TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #10-45(F)

DIGEST

Amends 405 IAC 5-3-13 to add partial hospitalization to services requiring prior authorization, to delete assertive community treatment intensive case management from the list of services requiring prior authorization, and to replace community mental health rehabilitation services with Medicaid rehabilitation option (MRO) services. Amends 405 IAC 5-20-8 to exclude persons holding a master's degree in social work, marital and family therapy, or mental health counseling from being reimbursed for partial hospitalization services; defines the conditions under which partial hospitalization services will be reimbursed, the standards for partial hospitalization programs, and the exclusions to reimbursement for partial hospitalization services; and removes partial hospitalization as a general service that is not reimbursable by Medicaid, except as provided under 405 IAC 5-21.5. Adds 405 IAC 5-21.5 to define MRO services and terms related to MRO services; to set out reimbursement for MRO services; to define behavioral health rehabilitation services, including the provision of behavioral health counseling and therapy, medication training and support, skills training and development, behavioral health level of need redetermination, crisis intervention, child and adolescent intensive resiliency services, adult intensive rehabilitation services, intensive alcohol or drug, or both, outpatient treatment, alcohol or drug, or both, counseling, peer recovery services, case management services, and psychiatric assessment and intervention; to define case management services, including services, standards, and exclusions; to define eligibility criteria for the MRO program services, program standards, and provider types that may provide services; to define prior authorization requirements for MRO services. Amends 405 IAC 5-29-1 to make technical corrections. Repeals 405 IAC 5-21-1, 405 IAC 5-21-2, 405 IAC 5-21-3, 405 IAC 5-21-4, 405 IAC 5-21-5, 405 IAC 5-21-6, and 405 IAC 5-21-8. Effective 30 days after filing with the Publisher.

405 IAC 5-3-13; 405 IAC 5-20-8; 405 IAC 5-21-1; 405 IAC 5-21-2; 405 IAC 5-21-3; 405 IAC 5-21-4; 405 IAC 5-21-5; 405 IAC 5-21-6; 405 IAC 5-21-8; 405 IAC 5-21.5; 405 IAC 5-29-1

SECTION 1. 405 IAC 5-3-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-13 Services requiring prior authorization

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 13. (a) Medicaid reimbursement is available for the following services with prior authorization:
(1) Reduction mammoplasties.
(2) Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem.
(3) Intersex surgery.
(4) Blepharoplasties for a significant obstructive vision problem.
(5) Sliding mandibular osteotomies for prognathism or micrognathism.
(6) Reconstructive or plastic surgery.
(7) Bone marrow or stem cell transplants.
(8) All organ transplants covered by the Medicaid program.
(9) Home health services.
(10) Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures.
(11) Temporomandibular joint surgery.
(12) Submucous resection of nasal septum and septoplasty when associated with significant obstruction.
(13) Weight reduction surgery, including gastroplasty and related gastrointestinal surgery.
(14) Any procedure ordinarily rendered on an outpatient basis, when rendered on an inpatient basis.
(15) All dental admissions.
(16) Brand medically necessary drugs.
~~(17) Other drugs as specified in accordance with 405 IAC 5-24-8.5.~~
~~(18)~~ **(17)** Psychiatric inpatient admissions, including admissions for substance abuse.
~~(19)~~ **(18)** Rehabilitation inpatient admissions.
~~(20) Assertive community treatment intensive case management as provided under 405 IAC 5-21-1.~~
~~(21)~~ **(19)** Orthodontic procedures for members under twenty-one (21) years of age for cases of craniofacial deformity or cleft palate.

~~(22)~~ **(20)** Genetic testing for detection of cancer of the breast or breasts or ovaries.
~~(23) Community mental health rehabilitation services.~~ **(21) Medicaid rehabilitation option services, except for crisis intervention.**
~~(24) As otherwise specified in this article.~~
(22) Partial hospitalization, as provided under 405 IAC 5-20-8.
(23) As otherwise specified in this article.

~~If any of the surgeries listed in this section are performed during a hospital stay for another condition, prior authorization is required for the surgical procedure.~~

(b) If any of the surgeries listed in this section are performed during a hospital stay for another condition, prior authorization is required for the surgical procedure.

~~(b)~~ **(c)** Requests for prior authorization for the surgical procedures in this section will be reviewed for medical necessity on a case-by-case basis in accordance with this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; filed Sep 1, 2000, 2:16 p.m.: 24 IR 14; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1613; filed Feb 26, 2004, 3:45 p.m.: 27 IR 2244; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2132; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1903; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:32 a.m.: 20090916-IR-405080192FRA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

SECTION 2. 405 IAC 5-20-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-8 Outpatient mental health services

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 8. Medicaid reimbursement is available for outpatient mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as a health service provider in psychology (HSPP). Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:

(1) Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in 405 IAC 5-25.

(2) Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one (1) of the following practitioners:

(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A licensed clinical social worker.
(D) A licensed marital and family therapist.
(E) A licensed mental health counselor.
(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, **except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.**
(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

(3) The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:

(A) The physician, psychiatrist, or HSPP is responsible for seeing the recipient during the intake process or reviewing the medical information obtained by the practitioner listed in subdivision (2) within seven (7) days of the intake process. This review by the physician, psychiatrist, or HSPP must be documented in writing.
(B) The physician, psychiatrist, or HSPP must again see the patient or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed in subdivision (2) at intervals not to exceed ninety (90) days. This review must be documented in writing.

(4) Medicaid will reimburse partial hospitalization services under the following conditions and subject to prior authorization:

(A) Partial hospitalization programs must be highly intensive, time-limited medical services that

either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measureable *[sic]* **and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.**

(B) Partial hospitalization programs must have the ability to reliably contract for safety. Consumers with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.

