



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Medicaid Rehabilitation Option Services

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Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> Updated who can authorize services in the following sections: <ul style="list-style-type: none"> – AIRS Program Standards – CAIRS Program Standards – Psychosocial Rehabilitation Program Standards Replaced contact information in the PA Contractor and Mailing Address for MRO Claims sections with a reference to the <i>IHCP Quick Reference Guide</i> Updated the PA Policy Requirements section Updated the Rendering and Billing Providers section Updated the Reimbursement Rate section Added <i>HIP Maternity</i> in the Healthy Indiana Plan section Updated LON of 0 service description in Table 20 – Authorized Services – Children/Adolescents 	

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Section 1: Introduction

Note: For updates to coding, coverage and benefit information, see [IHCP Banner Pages](#) and [IHCP Bulletins](#) at in.gov/medicaid/providers.

This module provides information specifically for Indiana Health Coverage Programs (IHCP) providers enrolled as community mental health centers (CMHCs) and delivering Medicaid Rehabilitation Option (MRO) services.

For information about outpatient behavioral health services covered under the Medicaid State Plan (rather than under the MRO benefit), see the [Behavioral Health Services](#) module.

MRO services are designed to assist members in regaining a previous level of functioning that had been lost. Only members with a qualifying diagnosis and level of need (LON) are eligible for an MRO service package *in addition to* the outpatient behavioral health services covered under the Medicaid State Plan.

MRO services include community-based mental healthcare for individuals with serious mental illness, youth with serious emotional disturbance and/or individuals with substance use disorders. MRO services may include clinical attention in the member's home, workplace, mental health facility, emergency department or wherever needed. A qualified behavioral health professional, as outlined in *Indiana Administrative Code 405 IAC 5-21.5-1(c)*, must render these services.

The Indiana Family and Social Services Administration (FSSA) administers the MRO program, with policy and operational oversight provided through the FSSA Office of Medicaid Policy and Planning (OMPP) and Division of Mental Health and Addiction (DMHA).

Specific rules for MRO services can be found in *405 IAC 5-21.5*. Details provided in the applicable IAC are not repeated in this document except to clarify or expand on procedural issues. Unique MRO requirements are outlined based on the following topics:

- Common service standards
- Treatment plan requirements
- Supervising practitioner responsibilities
- Medicare and third-party liability (TPL) requirements
- Prior authorization (PA) status
- Claim format requirements
- Procedure code and narrative requirements

Section 2: Medicaid Rehabilitation Option Services

Indiana Health Coverage Programs (IHCP) Medicaid Rehabilitation Option (MRO) services are designed to assist in the rehabilitation of the member's optimum functional ability in activities of daily living by:

- Assessing the member's needs and strengths
- Developing an Individualized Integrated Care Plan (IICP) that outlines objectives of care, including how MRO services assist in reaching the member's rehabilitative and recovery goals
- Delivering appropriate services to the member

MRO Provider Agency Requirements

Community mental health centers (CMHCs) are the exclusive providers for the following Medicaid services and programs:

- MRO services
- Behavioral and Primary Healthcare Coordination (BPHC)
- Adult Mental Health Habilitation (AMHH)

All agencies providing MRO, BPHC or AMHH services must be certified by the Family and Social Service Administration (FSSA) Division of Mental Health and Addiction (DMHA) as a CMHC and be an enrolled Medicaid provider.

Designated CMHC staff advises applicants or members of their right to choose among providers and provider agencies, explains the process for making an informed choice of providers, and answers questions. Providers within an agency, and provider agencies themselves, may be changed as necessary or requested by the member.

MRO Provider Staff Qualifications

Provider staff delivering MRO services must meet appropriate federal, state and local regulations for their respective disciplines. Specific provider qualifications, program standards and exclusions are included in each service definition in this section.

Three predominant categories of providers may provide MRO services:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Each MRO service includes specific provider qualifications, including but not limited to licensed professionals, QBHPs and OBHPs. Provider qualifications are noted in the corresponding service definition.

Licensed Professional

A licensed professional is defined as any of the following provider types:

- Licensed physician (including licensed psychiatrist)
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed psychologist
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *Indiana Code IC 25-23.6-10.5*

Qualified Behavioral Health Professional

A QBHP is defined as any of the following provider types:

- An individual who is under the supervision of a licensed professional (as defined previously) or an advanced practice registered nurse (APRN) and who has had at least two years of clinical experience treating persons with mental illness, such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
 - Psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse (RN) in Indiana
 - Pastoral counseling from an accredited university
 - Rehabilitation counseling from an accredited university
- An individual who is under the supervision of a licensed professional (as defined previously) or an APRN; is eligible for and working toward licensure; and has completed a master's or doctoral degree, or both, in any of the following disciplines:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology from an accredited university
 - Mental health counseling from an accredited university
 - Marital and family therapy from an accredited university
- A licensed independent practice school psychologist who is under the supervision of a licensed professional (as defined previously) or an APRN
- An authorized health care professional (AHCP):
 - 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*
 - A nurse practitioner (NP) or a clinical nurse specialist (CNS) with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to *IC 25-23-1*

