SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

MED-PEER RECOVERY SERVICES

(CMHC Only)

I. Service Description

A. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO Eligible adults and children only and will not be provided through DCS funding.

1. Exception made in payment for Court Appearance and Child and Family Team Meeting. See Section VI- Billable Units.

B. The Service Standard is not a Medicaid Standard and includes services that are not billable to Medicaid.

C. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any preauthorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

D. Peer Recovery Services are 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.

II. Service Delivery

A. Peer Recovery Services must be identified in the Individualized Integrated Care Plan (IICP) and correspond to specific treatment goals.

B. The client is the focus of Peer Recovery Services.

C. Peer Recovery Services must demonstrate progress toward and/or achievement of client treatment goals identified in the IICP.

D. Peer Recovery Services are rehabilitative in nature.

E. Peer Recovery Services must be age appropriate for a client age eighteen (18) and under receiving services.

F. Documentation must support how the service specifically benefits the client.

G. Peer Recovery Services must be face-to-face and include the following components:

1. Assisting the client with developing self-care plans and other formal mentoring activities aimed at increasing active participation in person-centered planning and delivery of individualized services.

2. Assisting the client in the development of psychiatric advanced directives.

3. Supporting day-to-day problem solving related to normalization and reintegration into the community.
4. Education and promotion of recovery and anti-stigma activities associates with mental illness and addiction.

III. Target Population

A. Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:
   1. Clients age eighteen (18) and older.
      a) Peer Recovery Services may be provided to clients' ages sixteen (16) and seventeen (17) with an approved prior authorization.
   2. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
   3. Children and their families which have an IA or the children have the status of CHINS and/or JD/JS.
   4. All adopted children and adoptive families.

IV. Goals and Outcomes

A. Goal #1: To become socialized, recover, develop self-advocacy, develop natural supports, and maintain community living skills.

V. Qualifications

A. Peer Recovery Services must be provided by individuals meeting DMHA training and competency standards for Certified Recovery Specialist (CRS).

B. Individuals providing Peer Recovery Services must be under the supervision of a licensed professional or Qualified Behavioral Health Professional (QBHP).

VI. Billable Units

A. Peer Recovery Services is included in adult packages only and is limited to the following:
   1. Service Package 3: 104 units
   2. Service Package 4: 156 units
   3. Service Package 5: 208 units
   4. Service Package 5A: 260 units

B. Prior Authorization is required for clients requiring additional units for this service.

C. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding.
   1. Billing Code Title H0038 HW: Self-help/peer services, per 15 minutes

D. Exclusions:

1. Peer Recovery Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed.
2. Interventions targeted to groups are not billable as Peer Recovery Services.
3. Activities that may be billed under Skills Training and Development or Case Management services are not billable as Peer Recovery Services.
4. Peer Recovery Services are not reimbursable for children under the age of sixteen (16).
5. Peer Recovery Services that occur in a group setting are not reimbursable.

E. DCS Funding

1. Child and Family Team Meeting (CFTM):
   a) MRO provider of this service may be requested to participate in the CFTM.
   b) The MRO provider may bill DCS for the actual time spent in the CFTM.
2. Court:
   a) The MRO provider of this service may be requested to testify in court.
   b) A court appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance.
   c) If the MRO provider appeared in court two different days, they could bill for 2 court appearances.
      (1) A maximum of 1 court appearance per day.
   d) The rate of the court appearance includes all costs associated with the court appearance; therefore, additional costs associated with the appearance cannot be billed separately.
3. Reports:
   a) If the services provided are not funded by DCS, the “Reports” hourly rate will be paid.
   b) DCS will only pay for reports when DCS is not paying for these services.
   c) A referral for “Reports” must be issued by DCS in order to bill.
      (1) The provider will document the family’s progress within the report.
4. Interpretation, Translation, and Sign Language Services
   a) The location of and cost of interpretation, translation, and sign language services are the responsibility of the Service Provider.

b) If the service is needed in the delivery of services referred, DCS will reimburse the provider for the cost of the interpretation, translation, or sign language service at the actual cost of the service to the provider.

c) The referral from DCS must include the request for Interpretation Services and the agency's invoice for this service must be provided when billing DCS for the service.

d) Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.

e) The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.

f) If the agency utilizes their own staff to provide interpretation, they can only bill for the interpretation services. The agency cannot bill for performing two services at one time.

5. Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

a) 0 to 7 minutes – Do not bill (0.00 hour)

b) 8 to 22 minutes – 1 fifteen minute unit (0.25 hour)

c) 23 to 37 minutes - 2 fifteen minute units (0.50 hour)

d) 38 to 52 minutes – 3 fifteen minute units (0.75 hour)

e) 53 to 60 minutes – 4 fifteen minute units (1.00 hour)

VII. Case Record Documentation

A. Necessary case record documentation for service eligibility must include:

1. A completed, dated, signed DCS/Probation referral form authorizing service.
2. Documentation of regular contact with the referred families/children and referring agency.
3. Written reports no less than monthly or more frequently as prescribed by DCS.
4. Monthly reports are due by the 10th of each month following the month of service.

a) Case documentation shall show when report is sent.

VIII. Service Access

A. All services must be accessed and pre-approved through a referral form from the referring DCS staff.

B. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.

C. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS.

D. Providers must initiate a re-authorization for services to continue beyond the approved period.

E. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to DCS Practice Model

A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.

B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

X. Interpreter, Translation, and Sign Language Services

A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.

B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.

C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).

E. Sign Language should be done in the language familiar to the family.

F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.

H. No side comments or conversations between the Interpreters and the clients should occur.

XI. Trauma Informed Care

A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (http://www.samhsa.gov/nctic/):

1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"
3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

B. Trauma Specific Interventions: (modified from the SAMHSA definition)

1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XII. Training

A. Service provider employees are required to complete general training competencies at various levels.

B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.

C. Training requirements, documents, and resources are outlined at: http://www.in.gov/dcs/3493.htm

1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.

2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XIII. Cultural and Religious Competence

A. Provider must respect the culture of the children and families with which it provides services.

B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.

C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.

1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
3. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.

E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XIV. Child Safety

A. Services must be provided in accordance with the Principles of Child Welfare Services.

B. All services (even individual services) are provided through the lens of child safety.

1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.

2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statue, IC 31-33-5-1.

C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.