(C) Services may be provided for consumers of all ages who are not at imminent risk to harm to *[sic]* **self or others. Consumers who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. Consumers must have a diagnosed or suspected behavioral health condition and one (1) of the following:**

(i) A short-term deficit in daily functioning.

(ii) An assessment of the consumer indicating a high probability of serious deterioration of the consumer's general medical or behavioral health.

(D) Program standards shall be as follows:

(i) Services must be ordered and authorized by a psychiatrist.

(ii) Services require prior authorization pursuant to 405 IAC 5-3-13(a).

(iii) A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twenty-four (24) hours following admission to the program.

(iv) A psychiatrist must actively participate in the case review and monitoring of care.

(v) Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or a HSPP must appear in the consumer's clinical record.

(vi) At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.

(vii) For consumers under eighteen (18) years of age, documentation of active psychotherapy must appear in the consumer's clinical record.

(viii) For consumers under eighteen (18) years of age, a minimum of one (1) family encounter per five (5) business days of episode of care is required.

(ix) Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.

(x) Programs must not mix consumers receiving partial hospitalization services with consumers receiving outpatient behavioral health services.

(E) Exclusions shall be as follows:

(i) Consumers at imminent risk of harm to self or others are not eligible for services.

(ii) Consumers who concurrently reside in a group home or other residential care setting are not eligible for services.

(iii) Consumers who cannot actively engage in psychotherapy are not eligible for services.

(iv) Consumers with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services.

(v) Consumers who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services.

~~(4)~~ **(5)** Medicaid will reimburse for evaluation and group, family, and individual psychotherapy when provided by a psychologist endorsed as an HSPP.

~~(5)~~ **(6)** Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when provided by a physician or an HSPP.

~~(6)~~ **(7)** Prior authorization is required for mental health services provided in an outpatient or office setting that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time, except neuropsychological and psychological testing, which is subject to prior authorization as stated in subdivision ~~(5).~~ **(4)(D)(ii).**

~~(7)~~ **(8)** The following are services that are not reimbursable by the Medicaid program:

(A) Daycare.

(B) Hypnosis.

(C) Biofeedback.

(D) Missed appointments.

~~(E) Partial hospitalization, except as set out in 405 IAC 5-21.~~

~~(8)~~ **(9)** All outpatient services rendered must be identified and itemized on the Medicaid claim form. Additionally, the length of time of each therapy session must be indicated on the claim form. The medical record documentation must identify the services and the length of time of each therapy session. This information must be available for audit purposes.

~~(9)~~ **(10)** A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must

be attached to the prior authorization form and available for audit purposes.

~~(10)~~ **(11)** For psychiatric diagnostic interview examinations, Medicaid reimbursement is available for one (1) unit per recipient, per provider, per rolling twelve (12) month period of time, except as follows:

(A) A maximum of two (2) units per rolling twelve (12) month period of time per recipient, per provider, may be reimbursed without prior authorization, when a recipient is separately evaluated by both a physician or HSPP and a midlevel practitioner.

(B) Of the two (2) units allowed without prior authorization, as stated in clause (A), one (1) unit must be provided by the physician or HSPP and one (1) unit must be provided by the midlevel practitioner.

(C) All additional units require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; filed Sep 27, 1999, 8:55 a.m.: 23 IR 315; filed Jun 9, 2000, 9:55 a.m.: 23 IR 2707; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 28, 2001, 9:56 a.m.: 25 IR 61; errata filed Nov 21, 2001, 11:33 p.m.: 25 IR 1184; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

SECTION 3. 405 IAC 5-21.5 IS ADDED TO READ AS FOLLOWS:

Rule 21.5. Medicaid Rehabilitation Option Services

405 IAC 5-21.5-1 Definitions

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 1. (a) As used in this rule, "Medicaid rehabilitation option" (MRO) refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his or her practice, for the maximum reduction of a mental disability and the restoration of a consumer's best possible functional level.

(b) As used in this rule, "licensed professional" means any of the following persons:
(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 (LCAC), as defined under IC 25-23.6-10.5.

(c) As used in this rule, "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 under subsection (b) 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 under subsection (b) 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 health care professional (AHCP), as used in this rule, means any of the following persons:

(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 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.

(d) As used in this rule, "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 under subsection (b) above, or a QBHP, as defined under subsection (c) above.

(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5 supervised by either a licensed professional, as defined under subsection (b) above, or a QBHP, as defined under subsection (c) above.

(e) As used in this rule, "approved division of mental health and addiction (DMHA) assessment tool" refers to a state designated, consumer-appropriate instrument for a provider's assessment of consumer functional impairment.

(f) As used in this rule, "clinic option" refers to services defined under 405 IAC 5-20-8.

(g) As used in this rule, "detoxification services" refer to services defined under 440 IAC 9-2-4.

(h) As used in this rule, "level of need" refers to a recommended intensity of behavioral health services, based on a pattern of a consumer's and family's needs, as assessed using a standardized assessment instrument.

(i) As used in this rule, "rehabilitative" refers to the federal definition of rehabilitative, as defined under 42 CFR 440.130(d).

(j) As used in this rule, "nonprofessional caregiver" refers to an individual who does not receive compensation for providing care or services to a Medicaid consumer.

(k) As used in this rule, "professional caregiver" refers to an individual who receives payment for providing services to a Medicaid consumer.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-1; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-2 Reimbursement

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-29

Sec. 2. (a) The office of Medicaid policy and planning (OMPP) will reimburse MRO services for consumers who meet specific diagnosis and level of need criteria under the approved DMHA assessment tool. The listing of diagnostic and level of need criteria approved for reimbursement shall be as follows:

(1) Will be listed and published in a provider manual by the OMPP.

(2) May be updated by the OMPP as needed.

