13.b. Screening services

Reimbursement is available for medically reasonable and necessary screening services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:
(1) be medically reasonable and necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
(2) not be considered a noncovered service, or otherwise excluded from coverage.

Services excluded from coverage are the following:

(a) Radiology examinations of any body part taken as a routine study not necessary to the diagnosis or treatment of a medical condition.
(b) Doppler Evaluations - The ultrasonic measurement cannot be used for routine screening purposes.
(c) Vision Care Services - Screening services (excluding EPSDT) for recipients are not covered by Medicaid, and payment will not be made for such care.
(d) Podiatric Services - Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on patients on a routine basis for screening purposes.

13.c. Preventive services

Reimbursement is available for medically reasonable and necessary preventative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:
(1) be medically reasonable and necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
(2) not be considered a noncovered service, or otherwise excluded from coverage.

13.d. Rehabilitative services

Reimbursement is available for medically reasonable and necessary rehabilitative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:

(1) be medically reasonable and necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
(2) not be considered a noncovered service, or otherwise excluded from coverage.

All therapies provided in a rehabilitation center must be provided in accordance with the following:

Demonstration of the inability of the recipient to function independently with demonstrated impairment:
(1) Cognitive function (attention span, memory, or intelligence).
(2) Communication (aphasia with major receptive or expressive dysfunction).
(3) Continence (bladder or bowel).
(4) Mobility (transfer, walk, climb stairs, or wheelchair).
(5) Pain management (pain behavior limits functional performance).
(6) Perceptual motor function (spatial orientation or depth or distance perception).
(7) Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis).

The intensity of service criteria shall be as follows:
(1) Multidisciplinary team evaluations should occur at minimum every two (2) weeks.
(2) Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
(A) Occupational therapy.
(B) Speech therapy.
(3) Participation in a rehabilitation program under the direction of a qualified physician.
(4) Skilled rehabilitative nursing care or supervision required at least daily.

Discharge criteria may include, at minimum, the following:
(1) Evidence in the medical record indicating the patient has achieved stated goals.
(2) Medical complications precluding intensive rehabilitative effort.
(3) Multidisciplinary therapy is no longer needed.
(4) Additional functional improvement is not anticipated.
(5) Patient's functional status has remained unchanged for fourteen (14) days.

Educational services are not covered.

13.d.1. Medicaid Rehabilitation Option

Reimbursement is available for Medicaid Rehabilitation Option (MRO) services, which are defined as:

(1) Behavioral Health Counseling and Therapy services. Refers to a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan.

These services include the following:

- Individual counseling and therapy
- Family/Couple (Individual) with the consumer present counseling and therapy
- Family/Couple (Individual) without the consumer present counseling and therapy
- Group counseling and therapy
- Family/Couple (Group) with the consumer present counseling and therapy
- Family/Couple (Group) without the consumer present counseling and therapy

Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed professional, except for a licensed clinical addiction counselor, defined as: Individuals wishing to be addiction counselors or clinical addiction counselors must meet the education, counseling experience, examination and exemptions, renewal of licensure, and temporary permit requirements of the State of Indiana.
- Qualified Behavioral Health Professional (QBHP)

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5	Individual Counseling and Therapy	48
5A	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5	Group Counseling and Therapy	60
5A	Group Counseling and Therapy	60

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5 /6	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5 /6	Group Counseling and Therapy	60

(2) Medication Training and Support services. Refers to monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing/medical assessments. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed physician
- Authorized health care professional
- Licensed physician assistant (PA)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical Assistant (MA) who has graduated from a two (2) year clinical program

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5	Medication Training and Support	104
5A	Medication Training and Support	104

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5 /6	Medication Training and Support	104

(3) Skills Training and Development services. Refers to the development and/or restoration of skills (i.e., self-care, daily life management, or problem solving skills) directed toward restoring an individual to his best possible functional level, eliminating psychosocial barriers, and restoring a consumer's abilities that are essential to independent living. Development and/or restoration of skills is provided

through structured interventions for attaining recovery goals identified in the individualized integrated care plan and the monitoring of progress in achieving those skills. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5	Skills Training and Development	900
5A	Skills Training and Development	1000

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5 /6	Skills Training and Development	900

(4) Behavioral Health Level of Need Redetermination. Refers to services required to assess an individual's functional needs and strengths, determine level of need, and make changes to the individualized integrated care plan. The assessment is used as a clinical guide and a treatment planning tool which assists providers in creating a person-centered plan of care. The redetermination includes face-to-face contact with the consumer and face-to-face or telephone collateral contacts with family members or non-professional caretakers, which results in a completed redetermination. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction.