Other Behavioral Health Professional

An OBHP is defined as any of the following provider types:

- An individual with an associate or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by the MRO provider agency and supervised by a licensed professional (as defined previously) or a QBHP (as defined previously)
- A licensed addiction counselor (LAC), as defined under *IC 25-23.6-10.5*, supervised by a licensed professional (as defined previously) or a QBHP (as defined previously)

Individualized Integrated Care Plan Requirements

The Individualized Integrated Care Plan (IICP) is a treatment plan that integrates all components and aspects of care deemed medically necessary, clinically indicated and provided in the most appropriate setting to achieve recovery. An IICP must be developed for each MRO member (*Indiana Administrative Code 405 IAC 5-21.5-16*). The IICP focuses on treating the disability and improving the member's level of functioning. The IICP must include all indicated medical and remedial services needed by the member to promote and facilitate independence and recovery.

MRO services are eligible for reimbursement before the development of a treatment plan under the MRO program if the services are provided by a behavioral health professional working in a CMHC for any IHCP-eligible individual who is undertaking intake assessment or counseling in a CMHC.

Members are able to receive services under the MRO program prior to the development of a plan of treatment; however, an intake assessment is still required to verify member eligibility for MRO services. Services included within an IICP are to commence within two weeks of an individual's intake assessment.

Intake Assessment and Development of the IICP

The IICP is developed through a collaborative effort that includes the member, identified community supports (family and nonprofessional caregivers), and all individuals involved in assessing or providing care for the member. The IICP is developed after completing a holistic clinical and biopsychosocial assessment. The holistic assessment includes documentation in the member's medical record of the following:

- Review, discussion and documentation of the member's recovery desires, needs and goals (recovery-oriented goals)
- Review of psychiatric symptoms and how they affect the member's functioning and ability to attain recovery desires, needs and goals
- Review of the member's skills and the support needed for the member to participate in a recovery process, including the ability to function in living, working and learning environments
- Review of the member's strengths and needs, including medical, behavioral, social, housing and employment

An IICP is developed with the member and must reflect the member's desires and choices. The member's signature demonstrating his or her participation in the development and ongoing IICP reviews is required. If a member refuses to sign, the provider must document that the IICP was discussed, and the member chose not to sign.

Required Components of the IICP

The IICP must include the following documentation:

- Outline of goals directed at recovery that promotes the following:
 - Independence and integration into the community
 - Treatment of behavioral health symptoms
 - Rehabilitating areas of functional deficits related to the behavioral health disorders
- Identification of individuals or teams responsible for treatment, coordination of care, linkage, and referrals to internal or external resources, and care providers to meet identified needs
- A comprehensive listing of all specific treatments and services that will be provided to the member
- Documentation of frequency, duration and time frame of each service

- Documentation of a face-to-face visit or IICP review by the supervising practitioner (as defined in the [MRO Treatment Plan Supervision Standards](#) section) at intervals not to exceed 90 days
- Signature of the member affirming their participation in the IICP development and ongoing reviews (or documentation from the provider that the IICP was discussed and the member chose not to sign)

Certification of the Diagnosis and the IICP

A licensed professional, QBHP or OBHP may complete the IICP. The diagnoses and IICP *must be certified* by a supervising practitioner (as defined in the [MRO Treatment Plan Supervision Standards](#) section).

Certification should be consistent with the agency's clinical plan for professional services or similar document defining services under policies and procedures for the facility. Certification standards include the following:

- Statement of agreement with the diagnoses and the IICP
- Printed name, signature and credentials of the licensed professional, QBHP or OBHP who completed the IICP
- Printed name, signature (written or electronic) and credentials of the certifying practitioner
- Date signed

The supervising practitioner is responsible for seeing the member during the intake process (or reviewing information submitted by a licensed professional, QBHP or OBHP), and approving the initial IICP within seven days of intake assessment. IICP updates must be conducted at a minimum of every 90 days by a supervising practitioner. The supervising practitioner must see the member or review the IICP at intervals not to exceed 90 days. These reviews must be documented in writing with acknowledgement that ongoing services, as documented in the IICP, are required. A simple signature notation or medication management progress note that does not directly reference the IICP does not constitute sufficient review.

MRO Treatment Plan Supervision Standards

The supervising practitioner for MRO services must be:

- Enrolled in the IHCP as a rendering provider with one of the following types and specialties:
 - Type 31 – *Physician*, any applicable specialty
 - Type 09 – *Advanced Practice Registered Nurse*, any applicable specialty
 - Type 11 – *Behavioral Health Provider* with any of the following specialties:
 - Specialty 114 – *Health Service Provider in Psychology*
 - Specialty 618 – *Licensed Clinical Social Worker*
 - Specialty 619 – *Licensed Marriage and Family Therapist*
 - Specialty 620 – *Licensed Mental Health Counselor*
 - Specialty 621 – *Licensed Clinical Addiction Counselor*

- Linked to the MRO provider (CMHC group enrollment)
- Responsible for the following:
 - Review information submitted by other practitioners who rendered services to the member, as required.
 - Approve and certify the initial IICP and diagnosis within seven days of intake assessment
 - See the member or review the IICP at intervals not to exceed 90 days. (Changes made in the IICP during the period between reviews do not require additional review from a supervising practitioner.)
 - Be available to see the member in emergency situations and when additional consultations are required.
 - Keep all documentation in the member’s medical record.