(b) Services are provided:

(1) through a behavioral health service provider that is an enrolled as a Medicaid provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate; and

(2) by personnel who meet appropriate federal, state, and local regulations for their respective disciplines or are under the supervision or direction of a licensed professional or QBHP.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-2; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-3 Behavioral health rehabilitation services

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 3. (a) The services reimbursable as behavioral health rehabilitation services are clinical behavioral health services that are provided for consumers, families, or groups of persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Behavioral health rehabilitation services are as follows:

(1) Behavioral health counseling and therapy.
(2) Medication training and support.
(3) Skills training and development.
(4) Behavioral health level of need redetermination.
(5) Crisis intervention.
(6) Child and adolescent intensive resiliency services.
(7) Adult intensive rehabilitative services.
(8) Intensive outpatient alcohol or drug treatment.
(9) Alcohol or drug (substance-related disorder) counseling.
(10) Peer recovery services.
(11) Case management.
(12) Psychiatric assessment and intervention.

(b) Outpatient behavioral health rehabilitation services may include clinical attention in the consumer's home, workplace, emergency room, or wherever needed.

(c) Outpatient behavioral health rehabilitation services are rehabilitative in nature and must be indicated in an individualized integrated care plan.

(d) Level of need requirements and maximum allowable units:
(1) will be listed and published in a provider manual by the OMPP; and
(2) may be updated by the OMPP as needed.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-3; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-4 Behavioral health counseling and therapy

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3; IC 25-23.6-10.5

Sec. 4. (a) The services reimbursable as individual or group behavioral health counseling and therapy consist of a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. The service must be provided at the consumer's home or at other locations outside the clinic setting.

(1) Requirements for individual or group behavioral health counseling and therapy services shall be as follows:

(A) Services may be provided for consumers of all ages.
(B) Providers must meet the either of the following qualifications:

(i) A licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.
(ii) A QBHP.
(2) Programming standards shall be as follows:
(A) The service requires face-to-face contact.
(B) The consumer is the focus of the service.
(C) Documentation must support how the service benefits the consumer, including when services are provided in a group setting.
(D) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
(E) Service goals must be rehabilitative in nature.
(F) When provided in a group setting, services must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age.
(3) Exclusions shall be as follows:
(A) Services provided in a clinic setting and services provided as a part of school-based services are not billable under the MRO program, and must be billed to the clinic option.
(B) Licensed clinical addiction counselors, as defined under IC 25-23.6-10.5, may not provide this service.
(C) If medication management is a component of the service session, then medication training and support may not be billed separately for the same visit by the same provider.

(b) The services reimbursable as family or couple behavioral health counseling and therapy consist of a series of time-limited, structured, and face-to-face sessions, with or without the consumer present, that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with family members or nonprofessional caregivers. The service must be provided at home or other locations outside the clinic setting.
(1) Requirements for family or couple behavioral health counseling and therapy services shall be as follows:
(A) Services may be provided for consumers of all ages.
(B) Providers must meet either of the following qualifications:
(i) A licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.
(ii) A QBHP.
(C) Services may be delivered in an individual or group setting.
(2) Programming standards shall be as follows:
(A) The service requires face-to-face contact.
(B) The consumer is the focus of the service.
(C) Documentation must support how the service benefits the consumer, including when the consumer is not present and when services are provided in a group setting.
(D) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
(E) Service goals must be rehabilitative in nature.
(F) When provided in a group setting, services must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age.
(3) Exclusions shall be as follows:
(A) Services provided in a clinic setting and service provided as a part of school-based services are not billable under the MRO program, and must be billed to the clinic option.
(B) Licensed clinical addiction counselors, as defined under IC 25-23.6-10.5, may not provide this service.
(C) If medication management is a component of the service session, then medication training and support may not be billed separately for the same visit by the same provider.
(D) Services may not be provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-4; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-5 Medication training and support

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 5. (a) The services reimbursable as individual medication training and support involve face-to-face contact with the consumer for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. This service also includes certain related nonface-to-face activities. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for consumers of all ages.

(2) Medication training and support services must be provided within the scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).

(D) A licensed practical nurse (LPN).

(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in an individual setting that includes monitoring self-administration of prescribed medications and monitoring side effects.

(B) When provided in a clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.

(C) When provided in a residential treatment setting, this service may include components of medication management services.

(D) Services may also include the following services that are not required to be provided face-to-face with the consumer:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that the consumer follows through and receives lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the consumer and physician.

(E) The consumer is the focus of the service.

(F) Documentation must support how the service benefits the consumer.

(G) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.

(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(B) Coaching and instruction regarding consumer self-administration of medications is not reimbursable under medication training and support.

(b) The services reimbursable as group medication training and support involve face-to-face contact with the consumer for the purpose of providing education and training about medications and medication side effects. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for consumers twelve (12) years of age and older.

(2) Medication training and support services must be within the provider's scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).

(D) A licensed practical nurse (LPN).

(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in a group setting that includes education and training on the administration of prescribed medications and side effects, or conducting medication groups or classes.

(B) When provided in the clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.

(C) When provided in a residential treatment setting, this service may include components of

medication management services.

(D) Services must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.

(E) The consumer is the focus of the service.

(F) Documentation must support how the service benefits the consumer, including when services are provided in a group setting.

(G) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.

(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) Services may not be provided for consumers under the age of twelve (12) years in a group setting.

(B) If clinic option medication management, counseling, or psychotherapy is provided and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(C) Coaching and instruction regarding consumer self-administration of medications is not reimbursable under medication training and support.

(D) The following services are excluded:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that the consumer follows through, and receives lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the consumer and physician.

(c) The services reimbursable as family or couple medication training and support with or without the consumer present may take place with a family member or other nonprofessional caregiver in an individual setting, and involve face-to-face contact for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing and medical assessments. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for consumers of all ages.

(2) Medication training and support services must be provided within the scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).

(D) A licensed practical nurse (LPN).