The following providers are qualified to deliver this service:

- Individuals meeting the Division of Mental Health and Addiction's (DMHA) training competency standards for the performance of the DMHA approved assessment tool.

Limitations:

- Reimbursement is allowed for one redetermination per 180 days for Adults LON 3-5A and Children/Adolescents LON 3-6.

- Care Coordination services. Refers to services that help consumers gain access to needed medical, social, educational, and other services. Care coordination services include the assessment of the eligible consumer to determine service needs, development of an individualized integrated care plan, referral and related activities to help the consumer obtain needed services, monitoring and follow-up, and evaluation. Care coordination is a service on behalf of the consumer, not to the consumer, and is management of the case, not the consumer.

  The following providers are qualified to deliver this service:
  - A licensed professional
  - A QBHP
  - An OBHP

  Limitations:
- Activities billed under behavioral health level of need redetermination.
- The actual or direct provision of medical services or medical treatment.

(5) Crisis Intervention services. Refers to short-term emergency behavioral health services, available twenty-four (24) hours a day, seven (7) days a week. Crisis Intervention includes, but is not limited to crisis assessment, planning and counseling specific to the crisis, intervention at the site of the crisis (when clinically appropriate), and pre-hospital assessment. The goal of Crisis Intervention is to resolve the crisis, and transition the consumer to routine care through stabilization of the acute crisis and linkage to necessary services. Crisis Intervention may be provided in an emergency room, crisis clinic setting, or within the community. Services may be provided to any Medicaid eligible individual in need of crisis services.

The following providers are qualified to deliver this service:
- Licensed professional
- QBHP
- OBHP

There are no limitations on this service.

(6) Child and Adolescent Intensive Resiliency Services (CAIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an individualized integrated care plan. CAIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. CAIRS is designed to alleviate emotional or behavioral problems with the goal of reintegrating the child into the community setting. CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS is time-limited, curriculum-based, with goals that include reintegration into age appropriate community settings (e.g., school and activities with pro-social peers). Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, or addiction.

The following providers are qualified to deliver this service:
- Licensed professional
- QBHP
- OBHP

Limitations:

- The program is required to operate 2-4 hours per day and 3-5 days per week.
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	252-Limited to 90 consecutive days
5 /6	CAIRS	252-Limited to 90 consecutive days

(7) Adults Intensive Rehabilitative Services (AIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting for consumers who require structured rehabilitative services to maintain the consumer on an outpatient basis. AIRS is curriculum based and designed to alleviate emotional or behavior problems with the goal of reintegrating the consumer into the community, increasing social connectedness beyond a clinical setting, and/or employment. AIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness, or addiction.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations:

- The program is required to operate 2-6 hours per day and 3-5 days per week
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	270-Limited to 90 consecutive days
5 /6	CAIRS	270-Limited to 90 consecutive days

(8) Intensive Outpatient Treatment (IOT). Refers to a treatment program that operates at least three (3) hours per day, at least three (3) days per week, and are based on an individualized integrated care plan. IOT is planned and organized with addiction professionals and clinicians in a group setting to provide multiple treatment service components for rehabilitation of alcohol and other drug abuse or dependence. IOT includes referral to 12-step programs, peers and other community supports, education on addiction disorders, skills training in communication, anger management, stress management and relapse prevention, as well as individual, group and family therapy. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (3 hour)
4	IOT	40
5	IOT	40

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (3 hour)
4	IOT	40
5 /6	IOT	40