Some MRO services include additional supervision requirements related to certain provider qualifications or service standards (see the [MRO Service Requirements](#) section of this document). Where clinical supervision is required, it is expected that the provider has and follows clearly delineated policies and procedures for defining, implementing and documenting clinical supervision as defined and required by MRO service standards. Supervision of the plan of treatment is at the discretion of the MRO provider to define and implement.

MRO Service Requirements

As stated in 405 IAC 5-21.5, IHCP reimbursement for MRO services is available for members who meet specific diagnosis and level of need (LON) criteria under the approved DMHA assessment tool – Adult Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths (CANS). Additional MRO services beyond what is available for the assigned service package may be added with prior authorization (PA). MRO services are clinical behavioral health services provided to members and families of members living in the community who need aid intermittently for emotional disturbances, mental illness and addiction. Services may be provided in individual or group settings and in the community.

Note: The distinction of whether a service is “rehabilitative” versus “habilitative” is often more rooted in an individual’s level of functioning than in the actual service provided. 405 IAC 5-21.5 describes MRO services as any “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 member’s best possible functional level.” In accordance with House Enrolled Act (HEA) 1347 (2016), APRNs can also recommend MRO services.

The IHCP provides reimbursement for the following MRO behavioral health services:

- Addiction Counseling
- Adult Intensive Rehabilitative Services (AIRS)
- Behavioral Health Counseling and Therapy
- Behavioral Health Level of Need Redetermination
- Case Management
- Child and Adolescent Intensive Resiliency Services (CAIRS)
- Medication Training and Support
- Psychiatric Assessment and Intervention
- Psychosocial Rehabilitation (Clubhouse Services)
- Skills Training and Development

The following sections provide information about these services, including service unit limitations, appropriate Healthcare Common Procedure Coding System (HCPCS) billing codes and modifiers, target populations eligible for the service, program standards and exclusions. For the purposes of MRO, a “day” is a calendar day, unless otherwise specified.

Note: For services that require face-to-face interaction with the member, services delivered via telehealth satisfy this requirement. The services must be covered for telehealth and provided in accordance with the policies and procedures described in the [Telehealth and Virtual Services](#) module.

Addiction Counseling (Individual or Group Setting)

Addiction Counseling is a planned and organized service with the member and/or the member’s family or nonprofessional caregivers, where addiction professionals and clinicians provide counseling intervention that works toward the goals identified in the IICP. Addiction Counseling is designed to be a less intensive alternative to IOT. See the following tables for applicable billing codes.

Table 1 – HCPCS Codes for MRO Addiction Counseling (Individual Setting)

Code and Modifiers	Code Description
H2035 HW	Alcohol and/or other drug treatment program, per hour; funded by state mental health agency
H2035 HW HR	Alcohol and/or other drug treatment program, per hour; funded by state mental health agency; family/couple with client present
H2035 HW HS	Alcohol and/or other drug treatment program, per hour; funded by state mental health agency; family/couple without client present

Table 2 – HCPCS Codes for MRO Addiction Counseling (Group Setting)

Code and Modifiers	Code Description
H0005 HW	Alcohol and/or drug services; group counseling by clinician; funded by state mental health agency
H0005 HW HR	Alcohol and/or drug services; group counseling by clinician; funded by state mental health agency; family/couple with client present
H0005 HW HS	Alcohol and/or drug services; group counseling by clinician; funded by state mental health agency; family/couple without client present

Service Unit Limitations

Addiction Counseling is limited to the following:

- 32 hours for service packages 3, 4, 5 and 6
- 50 hours for service package 5A

PA is required if the member needs additional units of this service. These maximum limits include all units billed under the procedure-code-and-modifier combinations listed in Tables 1 and 2. See [Appendix A](#) for information regarding units and service packages.

Target Population

Addiction Counseling may be provided for members of all ages with a substance-related disorder and the following:

- An ANSA or CANS LON of 3 or higher
- Minimal or manageable medical conditions
- Minimal withdrawal risk
- Emotional, behavioral and cognitive conditions that do not prevent the member from benefiting from this level of care

Provider Qualifications

The following providers may deliver Addiction Counseling:

- Licensed professionals
- QBHPs

Program Standards

The following program standards apply to Addiction Counseling:

- The member is the focus of Addiction Counseling.
- Documentation must support how Addiction Counseling benefits the member, including when services are provided in a group setting and when the member is not present.
- Addiction Counseling requires face-to-face contact with the member and/or the member's family or nonprofessional caregivers.
- Addiction Counseling consists of regularly scheduled sessions.
- Addiction Counseling is intended to be a less intensive alternative to IOT.
- Addiction Counseling may include the following:
 - Education on addiction disorders
 - Skills training in communication, anger management, stress management and relapse prevention
- Addiction Counseling must demonstrate progress toward, and achievement of, member treatment goals identified in the IICP.
- Addiction Counseling goals are rehabilitative in nature.
- If services are delivered by a QBHP (other than an NP or CNS), then a licensed professional or APRN must supervise the program and approve the program's content and curriculum.
- Addiction Counseling must be provided in an age-appropriate setting for members less than 18 years of age receiving services.
- Addiction Counseling must be individualized.
- Referral to available community-based support services is expected.

