TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #09-87(F)

DIGEST

Amends 405 IAC 5-3-13 for the purpose of including neuropsychological and psychological testing as services that require prior authorization. Amends 405 IAC 5-20-8 for purposes of adding practitioners who may be reimbursed for neuropsychological and psychological testing and includes practitioner obligations. Effective 30 days after filing with the Publisher.

405 IAC 5-3-13; 405 IAC 5-20-8

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) Psychiatric inpatient admissions, including admissions for substance abuse.
(18) Rehabilitation inpatient admissions.
(19) Orthodontic procedures for members under twenty-one (21) years of age for cases of craniofacial deformity or cleft palate.
(20) Genetic testing for detection of cancer of the breast or breasts or ovaries.
(21) Medicaid rehabilitation option services, except for crisis intervention.
(22) Partial hospitalization, as provided under 405 IAC 5-20-8.
(23) Neuropsychological and psychological testing.
~~(23)~~ **(24)** As otherwise specified in this article.

(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.

(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; filed Jul 19, 2010, 11:24 a.m.: 20100818-IR-405090087FRA)

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~~ **the** 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.

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

(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.~~ **the services are provided by one (1) of the following practitioners:**

(A) A physician.

(B) An HSPP.

(C) A practitioner listed in subdivision (7).

(7) The following practitioners may only administer neuropsychological and psychological testing under the direct supervision of a physician or HSPP:

(A) A licensed psychologist.

(B) A licensed independent practice school psychologist.

(C) A person holding a master's degree in a mental health field and one (1) of the following:

(i) A certified specialist in psychometry (CSP).

(ii) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

(8) The physician and HSPP are responsible for the interpretation and reporting of the testing performed.

(9) The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one (1) of the practitioners listed in subdivision (7).

~~(7)~~ **(10)** 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 (4)(D)(ii).

~~(8)~~ **(11)** The following are services that are not reimbursable by the Medicaid program:

(A) Daycare.

(B) Hypnosis.

(C) Biofeedback.

(D) Missed appointments.

~~(9)~~ **(12)** 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.

~~(10)~~ **(13)** 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.

~~(11)~~ **(14)** 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.

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