(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in an individual setting with family members or other nonprofessional caregivers on behalf of the consumer.

(B) When provided in a clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.

(C) When provided in a residential treatment setting, this service may include components of medication management services.

(D) Services may also include the following services that are not required to be provided face-to-face with the consumer:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that the consumer follows through and receives lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the consumer and physician.

(E) The consumer is the focus of the service.

(F) Documentation must support how the service benefits the consumer, including when the consumer is not present.

(G) Services must demonstrate movement toward or achievement of consumer treatment goals

identified in the individualized integrated care plan.
(H) Service goals must be rehabilitative in nature.
(4) Exclusions shall be as follows:
(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.
(B) Coaching and instruction regarding consumer self-administration of medications is not reimbursable under medication training and support.
(C) Services may not be provided to professional caregivers.

(d) The services reimbursable as family or couple medication training and support with or without the consumer present may take place with a family member or other nonprofessional caregiver in a group setting, and involve face-to-face contact for the purpose of providing education and training about medications and medication side effects. Requirements for medication training and support services shall be as follows:
(1) Services may be provided for consumers of all ages.
(2) Medication training and support services must be provided within the provider's scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:
(A) A licensed physician.
(B) An authorized health care professional (AHCP).
(C) A licensed registered nurse (RN).
(D) A licensed practical nurse (LPN).
(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.
(3) Programming standards shall be as follows:
(A) Services must be provided face-to-face in a group setting with family members or other nonprofessional caregivers on behalf of a consumer. Services include education and training on the administration of prescribed medications and side effects, or conducting medication groups or classes.
(B) When provided in a clinic setting, this service may support, but may not duplicate, activities associated with medication management activities available under the clinic option.
(C) When provided in a residential treatment setting, this service may include components of medication management services.
(D) The consumer is the focus of the service.
(E) Documentation must support how the service benefits the consumer, including when the consumer is not present and when services are provided in a group setting.
(F) Services must result in demonstrated movement towards, or achievement of, the consumer's treatment goals identified in the individualized integrated care plan.
(G) Service goals must be rehabilitative in nature.
(H) Services must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age.
(4) Exclusions shall be as follows:
(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.
(B) Coaching and instruction regarding consumer self-administration of medications is not reimbursable under medication training and support.
(C) The following services are excluded:
(i) Transcribing physician or AHCP medication orders.
(ii) Setting or filling medication boxes.
(iii) Consulting with the attending physician or AHCP regarding medication-related issues.
(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.
(v) Ensuring that consumers follow through and receive lab work and services pursuant to other clinical orders.
(vi) Follow-up reporting of lab and clinical test results to the consumer and the physician.
(D) Services may not be provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-5; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-6 Skills training and development

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 6. (a) The services reimbursable as individual or group skills training and development involve face-to-face contact that results in the development of skills directed toward eliminating psychosocial barriers. The development of skills is provided through structured interventions for attaining goals identified in the individualized integrated care plan and the monitoring of the consumer's progress in achieving those skills. Requirements for individual or group skills training and development shall be as follows:

(1) Services may be provided for consumers of all ages.

(2) Services may be provided in an individual setting or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(C) An OBHP.

(4) Programming standards shall be as follows:

(A) The service requires face-to-face contact with the consumer.

(B) Consumers are expected to show a benefit from services, with the understanding that improvement may be incremental.

(C) Services must result in demonstrated movement towards, or achievement of, the consumer's treatment goals identified in the individualized integrated care plan.

(D) Services are rehabilitative in nature and time limited.

(E) The consumer is the focus of the service.

(F) Documentation must support how the service benefits the consumer, including when the service is provided in a group setting.

(G) When provided in a group setting, services must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age.

(5) Exclusions shall be as follows:

(A) Services that are habilitative in nature, except for the achievement of developmental milestones for consumers less than eighteen (18) years of age that would have occurred absent an emotional disturbance.

(B) Skill building activities not identified in the individualized integrated care plan.

(C) Job coaching.

(D) Activities purely for recreation or diversion.

(E) Academic tutoring.

(6) Individual and group skills training and development services are not reimbursable if delivered on the same day as child and adolescent intensive rehabilitative services or adult intensive rehabilitative services.

(b) The services reimbursable as family or couple skills training and development with or without the consumer present involve face-to-face contact with family members or nonprofessional caregivers that result in the development of skills for the consumer directed toward eliminating psychosocial barriers. The development of skills is provided through structured interventions for attaining goals identified in the individualized integrated care plan and the monitoring of progress in achieving those skills. Requirements for these services without the consumer present shall be as follows:

(1) Services may be provided for family members or other nonprofessional caregivers supporting a consumer.

(2) Services may be provided in an individual or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(C) An OBHP.

(4) Programming standards shall be as follows:

(A) The services require face-to-face contact with family members or nonprofessional caregivers on behalf of the consumer.

(B) Consumers are expected to show benefit from services, with the understanding that improvement may be incremental.

(C) Services must result in demonstrated movement towards, or achievement of, the consumer's treatment goals identified in the individualized integrated care plan.

(D) Services must be rehabilitative in nature and time limited.
(E) The consumer is the focus of the service.
(F) Documentation must support how the service benefits the consumer, including when the consumer is not present and when the service is provided in a group setting.
(G) When provided in a group setting, services must be provided in an age appropriate setting for consumers less than eighteen (18) years of age.

(5) Exclusions shall be as follows:

(A) Skills training that is habilitative in nature, except for the achievement of developmental milestones for consumers less than eighteen (18) years of age that would have occurred absent an emotional disturbance.
(B) Skill building activities not identified in the individualized integrated care plan.
(C) Job coaching.
(D) Activities purely for recreation or diversion.
(E) Academic tutoring.
(F) Services may not be provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-6; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-7 Behavioral health level of need redetermination

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 7. (a) The services reimbursable as behavioral health level of need redetermination are services associated with the DMHA approved assessment tool required to determine level of need, assign an MRO service package, and make changes to the individualized integrated care plan.