Exclusions

The following exclusions apply to Addiction Counseling:

- Members with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Members at imminent risk of harm to self or others are not eligible for this service.

- Addiction Counseling may not be provided for professional caregivers.
- Addiction Counseling sessions that consist of education services only are not reimbursed.
- Group Addiction Counseling is not reimbursed for members who receive IOT (procedure codes H0015 or S9480, or revenue codes 905 or 906) on the same day.

Examples

Addiction Counseling, Family/Couple (Individual Setting) Example

An MRO member and his girlfriend met with a QBHP for a one-hour session to discuss the impact of the member's use of substances on their relationship.

This service may be billed as Addiction Counseling, Family/Couple (H2035 HW HR).

Addiction Counseling (Group Setting) Example

An MRO member just completed eight weeks of IOT and is ready to be stepped down to a Relapse Prevention program. This member participates in group counseling from 5 p.m. to 6 p.m. on Monday and Tuesday each week. It is anticipated the member will reach recovery-focused goals within four to six weeks.

This service is billable as Addiction Counseling (H0005 HW).

Adult Intensive Rehabilitative Services

AIRS is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured rehabilitative services to serve and support the member on an outpatient basis. AIRS is curriculum-based and designed to alleviate emotional or behavioral problems with the goal of reintegrating the member into the community, increasing social connectedness beyond a clinical and/or employment setting. See the following table for the applicable billing code.

Table 3 – HCPCS Code for MRO AIRS

Code and Modifiers	Code Description
H2012 HW HB U1	Behavioral health day treatment, per hour; funded by state mental health agency; adult program; group setting

Service Unit Limitations

AIRS is included in adult service packages 4 and 5 and limited to 270 hours. Authorization for AIRS is limited to 90 consecutive days. PA is required if the member needs AIRS past 90 days. See [Appendix A](#) for information regarding units and service packages.

Target Population

AIRS may be provided for members at least 18 years of age with serious mental illness who:

- Have an ANSA LON of 4 or 5
- Need structured therapeutic and rehabilitative services
- Have significant impairment in day-to-day personal, social and/or vocational functioning
- Do not require acute stabilization, including inpatient or detoxification services
- Are not at imminent risk of harm to self or others

AIRS may be provided to members between the ages of 16 and 18 with an approved PA.

Provider Qualifications

The following providers may deliver AIRS:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

The following program standards apply to AIRS:

- AIRS must be authorized by a physician, HSPP, LCSW, LMFT, LMHC, LCAC or APRN.
- Direct services must be supervised by a licensed professional or APRN.
- Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
- Member goals must be designed to facilitate community integration, employment and use of natural supports.
- Therapeutic services include clinical therapies, psycho-educational groups and rehabilitative activities.
- A weekly review and update of progress occurs and must be documented in the member's clinical record.
- AIRS programs must be offered a minimum of two hours and up to six hours per day, three to five days per week, excluding time associated with formal educational or vocational services.
- AIRS must be provided in an age-appropriate setting for members less than 18 years of age.
- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when provided in a group setting.
- Services must demonstrate movement toward or achievement of member treatment goals identified in the IICP.
- Service goals must be rehabilitative in nature.

Exclusions

The following exclusions apply to AIRS:

- AIRS is not reimbursed for members who receive individual or group Skills Training and Development (H2014 HW or H2014 HW U1) or Psychosocial Rehabilitation services (H2017 HW) on the same day.
- A member may not receive both CAIRS and AIRS on the same day.
- Services that are purely recreational or diversionary in nature, or that do not have therapeutic or programmatic content, are not reimbursable.
- Formal educational or vocational services are not reimbursed.
- AIRS that are provided in a residential setting are not reimbursable.

Example

AIRS Exclusion Example

A member participates in a time-limited, curriculum-based series of groups at his group home. These groups occur from 9 a.m. to noon and 1 p.m. to 3 p.m., Monday through Friday, and are a combination of clinical therapies, psycho-educational groups and rehabilitative activities.

Not billable as AIRS due to being held in a residential setting.

Behavioral Health Counseling and Therapy (Individual or Group Setting)

Behavioral Health Counseling and Therapy is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the IICP. The face-to-face interaction may be with the member and/or the member's family or nonprofessional caregivers. Behavioral Health Counseling and Therapy must be provided at the member's home or at other locations outside the clinic or school setting. When Behavioral Health Counseling and Therapy services are clinic-based or school-based, they must be billed as an outpatient behavioral health service (see the [Behavioral Health Services](#) module) rather than as an MRO service. See the following tables for applicable billing codes.