(9) Addiction Counseling services. Refers to a planned and organized service where addiction professionals and clinicians provide counseling intervention. Addiction Counseling is designed to be a less intensive alternative to Intensive Outpatient Treatment (IOT). In addition to individual, group, and family addiction counseling, other activities included are: education on addiction disorders and skills training in communication, anger management, stress management and relapse prevention. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5	Addiction Counseling	32
5A	Addiction Counseling	50

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5 /6	Addiction Counseling	32

(10) Peer Recovery services. Refers to individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services which may be provided include:

- Assisting the consumer with developing self-care plans, and other formal mentoring activities aimed at increasing active participation in person-centered planning and delivery of individualized services.
- Assisting the consumer in the development of psychiatric advanced directives.
- Supporting day-to-day problem solving related to normalization and reintegration into the community.
- Education and promotion of recovery and anti-stigma activities associated with mental illness and addiction.

Peer Recovery Services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan (IICP). An IICP is developed with the consumer and must reflect the consumer's desires and choices. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness or addiction. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Certified Recovery Specialists (CRS). A CRS is an individual meeting DMHA training and competency standards for Peer Recovery services. Individuals providing Peer Recovery Services must be under the supervision of a Licensed professional or QBHP.

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Peer Recovery	104
4	Peer Recovery	156
5	Peer Recovery	208
5A	Peer Recovery	260

(11) Psychiatric Assessment and Intervention services. Refers to face-to-face and non-face-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to consumers who are receiving services from an interdisciplinary team. Services may be provided for persons with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community.

The following providers are qualified to deliver this service:

- Physician
- Authorized healthcare professional

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
5	Psychiatric Assessment and Intervention	25
5A	Psychiatric Assessment and Intervention	100

Service Packages and Prior Authorization
MRO service packages are assigned to persons with a behavioral health need as demonstrated by a qualifying diagnosis and level of need. Services packages are designed to authorize a set of services and units of service necessary for the majority of persons with similar functional needs to achieve recovery. Service packages are assigned for 180 days based on the level of need assessment. Within the last 30 days of an assigned service package, a provider may reassess the person and a new service package will be assigned to start the day after the existing service package ends.

- Prior authorization is available under the following circumstances: A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
- A member requires a medically necessary MRO service not authorized in his or her MRO service package.
- A member does not have one or more qualifying MRO diagnoses and/ or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
- A member is newly eligible to the Medicaid program, or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive request for prior authorization is appropriate for MRO services provided during the retroactive period.

Providers must demonstrate that the service requested is medically necessary.

Individualized Integrated Care Plan Requirements
The supervising physician or health service provider in psychology (HSPP) bears the ultimate responsibility for certifying the diagnosis and individualized integrated care plan for MRO services. The supervising physician or HSPP is responsible for seeing the patient during the intake process or reviewing information submitted by the other licensed professionals, qualified behavioral health provider (QBHP), or other behavioral health provider (OBHP) and approving the individualized integrated care plan within seven (7) days. The supervising physician or HSPP must provide face to face visits with the patient or review the individualized integrated care plan submitted by the QBHP at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the physician or HSPP assuming responsibility for the care plan.

Provider Qualification Definitions
A licensed professional is defined as:
(1) A licensed psychiatrist.
(2) A licensed physician.
(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
(4) A licensed clinical social worker (LCSW).
(5) A licensed mental health counselor (LMHC).
(6) A licensed marriage and family therapist (LMFT).
(7) A licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.

A "qualified behavioral health professional" (QBHP) means any of the following persons:
(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:

(a) In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana.
(b) In pastoral counseling from an accredited university.
(c) In rehabilitation counseling from an accredited university.

(2) An individual who is under the supervision of a licensed professional, as defined above, is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:

(a) In social work from a university accredited by the Council on Social Work Education.
(b) In psychology from an accredited university.
(c) In mental health counseling from an accredited university.
(d) In marital and family therapy from an accredited university.

(3) A licensed independent practice school psychologist under the supervision of a licensed professional, as defined in subsection (b) above. (4) An authorized healthcare provider (AHCP), defined as follows:

(a) a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
(b) a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1. .