(b) The redetermination requires face-to-face contact with the consumer and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which result in a completed redetermination.

(c) Requirements for behavioral health level of need redetermination services shall be as follows:
(1) Services may be provided for consumers of all ages.
(2) Services must be provided by individuals meeting DMHA training competency standards for the use of the DMHA-approved assessment tool.
(3) The DMHA assessment tool must be completed at least every six (6) months for the purpose of determining the continued need for MRO services.
(4) Reassessment may occur when there is a significant event or change in consumer status.
(5) Exclusions shall be as follows:

(A) MRO redetermination should not be duplicative of assessments available with clinic option services.
(B) This service may not be billed as part of the initial bio-psychosocial assessment when a consumer is entering treatment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-7; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-8 Crisis intervention

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 8. (a) The services reimbursable as crisis intervention services are short-term emergency behavioral health services, available twenty-four (24) hours per day, seven (7) days per week.

(b) These services include crisis assessment, planning, and counseling specific to the crisis,

intervention at the site of the crisis when clinically appropriate, and pre-hospital assessment.

(c) The goal of crisis services is to resolve the crisis and transition the consumer to routine care through stabilization of the acute crisis and linkage to necessary services. This service may be provided in an emergency room, crisis clinic setting, or in the community.

(d) The requirements for crisis intervention services shall be as follows:
(1) Services may be provided for all Medicaid consumers who are as follows:
(A) At imminent risk of harm to self or others.
(B) Experiencing a new symptom that places the consumer at risk.
(2) Providers must meet any of the following qualifications:
(A) A licensed professional.
(B) A QBHP.
(C) An OBHP.

(e) Program standards shall be as follows:
(1) The consulting physician, AHCP, or HSPP must be accessible twenty-four (24) hours per day, seven (7) days per week.
(2) Services are provided face-to-face with the consumer.
(3) Services may include contacts with the family and other nonprofessional caretakers to coordinate community service systems. Contacts are not required to be face-to-face and must be in addition to face-to-face contact with the consumer.
(4) Services should be limited to occasions when a consumer suffers an acute episode despite the provision of other community behavioral health services.
(5) The intervention should be consumer-centered and delivered on an individual basis.
(6) These services are available to any Medicaid eligible individual in crisis, as defined in this section.
(7) Documentation of action to facilitate a face-to-face visit must be made within one (1) hour of the initial contact with the provider for consumers at imminent risk of harm to self or others.
(8) Documentation of action to facilitate a face-to-face visit must be made within four (4) hours of initial contact with the provider for consumers experiencing a new symptom that places the consumer at risk.
(9) Crisis intervention does not require prior authorization.
(10) The individualized integrated care plan must be updated to reflect the crisis intervention for consumers currently active with the provider.
(11) A brief individualized integrated care plan must be developed and certified for consumers new to the provider, with a full individualized integrated care plan developed following the resolution of the crisis.

(f) Exclusions shall be as follows:
(1) Interventions targeted to groups are not billable as crisis intervention.
(2) Time spent in an inpatient setting is not billable as crisis intervention.
(3) Interventions to address an established problem or need documented in the individualized integrated care plan may not be billed under crisis intervention.
(4) Routine intakes provided without an appointment or after traditional hours do not constitute crisis intervention.
(5) Declared disaster crisis activities and services delivered by a disaster crisis team are excluded.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-8; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-9 Child and adolescent intensive resiliency services

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 9. (a) The services reimbursable as child and adolescent intensive resiliency services (CAIRS) are time-limited, nonresidential services provided to children or adolescents in a clinically supervised setting that provides an integrated system of individual, family, and group interventions based on an

individualized integrated care plan.

(b) Services are designed to alleviate emotional or behavioral problems. Services are curriculum-based with goals that include reintegration into age appropriate community settings.

(c) The requirements for CAIRS shall be as follows:
(1) Services may be provided for consumers at least five (5) years of age and less than eighteen (18) years of age with severe emotional disturbance who:
(A) need structured therapeutic and rehabilitative services;
(B) have significant impairment in day-to-day personal, social, or vocational functioning;
(C) do not require acute stabilization, including inpatient or detoxification services; and
(D) are not at imminent risk of harm to self or others.
(2) Services may be provided to consumers eighteen (18) years of age and older and less than twenty-one (21) years of age with prior authorization.

(d) Services may be provided in a facility provided by a school district.

(e) Providers must meet any of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.

(f) Programming standards shall be as follows:
(1) Services must be authorized by a physician or an HSPP.
(2) Direct services must be supervised by a licensed professional.
(3) Services are provided in close coordination with the educational program provided by a local school district.
(4) Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
(5) Consumer goals and a transitional plan must be designed to reintegrate the consumer into the school setting.
(6) Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
(7) A weekly review and update of the consumer's progress is prepared and is documented in the consumer's clinical record.
(8) Services must be provided in an age appropriate setting for a consumer eighteen (18) years of age and under.
(9) The consumer is the focus of the service.
(10) Documentation must support how the service benefits the consumer, including when provided in a group setting.
(11) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
(12) Service goals must be rehabilitative in nature.
(13) Services must be provided in an age appropriate setting for consumers less than eighteen (18) years of age receiving services.

(g) Exclusions from reimbursement shall be as follows:
(1) Services for consumers less than five (5) years of age.
(2) Services without a prior authorization for consumers eighteen (18) years of age and older, but less than twenty-one (21) years of age.
(3) Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content.
(4) Formal educational or vocational services.
(5) CAIRS will not be reimbursed for a consumer who receives both CAIRS and adult intensive rehabilitative services on the same day.
(6) CAIRS will not be reimbursed for a consumer who receives both CAIRS and individual or group skills training and development on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-9; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-10 Adult intensive rehabilitative services

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 10. (a) The services reimbursable as adult intensive rehabilitative services (AIRS) are time-limited, nonresidential services provided in a clinically supervised setting to a consumer who requires structured rehabilitative services in order to maintain the consumer on an outpatient basis.