Table 4 – HCPCS Codes for MRO Behavioral Health Counseling and Therapy (Individual Setting)

Code and Modifiers	Code Description
H0004 HW	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency
H0004 HW HR	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple with client present
H0004 HW HS	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple without client present

Table 5 – HCPCS Codes for MRO Behavioral Health Counseling and Therapy (Group Setting)

Code and Modifiers	Code Description
H0004 HW U1	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; group setting
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple with client present; group setting
H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple without client present; group setting

Service Unit Limitations

In an individual setting, Behavioral Health Counseling and Therapy is limited to the following:

- 32 units for service package 3
- 48 units for service packages 4, 5, 5A and 6

In a group setting, Behavioral Health Counseling and Therapy is limited to the following:

- 48 units for service package 3
- 60 units for service packages 4, 5, 5A and 6

PA is required if the member needs additional units of this service. These maximum limits include any units billed under the procedure-code-and-modifier combinations listed in Tables 4 and 5. See [Appendix A](#) for information regarding units and service packages.

Target Population

Behavioral Health Counseling and Therapy may be provided for members of all ages with an ANSA or CANS LON of 3 or higher.

Provider Qualifications

The following providers may deliver Behavioral Health Counseling and Therapy:

- Licensed professionals, except for LCACs, as defined under *IC 25-23.6-10.5*
- QBHPs

Program Standards

The following program standards apply to Behavioral Health Counseling and Therapy:

- Behavioral Health Counseling and Therapy requires face-to-face contact.
- The member is the focus of the service.
- Documentation must support how Behavioral Health Counseling and Therapy benefits the member, including when services are provided in a group setting and when the member is not present.
- Behavioral Health Counseling and Therapy must demonstrate movement toward and/or achievement of member treatment goals identified in the IICP.
- Behavioral Health Counseling and Therapy goals must be rehabilitative in nature.
- Group-based Behavioral Health Counseling and Therapy must be provided in an age-appropriate setting for members less than 18 years of age.

Exclusions

The following exclusions apply to Behavioral Health Counseling and Therapy:

- Behavioral health counseling and therapy services provided in a clinic setting and/or as a part of school-based services are not billable as MRO services and must instead be billed as an outpatient behavioral health service (as described in the [Behavioral Health Services](#) module).
- LCACs, as defined under *IC 25-23.6-10.5*, may not provide Behavioral Health Counseling and Therapy.
- If medication management is a component of the Behavioral Health Counseling and Therapy session, then Medication Training and Support may not be billed separately for the same visit by the same provider.
- Family/Couple Behavioral Health Counseling and Therapy may not be provided for professional caregivers.

Examples

Behavioral Health Counseling and Therapy (Individual Setting) Example

A 12-year-old male has been having difficulties at home and school and frequently hits others when he does not get his way. His parents are invited to meet with his therapist at their home to discuss his behavior and its impact on his family. His parents report being angry with him most of the time. They report that they want to be constructive in their interaction with him. The therapist focuses the session on where the boy fits into the family and works with the parents to gain an understanding of triggers and ways to diffuse outbursts when he is at home. He is not present for this service.

This service may be billed as Family/Couple Behavioral Health Counseling and Therapy (Individual Setting) without the Member Present (H0004 HW HS).

Behavioral Health Counseling and Therapy Exclusion Example

A 12-year-old male has been having difficulties at home and school and frequently hits others when he does not get his way. His parents are invited to meet with the therapist in the therapist's office to discuss his behavior and its impact on his family. His parents report being angry with him most of the time. They report that they want to be constructive in their interaction with him. The therapist focuses the session on where the boy fits into the family and works with the parents to gain an understanding of triggers and ways to diffuse outbursts when he is at home. He is not present for this service.

This service example is not billable as MRO due to the office and clinic setting, but it may be billed as an outpatient behavioral health service if requirements are met.

Behavioral Health Level of Need Redetermination

Behavioral Health Level of Need Redetermination is a service associated with the DMHA-approved assessment tool – CANS or ANSA – required to determine LON, assign an MRO service package and make changes to the IICP. The redetermination requires face-to-face contact with the member and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which results in a completed redetermination. See the following table for the applicable billing code.

Table 6 – HCPCS Code for MRO Behavioral Health Level of Need Redetermination

Code and Modifier	Code Description
H0031 HW	Mental health assessment, by nonphysician; funded by state mental health agency

Service Unit Limitations

Reimbursement for one needs-and-strengths redetermination assessment is allowed per member, per service package (with the exception of CANS service package 2). PA for this service is not available for additional units or for members who do not have an MRO service package. See [Appendix A](#) for information regarding units and service packages.

Target Population

Behavioral Health Level of Need Redetermination may be provided for members of all ages with an ANSA or CANS LON of 3 or higher.

Provider Qualifications

Providers must meet DMHA training competency standards for the performance of the DMHA-approved assessment tool (CANS or ANSA).

