criteria for medical necessity as evidenced by:

	ASAM Dimension	Level of Care	Criteria
1.			
2.			
3.			
4.			
5.			
6.			

By submission of this form, the provider:

- Affirms the assessment of the recipient's symptomatology and current level of functionality is documented in the recipient's record and indicates the units and duration of services requested are medically necessary,
- Affirms the recipient's record includes documentation of the clinical team recommendation of the requested services as medically necessary, and
- Acknowledges the services are subject to post-payment review for medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules.

The Department of Health and 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.

19. Signature _____ Title _____

If this form requests more than $10,000 of services in field 17, it must be approved by the Division of Behavioral Health (DBH) Treatment & Recovery staff before it is submitted to Affiliated Computer Services, Inc.

20. DBH Signature _____ Date _____

Substance Abuse Prior Authorization Request Instructions

Submission Requirements: This prior authorization (PA) form must be completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual and must bear the signature of a person authorized to bind the requesting facility. **If field 17 (Total $ Requested) is less than $10,000, submit the request directly to Affiliated Computer Services, Inc. (ACS). If field 17 is $10,000 or more, submit the request to your DBH Treatment and Recovery Regional Office.**

Page 1:

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled substance abuse facility.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the substance abuse facility.
4. **Contact Name and Address:** Enter the name and address of the person ACS should contact regarding the authorization request. The authorization decision will be returned to the address entered here.
5. **Phone No.:** Enter the contact person's telephone number.
6. **Fax No.:** Enter the contact person's fax number, if applicable.
7. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
8. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
9. **Date of Birth:** Enter the recipient's date of birth.
10. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
11. **Gender (recipient's):** Check appropriate box for male or female.
12. **Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
13. **New Request:** Mark this box if the prior authorization request is a request to initially exceed the annual service limits identified in the Provider Billing Manual. Enter the dates requested for the initial prior authorization. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
14. **Update to existing PA:** Mark this box when:
    - Requesting an update to add additional units of service to the existing PA record referred to in Field 14b.
    - Adding services not already included in the existing PA record referred to in Field 14b.
    - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 14b.

    a. Update: Enter the "from" and "thru" dates for the authorization period being requested. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.

    b. PA Number: Enter the number of the PA record being updated.
15. **Units Req:** Enter the number of **additional units** of services being requested. Always use the lowest unit size available when entering the Units Required.
16. **$ Req:** Multiply the units requested (field 15) by the maximum allowed dollar amount (Max $).
17. **Total $ Requested:** Enter the sum of the $ Req column (field 16).

Page 2: Enter the request date, Provider name and ID number, Contact person and phone number, recipient name and ID number as entered on page 1. **If you do not enter this information, ACS may not be able to process your authorization.**

18. **Client meets American Society of Addiction Medicine (ASAM) criteria for medical necessity as evidenced by:** Indicate the clinical justification for the extension.
19. **Signature:** The signature must be by a person authorized to bind the facility to the completed form as accurate and subject to Medical Assistance program rules. Please include the title of the person signing the prior authorization request form.
20. **DBH Signature:** The DBH signature indicates DBH reviewed the form and may have discussed the request with the clinic staff for clarification. The signature does not indicate acceptance of the requested services or units as medically necessary. Medical necessity may be determined during a post-payment review according to Medical Assistance program rules. The division may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medical Assistance program rules.