(b) Services are curriculum based and designed to alleviate emotional or behavioral problems with the goals of:
(1) reintegrating the consumer into the community;
(2) increasing social connectedness beyond a clinical setting; or
(3) employment.

(c) The requirements for AIRS shall be as follows:
(1) Services may be provided for consumers who:
(A) are at least eighteen (18) years of age with serious mental illness who need structured therapeutic and rehabilitative services;
(B) have significant impairment in day-to-day personal, social, or vocational functioning;
(C) do not require acute stabilization, including inpatient or detoxification services; and
(D) are not at imminent risk of harm to self or others.
(2) Services may be provided to consumers less than eighteen (18) years of age, but not less than sixteen (16) years of age with prior authorization.

(d) Providers must meet any of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.

(e) Programming standards shall be as follows:
(1) Services must be authorized by a physician or a HSPP.
(2) Direct services must be supervised by a licensed professional.
(3) Clinical oversight must be provided by a licensed physician, who is on-site weekly and is available to program staff when not physically present.
(4) Consumer goals must be designed to facilitate community integration, employment, and use of natural supports.
(5) Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
(6) A weekly review and update of progress takes place and is documented in the consumer's clinical record.
(7) Services must be provided in an age appropriate setting for consumers less than eighteen (18) years of age receiving services.
(8) The consumer is the focus of the service.
(9) Documentation must support how the service benefits the consumer, including when provided in a group setting.
(10) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
(11) Service goals must be rehabilitative in nature.

(f) Exclusions from reimbursement shall be as follows:
(1) Services that are purely recreational or diversionary in nature or that do not have therapeutic or programmatic content.
(2) Formal educational or vocational services.

(3) AIRS will not be reimbursed for a consumer who receives both AIRS and individual or group skills training and development on the same day.
(4) AIRS will not be reimbursed for a consumer who receives both AIRS and CAIRS on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-10; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-11 Intensive alcohol or drug (substance-related disorder) outpatient treatment

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 11. (a) The services reimbursable as intensive alcohol or drug outpatient treatment services are treatment programs that operate at least three (3) hours per day, and at least three (3) days per week, and are based on an individualized integrated care plan.

(b) Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of alcohol and drug abuse or dependence in a group setting.

(c) Requirements for intensive alcohol or drug outpatient treatment shall be as follows:
(1) Services may be provided for consumers of all ages with a substance-related disorder; minimal or manageable medical conditions; minimal or manageable withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the consumer from benefiting from this level of care.
(2) Providers must meet any of the following qualifications:
(A) A licensed professional.
(B) A QBHP.
(C) An OBHP.

(d) Programming standards shall be as follows:
(1) Regularly scheduled sessions within a structured program must be at least three (3) hours per day and at least three (3) days per week.
(2) The program shall include the following components:
(A) Referral to twelve (12) step programs, peer and other community supports.
(B) Education on addiction disorders.
(C) Skills training in communication, anger management, stress management, and relapse prevention.
(D) Individual, group, and family counseling. Counseling must be provided by a licensed professional or QBHP.
(3) An individual who is a licensed professional is responsible for the overall management of the clinical program.
(4) Treatment must be individualized.
(5) Services must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.
(6) At least one (1) of the direct service providers must be a licensed addiction counselor or a licensed clinical addiction counselor.
(7) The consumer if the focus of the service.
(8) Documentation must support how the service benefits the consumer, including when the service is provided in a group setting.
(9) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
(10) Service goals must be rehabilitative in nature.

(e) Exclusions shall be as follows:
(1) Consumers with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.
(2) Consumers at imminent risk of harm to self or others.
(3) Intensive outpatient treatment will not be reimbursed for consumers who receive group addiction

counseling or family/couple group addiction counseling on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-11; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-12 Alcohol or drug (substance-related disorder) counseling

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 12. (a) The services reimbursable as individual or group alcohol or drug counseling are services where addiction professionals and clinicians provide counseling intervention that work toward goals identified in the individualized integrated care plan. Services are designed to be a less intensive alternative to intensive outpatient treatment.

(1) The requirements for alcohol or drug counseling shall be as follows:

(A) Services may be provided for consumers of all ages with a substance-related disorder and with minimal or manageable medical conditions; minimal withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the consumer from benefiting from this level of care.

(B) Providers must meet any of the following qualifications:

(i) A licensed professional.

(ii) A QBHP.

(C) Programming standards shall be as follows:

(i) The consumer is the focus of the service.

(ii) Documentation must support how the service specifically benefits the consumer, including when services are provided in a group setting.

(iii) Services must demonstrate progress toward or achievement of consumer treatment goals identified in the individualized integrated care plan.

(iv) Service goals must be rehabilitative in nature.

(v) Services are intended to be a less intensive alternative to intensive outpatient treatment.

(vi) Services must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.

(vii) A licensed professional must supervise the program and approve the content and curriculum of the program.

(viii) Treatment must consist of regularly scheduled services.

(2) Exclusions shall be as follows:

(A) Consumers with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.

(B) Consumers at imminent risk of harm to self or others.

(C) Group addiction counseling will not be reimbursed for consumers who receive intensive outpatient treatment on the same day.

(D) Counseling sessions that consist of education only services will not be reimbursed.