Program Standards

The following program standards apply to Behavioral Health Level of Need Redetermination:

- The DMHA-approved **CANS** assessment tool must be completed within **30 days** prior to the end date of an existing service package to determine the continued need for MRO services.
- The DMHA-approved **ANSA** assessment tool must be completed within **60 days** prior to the end date of an existing service package to determine the continued need for MRO services.
- Reassessment may occur when there is a significant event or change in member status.
- Reimbursement is available only for one assessment per service package.

Exclusions

The following exclusions apply to Behavioral Health Level of Need Redetermination:

- MRO redetermination should not be duplicative of assessments available as outpatient behavioral health services under the member's general Medicaid benefit.
- Behavioral Health Level of Need Redetermination may not be billed as part of the initial biopsychosocial assessment when a member is entering treatment.

Examples

Behavioral Health Level of Need Redetermination Example

A member's initial ANSA assessment took place July 3, 2019. The member was seen in her home on Dec. 12, 2019, from 10 a.m. to 10:55 a.m. by an OBHP. Together, they contacted the member's mother over the telephone to obtain information and completed the member's ANSA reassessment. Time spent was 55 minutes. The ANSA reassessment and LON results were placed in the assessment section of the medical record.

This service is billable as Behavioral Health Level of Need Redetermination (H0031 HW).

Behavioral Health Level of Need Redetermination Exclusion Example

A member was seen today for her initial biopsychosocial assessment and initial ANSA. Please refer to the ANSA assessment and LON results located in the assessment section of this medical record.

This service is not billable as Behavioral Health Level of Need Redetermination due to it being her initial ANSA assessment. If the ANSA was conducted as part of the initial biopsychosocial assessment, the service may be billed as an outpatient behavioral health service under the member's general Medicaid benefit.

Case Management

Case Management consists of services that help members gain access to needed medical, social, educational and other services, including:

- Direct assistance in gaining access to services
- Coordination of care
- Oversight of the entire case
- Linkage to appropriate services

Case Management does not include direct delivery of medical, clinical or other direct services. Case Management is *on behalf of* the member, not *to* the member, and is management of the *case*, not the *member*. See the following table for the applicable billing code.

Table 7 – HCPCS Code for MRO Case Management

Code and Modifiers	Code Description
T1016 HW	Case management, each 15 minutes; funded by state mental health agency

Service Unit Limitations

Case Management is limited to the following:

- 100 units for service package 2 (for members less than 18 years of age)
- 200 units for service package 3
- 300 units for service package 4
- 400 units for service packages 5 and 6
- 500 units for service package 5A

PA is required if additional units of this service are needed. See [Appendix A](#) for information regarding units and service packages.

For information on service unit limitations for members using MRO in conjunction with BPHC, see the [Behavioral and Primary Healthcare Coordination](#) section.

Target Population

Case Management may be provided for members of all ages with an ANSA LON of 3 or higher or a CANS LON of 2 or higher.

Provider Qualifications

The following providers may deliver Case Management:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

The following program standards apply to Case Management:

- Case Management must provide direct assistance in gaining access to needed medical, social, educational and other services.
- Case Management includes the development of an IICP, referrals to services, and activities or contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the mental health and/or addiction needs of the eligible member.
- Case Management may include:
 - *Needs Assessment:* Focusing on needs identification of the member to determine the need for any medical, educational, social or other services. Specific assessment activities may include:
 - Taking member history
 - Identifying the needs of the member
 - Completing the related documentation
 - Gathering information from other sources, such as family members or medical providers

- *IICP Development*: The development of a written IICP based on the information collected through the assessment phase. The IICP identifies the rehabilitative activities and assistance needed to accomplish the objectives.
- *Referral/Linkage*: Activities that help link the member with medical, social and educational providers and/or other programs and services that are capable of providing needed rehabilitative services.
- *Monitoring/Follow-up*: Activities and contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the member. The activities and contacts may be with the following:
 - Member
 - Family members
 - Nonprofessional caregivers
 - Providers
 - Other entities

Monitoring and follow-up are necessary to help determine if services are being furnished in accordance with the member's IICP, the adequacy of the services in the IICP, and changes in the needs or status of the member. This function includes making necessary adjustments in the IICP and service arrangement with providers.
- *Evaluation*: The case manager must periodically reevaluate the member's progress toward achieving the IICP's objectives. Based on the case manager's review, a determination would be made whether changes should be made. Time devoted to formal supervision of the case between case manager and licensed supervisor are included activities and should be documented accordingly. The supervision must be documented appropriately and billed under one provider only.