Other behavioral health professional (OBHP) means any of the following persons:
(1) An individual with an associate or bachelor degree, or equivalent behavioral health experience, meeting minimum competency
standards set forth by a behavioral health service provider and supervised by either a licensed professional, as defined above, or a QBHP, as defined above.
(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5 supervised by either a licensed professional, as defined above, or a QBHP, as defined above.

Assurances.

- All medically necessary MRO services will be provided to children under the age of 21.
- All rehabilitative services are provided to or directed exclusively toward the treatment of Medicaid eligible individual.
- Any willing and qualified provider may participate in the delivery of MRO services.
- Individuals denied prior authorization for MRO services shall have an opportunity for a fair hearing.
- MRO services are sufficiently available in amount, duration and scope to reasonably achieve their purpose.

Limitations. Medicaid will reimburse for Medicaid Rehabilitation Option services when:

(a) provided to a person who
    i. meets specific diagnosis and level of need criteria under the approved DMHA assessment tool demonstrating a behavioral health need or
    ii. receives prior authorization approval for a medically necessary service;
(b) provided by personnel who meet appropriate federal, state and local regulations for their respective discipline or are under the supervision/direction of a qualified behavioral health professional; and through a behavioral health service provider that is an enrolled as a Medicaid provider that offers a full continuum of care as defined as a range of services the provision of which is assured by a provider. The term includes the following individualized treatment planning to increase patient coping skills and symptom management, which

may include: twenty-four (24) hour a day crisis intervention; care coordination to fulfill individual patient needs, including assertive care coordination when indicated; outpatient services, including intensive outpatient services, substance abuse services, counseling, and treatment; acute stabilization services, including detoxification services; residential services; day treatment; family support services; medication evaluation and monitoring; and services to prevent unnecessary and inappropriate treatment and hospitalization.

(c) providers wishing to provide MRO services must be certified to provide a continuum of care to Medicaid consumers. These providers may subcontract for services as appropriate.

14. Services for individuals age 65 or older in institutions for mental diseases

Provided with limitations.

14.a.

Inpatient hospital services Reimbursement is available for medically reasonable and necessary inpatient psychiatric hospital services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Prior authorization is required for all inpatient psychiatric admissions including admissions for substance abuse

Reimbursement is available for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

(1) Danger to the individual.
(2) Danger to others.
(3) Death of the individual.

Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization or stay in a psychiatric residential treatment facility is found not to have been medically necessary.

The payment will be made only for ambulance services, and neither for non-ambulatory services nor commercial ambulatory services. The payment will be equal to the amount under STEP SIX below, which is calculated as follows:

STEP ONE: The Office of Medicaid Policy and Planning (Office) shall identify Medicaid providers that received reimbursement for ambulance transportation during the quarter.

STEP TWO: For each Medicaid provider described in STEP ONE, the Office shall identify the ambulance transportation services for which the Medicaid provider was reimbursed.

STEP THREE: For each Medicaid provider described in STEP ONE, the Office shall calculate the reimbursement paid to the Medicaid provider for the ambulance transportation services identified under STEP TWO.

STEP FOUR: For each Medicaid provider described in STEP ONE, the office shall calculate the Medicaid provider's usual charges for each of the Medicaid provider's services identified under STEP TWO.

STEP FIVE: For each Medicaid provider described in STEP ONE, the Office shall subtract an amount equal to the reimbursement calculation for each of the ambulance transportation services under STEP THREE from an amount equal to the amount calculated for each of the ambulance transportation services under STEP FOUR.

STEP SIX: For each Medicaid provider described in STEP ONE, the Office shall calculate the sum of each of the amounts calculated for each ambulance transportation services under STEP FIVE.

In the event that available funds eligible for federal financial participation are insufficient to provide the full state share for a provider's payment as calculated using the steps above, the payment will be reduced in proportion to that deficiency.

Reimbursement is also available for oxygen used during ambulance transport and waiting time for certain trips.

Community Mental Health Rehabilitation Services

Payment will be based upon the lower of the provider's submitted charge or the OMPP maximum allowance for the procedure billed. Maximum allowances are established by the Department of Mental Health based upon a review of like charges by similar providers throughout the State. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community Mental Health Rehabilitation Services. The agency's fee schedule rate was set as of 7-1-2010 and is effective for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.