(b) The services reimbursable as family or couple alcohol or drug counseling are services where addiction professionals and clinicians provide face-to-face counseling intervention, with or without the consumer present, that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with family members or nonprofessional caregivers. Services are designed to be a less intensive alternative to intensive outpatient treatment. The requirements for alcohol or drug counseling shall be as follows:

(1) Services may be provided for family members or nonprofessional caregivers of consumers of all ages with a substance-related disorder and with minimal or manageable medical conditions; minimal withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the consumer from benefiting from this level of care.

(2) Services may be provided in an individual or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(4) Programming standards shall be as follows:

(A) The consumer is the focus of treatment.

(B) Documentation must support how the service specifically benefits the consumer, including

services provided in a group setting or without the consumer present.
(C) Services must demonstrate progress toward or achievement of the consumer's treatment goals identified in the individualized integrated care plan.
(D) Service goals must be rehabilitative in nature.
(E) Services are intended to be a less intensive alternative to outpatient treatment services.
(F) Services must be provided in an age appropriate setting for a consumer eighteen (18) years of age and under receiving services.
(G) A licensed professional must supervise the program and approve the content and curriculum of the program.
(H) Treatment must consist of regularly scheduled services.

(5) Exclusions shall be as follows:
(A) Consumers with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.
(B) Consumers at imminent risk of harm to self or others.
(C) Services may not be provided to professional caregivers.
(D) Counseling sessions that consist of education only services will not be reimbursed.
(E) Family or couple group alcohol or drug counseling will not be reimbursed for consumers who receive intensive outpatient treatment on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-12; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-13 Peer recovery services

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 13. The services reimbursable as peer recovery services are face-to-face, structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Requirements for peer recovery services shall be as follows:

(1) Services may be provided for consumers eighteen (18) years of age and older. Services may be provided for consumers age sixteen (16) or seventeen (17) with prior authorization. Services shall not be provided to or for a consumer less than sixteen (16) years of age.
(2) Services must be provided by individuals meeting DMHA training and competency standards for certified recovery specialists. Individuals providing peer recovery services must be under the supervision of a licensed professional or a QBHP.
(3) Programming standards shall be as follows:
(A) Services must be identified in the individualized integrated care plan and must correspond to specific treatment goals.
(B) Services must be provided face-to-face and include the following components:
(i) Assisting consumers with developing individualized integrated care plans and other formal mentoring activities aimed at increasing the active participation of consumers in person-centered planning and delivery of individualized services.
(ii) Assisting consumers with the development of psychiatric advanced directives.
(iii) Supporting consumers in problem solving related to reintegration into the community.
(iv) Education and promotion of recovery and anti-stigma activities.
(C) Documentation must support how the service specifically benefits the consumer.
(D) The consumer is the focus of the treatment.
(E) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
(F) Service goals must be rehabilitative in nature.
(G) Services must be provided in an age appropriate setting for a consumer eighteen (18) years of age and under receiving services.

(4) Exclusions shall be as follows:
(A) Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed.
(B) Interventions targeted to groups are not billable as peer recovery services.
(C) Activities that may be billed under skills training and development or case management services are not billable under peer recover services.
(D) Services are not reimbursable for consumers less than sixteen (16) years of age.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-13; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-14 Case management services

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 14. The services reimbursable as case management services are services that help consumers gain access to needed medical, social, educational, and other services. Case management 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. Case management is a service on behalf of the consumer, not to the consumer, and is management of the case, not the consumer. Requirements for case management services shall be as follows:

(1) Services may be provided for consumers of all ages.

(2) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(C) An OBHP.

(3) Programming standards shall be as follows:

(A) Medicaid case management services must provide direct assistance in gaining access to needed medical, social, educational, and other services.

(B) Case management services include:

(i) development of an individualized integrated care plan;

(ii) limited referrals to services; and

(iii) activities or contacts necessary to ensure that the individualized integrated care plan is effectively implemented and adequately addresses the mental health or addiction needs of the consumer.

(C) Services specifically may include the following:

(i) Needs assessment focusing on needs identification of the consumer in order to determine the need for any medical, educational, social, or other services.

(ii) Development of an individualized integrated care plan to identify the rehabilitative activities and assistance needed to accomplish the objectives of the plan.

(iii) Referral or linkage to activities that help link the consumer with services that are capable of providing needed rehabilitative services.

(iv) Monitoring or follow-up with the consumer, family members, nonprofessional caregivers, providers, or other entities, including making necessary adjustments in the individualized integrated care plan and service arrangement with providers.

(v) Evaluation consistent with the needs of the consumer; time devoted to formal supervision of the case between case manager and licensed supervisor are included activities and should be documented accordingly.

(D) Exclusions shall be as follows:

(i) Activities billed under behavioral health level of need redetermination.

(ii) The actual or direct provision of medical services or medical treatment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-14; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-15 Psychiatric assessment and intervention

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 15. The services reimbursable as psychiatric assessment and intervention services are face-to-face and nonface-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to consumers. Requirements for psychiatric assessment and intervention services shall be as follows:

(1) Services may be provided for consumers eighteen (18) years and older with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community. Services may be prior authorized for consumers less than eighteen (18) years of age.
(2) Providers must meet any of the following qualifications:
(A) A physician.
(B) An AHCP.
(3) Programming standards shall be as follows:
(A) Service delivery may include both face-to-face and certain nonface-to-face activities.
(B) Psychiatric assessment services are intensive and must be available twenty-four (24) hours per day, seven (7) days per week, and with emergency response.
(C) Services must include, but are not limited to, the following:
(i) Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional, behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a consumer's treatment.
(ii) Monitoring a consumer's medical and other health issues that are either directly related to a mental health disorder or a substance related disorder, or to the treatment of the disorder.
(iii) Consultation on assessment, service planning, and implementation with other members of the consumer's treatment team, the consumer's family, and nonprofessional caregivers.
(D) The consumer is the focus of the service.
(E) Documentation must support how the service benefits the consumer.
(F) Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
(G) Service goals must be rehabilitative in nature.
(4) Exclusions shall be as follows:
(A) Medication management activities provided in a clinic setting that may be reimbursed under the clinic option.
(B) Services that may be reimbursed under the clinic option.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-15; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-16 Diagnosis; individualized integrated care plan

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 16. The supervising physician or 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 a licensed professional, QBHP, or 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 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.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-16; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

405 IAC 5-21.5-17 Prior authorization

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 17. (a) MRO services are packaged according to diagnosis and level of need. Diagnosis and level of need qualifications for service packages, and services included within each service package:
(1) will be listed and published in a provider manual by the OMPP; and
(2) may be updated by the OMPP as needed.