Exclusions

The following exclusions apply to Behavioral Health Level of Need Redetermination:

- Activities billed under Behavioral Health Level of Need Redetermination are excluded.
- A service or service activity provided to the member at the same time as another service that is the same in nature and scope is excluded, regardless of funding source, including federal, state, local and private entities (for example, BPHC).
- The actual or direct provision of medical services or treatment is excluded. Examples include, but are not limited to:
 - Training in daily living skills
 - Training in work skills and social skills
 - Grooming and other personal services
 - Training in housekeeping, laundry or cooking
 - Transportation service
 - Individual, group or family therapy services
 - Crisis intervention services
 - Services that go beyond assisting the member in gaining access to needed services. Examples include, but are not limited to:
 - Paying bills and/or balancing the member's checkbook
 - Traveling to and from appointments with members
 - Court-ordered reports
 - Assistance completing Medicaid application or redetermination documentation

Example

Case Management Example

To help a member gain access to safe housing, an OBHP explores available housing options to review with the member, conducts a housing needs assessment, develops IICP goals for locating and maintaining housing, and provides supportive housing information.

This service is billable as Case Management (T1016 HW).

Child and Adolescent Intensive Resiliency Services

CAIRS is a time-limited, curriculum-based, nonresidential service provided to children and adolescents in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an IICP. CAIRS is designed to alleviate emotional or behavioral problems with a goal of reintegration into age-appropriate community settings (for example, school and activities with pro-social peers). CAIRS is provided in close coordination with the educational program provided by the local school district. See the following table for the applicable billing code.

Table 8 – HCPCS Code for MRO CAIRS

Code and Modifiers	Code Description
H2012 HW HA U1	Behavioral health day treatment, per hour; funded by state mental health agency; child/adolescent program; group setting

Service Unit Limitations

CAIRS is limited to 252 hours for child service packages 4, 5 and 6. Authorization for CAIRS is limited to 90 consecutive days. PA is required for members requiring additional units of this service. See [Appendix A](#) for information regarding units and service packages.

Target Population

CAIRS may be provided for members at least 5 years of age and less than 18 years of age with severe emotional disturbance who:

- Have a CANS LON of 4 or higher
- Need structured therapeutic and rehabilitative services
- Have significant impairment in day-to-day personal, social and/or vocational functioning
- Do not require acute stabilization, including inpatient or detoxification services
- Are not at imminent risk of harm to self or others

CAIRS may be provided to members age 18 and older, but less than 21 years of age, with an approved PA.

Provider Qualifications

The following providers may deliver CAIRS:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

The following program standards apply to CAIRS:

- CAIRS must be authorized by a physician, HSPP, LCSW, LMFT, LMHC, LCAC or APRN.
- Direct services must be supervised by a licensed professional or APRN.
- Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
- CAIRS must be provided in close coordination with the educational program provided by the local school district.
- CAIRS may be provided in a facility provided by the school district.
- Member goals and a transitional plan must be designed to reintegrate the member into the school setting and less intensive level of care.
- Therapeutic services include clinical therapies, psycho-educational groups and rehabilitative activities.
- A weekly review and update of progress occurs and must be documented in the member's clinical record.
- CAIRS must be provided in an age-appropriate setting for members less than 18 years of age.
- CAIRS programs must be offered a minimum of two hours and a maximum of four hours per day, three to five days per week, excluding time associated with formal educational or vocational services.
- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when provided in a group setting.
- CAIRS must demonstrate movement toward or achievement of member treatment goals identified in the IICP.
- CAIRS goals must be rehabilitative in nature.

Exclusions

The following exclusions apply to CAIRS:

- Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content are not reimbursable.
- Formal educational or vocational services are not reimbursable.
- CAIRS is not reimbursable for children less than 5 years of age.
- CAIRS is not reimbursable for members between the ages of 18 and 21 years without an approved PA. PA for CAIRS is not available for members age 21 or older.
- CAIRS is not reimbursed for members who receive individual or group Skills Training and Development (H2014 HW or H2014 HW U1) on the same day.
- A member may not receive both CAIRS and AIRS on the same day.

Example

CAIRS Example

A member goes to school from 8 a.m. to 4 p.m. Monday through Friday. On Tuesday and Thursday, she is in formal education services all day. On Monday, Wednesday and Friday, she receives behavioral health services from 8 a.m. to 9 a.m., formal education services and lunch from 9 a.m. to 3 p.m., and behavioral health services from 3 p.m. to 4 p.m.

CAIRS may be billed for two one-hour units of CAIRS service each day she participates (H2012 HW HA U1).

Medication Training and Support (Individual or Group Setting)

Medication Training and Support involves face-to-face contact with the member and/or the member's family or nonprofessional caregivers in an individual setting for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support can also include certain related non-face-to-face activities. Medication Training and Support can also be provided in a group setting for the purpose of providing education and training about medications and medication side effects. See the following tables for applicable billing codes.

Table 9 – HCPCS Codes for MRO Medication Training and Support (Individual Setting)

Code and Modifiers	Code Description
H0034 HW	Medication training and support, per 15 minutes; funded by state mental health agency
H0034 HW HR	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple with client present
H0034 HW HS	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple without client present

Table 10 – HCPCS Codes for MRO Medication Training and Support (Group Setting)

Code and Modifiers	Code Description
H0034 HW U1	Medication training and support, per 15 minutes; funded by state mental health agency; group setting
H0034 HW HR U1	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple with client present; group setting
H0034 HW HS U1	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple without client present; group setting

Service Unit Limitations

Medication Training and Support is limited to the following:

- 60 units for service package 3
- 104 units for service packages 4, 5, 5A and 6

PA is required for members who need additional units of this service. These maximum limits include any units billed under the procedure-code-and-modifier combinations listed in Tables 9 and 10. See [Appendix A](#) for information regarding units and service packages.