(b) Prior authorization is required as follows:

(1) A consumer uses all units of one (1) or more of the services authorized in the service package within the defined service package term, and additional units of that service are needed.
(2) A consumer needs a service that is not authorized within a service package.
(3) A service package provided through a certified DMHA ACT team.
(4) A consumer who is denied an MRO service package may submit prior authorization for a specific MRO service.
(5) Services may be prior authorized for retroactive Medicaid eligibility periods.

(c) Providers who may submit prior authorization, as referenced in 405 IAC 5-3-13, include any of the following:
(1) A doctor of medicine.
(2) A doctor of osteopathy.
(3) A HSPP.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-17; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

SECTION 4. 405 IAC 5-29-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-29-1 Noncovered services

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 1. The following services are not covered by Medicaid:
(1) Services that are not ~~medially~~ **medically** reasonable or necessary as defined in this article.
(2) Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law.
(3) Experimental drugs, treatments, or procedures, and all related services.
(4) Any new product, service, or technology not specifically covered in this article. The product, service, or technology will remain a noncovered product, service, or technology until such time as the office authorizes the coverage of the product, service, or technology. This subdivision does not apply to legend drugs.
(5) Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental.
(6) Services for the remediation of learning disabilities.
(7) Treatments or therapies of an educational nature.
(8) Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following:
(A) Acupuncture.
(B) Biofeedback therapy.
(C) Carbon dioxide five percent (5%) inhalator therapy for inner ear disease.
(D) Hyperthermia.
(E) Hypnotherapy.
(9) Hair transplants.
(10) Fallopian tuboplasty (reanastomosis of the fallopian tubes) for infertility or vasovasostomy (reanastomosis of the vas ~~deferns).~~ **deferens.** This procedure is covered only in conjunction with disease.
(11) Augmentation mammoplasties for cosmetic purposes.
(12) Dermabrasion surgery for acne pitting or marsupialization.
(13) Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem.
(14) Otoplasty for protruding ears unless one (1) of the following applies to the case:
(A) ~~Multifacted~~ **Multifaceted** craniofacial abnormalities due to congenital malformation or maldevelopment, for example, Pierre Robin syndrome.
(B) A recipient has pending or actual employment where protruding ears would interfere with the wearing of required protective devices.
(15) Scar removals or tattoo removals by excision or abrasion.
(16) Ear lobe reconstruction.
(17) Removal of keloids caused from pierced ears unless one (1) of the following is present:
(A) Keloids are larger than three (3) centimeters.
(B) Obstruction of the ear canal is fifty percent (50%) or more.
(18) Rhytidectomy.

(19) Penile implants.
(20) Perineoplasty for sexual dysfunction.
(21) Reconstructive or plastic surgery unless related to disease or trauma deformity.
(22) Sliding mandibular osteotomies unless related to prognathism or micrognathism.
(23) Blepharoplasties when not related to a significant obstructive vision problem.
(24) Radial keratotomy.
(25) Miscellaneous procedures or modalities, including, but not limited to, the following:
(A) Autopsy.
(B) Cryosurgery for chloasma.
(C) Conray dye injection supervision.
(D) Day care or partial day care or partial hospitalization except when provided pursuant to ~~405 IAC 5-21.~~ **405 IAC 5-20.**
(E) Formalized and predesigned rehabilitation programs, including, but not limited to, the following:
(i) Pulmonary.
(ii) Cardiovascular.
(iii) Work-hardening or strengthening.
(F) Telephone transmitter used for transtelephonic monitor.
(G) Telephone, or any other means of communication, consultation from one (1) doctor to another.
(H) Artificial insemination.
(I) Cognitive rehabilitation, except for treatment of traumatic brain injury.
(26) Ear piercing.
(27) Cybex evaluation or testing or treatment.
(28) High colonic irrigation.
(29) Services that are not prior authorized under the level-of-care methodology as required by ~~405 IAC 5-19.~~ **405 IAC 5-21.5.**
(30) Amphetamines when prescribed for weight control or treatment of obesity.
(31) Under federal law, drug efficacy study implementation drugs not covered by Medicaid.
(32) All anorectics, except amphetamines, both legend and nonlegend.
(33) Physician samples.

(Office of the Secretary of Family and Social Services; 405 IAC 5-29-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3356, filed Sep 27, 1999, 8:55 a.m.: 23 IR 320; filed Sep 1, 2000, 2:16 p.m.: 24 IR 15; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 380; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)

SECTION 5. THE FOLLOWING ARE REPEALED: 405 IAC 5-21-1; 405 IAC 5-21-2; 405 IAC 5-21-3; 405 IAC 5-21-4; 405 IAC 5-21-5; 405 IAC 5-21-6; 405 IAC 5-21-8.

LSA Document #10-45(F)
Notice of Intent: 20100127-IR-405100045NIA
Proposed Rule: 20100428-IR-405100045PRA
Hearing Held: May 28, 2010
Approved by Attorney General: May 26, 2010
Approved by Governor: May 27, 2010
Filed with Publisher: May 27, 2010, 9:15 a.m.
Documents Incorporated by Reference: 42 CFR 440.130
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Posted: 06/23/2010 by Legislative Services Agency
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