Target Population

Medication Training and Support may be provided in an individual setting for members of all ages with an ANSA or CANS LON of 3 or higher. For members age 12 and older, this service may be provided in a group setting.

Provider Qualifications

The following providers may deliver Medication Training and Support within the scope of practice as defined by federal and state law:

- Licensed physicians
- AHCPs
- Licensed registered nurses (RNs)
- Licensed practical nurses (LPNs)
- Medical assistants (MAs) who have graduated from a two-year clinical program

Program Standards

The following program standards apply to Medication Training and Support:

- Face-to-face contact with the member and/or the member's family or nonprofessional caregivers is provided and includes the following:
 - In an individual setting – Monitoring self-administration of prescribed medications and monitoring side effects
 - In a group setting – Education and training on the administration of prescribed medications and side effects and/or conducting medication groups or classes
- When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available through outpatient behavioral health services.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- Medication Training and Support delivered in an individual setting may also include the following services that are not required to be provided face-to-face with the member:
 - Transcribing physician or AHCP medication orders
 - Setting or filling medication boxes
 - Consulting with the attending physician or AHCP regarding medication-related issues
 - Ensuring linkage that lab and/or other prescribed clinical orders are sent
 - Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders
 - Follow-up reporting of lab and clinical test results to the member and physician
- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when the member is not present.
- Medication Training and Support must demonstrate movement toward and/or achievement of member treatment goals identified in the IICP.
- Group-based Medication Training and Support must be provided in an age-appropriate setting for members less than 18 years of age receiving services.
- Medication Training and Support goals are rehabilitative in nature.

Exclusions

The following exclusions apply to Medication Training and Support:

- If medication management, counseling or psychotherapy is provided as an outpatient behavioral health service, and medication management is a component, MRO Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding member self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.
- Medication Training and Support may not be provided for professional caregivers.
- When Medication Training and Support is provided in a group setting, the following non-face-to-face services are excluded:
 - Transcribing physician or AHCP medication orders
 - Setting up or filling medication boxes
 - Consulting with the attending physician or AHCP regarding medication-related issues
 - Ensuring linkage that lab and/or other prescribed clinical orders are sent
 - Ensuring that the member follows through and receives lab work and other clinical orders
 - Follow-up reporting of lab and clinical test results to the member and physician
- Medication Training and Support may not be provided in a group setting for members under the age of 12 years.

Example

Medication Training and Support (Individual Setting) Example

An RN meets with a member in his home to fill his pillbox and discuss the importance of taking medication regularly as prescribed. During the home visit, the nurse asks the member to identify the names of each of the medicines he takes and the reason why he takes them.

This service may be billed as Medication Training and Support (H0034 HW).

Psychiatric Assessment and Intervention

Psychiatric Assessment and Intervention services consist of face-to-face and non-face-to-face activities that are designed to provide psychiatric assessment, consultation and intervention services to members. See the following table for applicable billing codes.

Table 11 – HCPCS Codes for MRO Psychiatric Assessment and Intervention

Code and Modifiers	Code Description
H2019 HW	Therapeutic behavioral services, per 15 minutes; funded by state mental health agency
H2019 HW UA	Therapeutic behavioral services, per 15 minutes; funded by state mental health agency; non-face-to-face

Service Unit Limitations

Psychiatric Assessment and Intervention is included in adult service packages only and is limited to the following:

- 25 units for service package 5
- 100 units for services package 5A

These maximum limits include any units billed under H2019 HW or H2019 HW UA. PA is required for members requiring additional units of this service. See [Appendix A](#) for information regarding units and service packages.

Target Population

Psychiatric Assessment and Intervention may be provided for members age 18 and older with an ANSA LON of 5 or 5A, and a history of multiple hospitalizations and severe challenges in maintaining independent living within the community.

If needed for members under the age of 18 years, Psychiatric Assessment and Intervention may be prior authorized.

Provider Qualifications

The following providers may deliver Psychiatric Assessment and Intervention:

- Licensed physicians
- AHCPs

Program Standards

The following program standards apply to Psychiatric Assessment and Intervention:

- The programmatic goals of Psychiatric Assessment and Intervention must be clearly documented by the provider.
- Psychiatric Assessment and Intervention is intensive and must be available 24 hours per day, seven days a week, with emergency response.
- The member is the focus of Psychiatric Assessment and Intervention.
- Documentation must support how the service benefits the member, including when the service is not face-to-face.
- Psychiatric Assessment and Intervention must demonstrate movement toward or achievement of member treatment goals identified in the IICP.
- Psychiatric Assessment and Intervention goals must be rehabilitative in nature.
- Psychiatric Assessment and Intervention may include the following:
 - 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 member's treatment
 - Monitoring a member's medical and other health issues that are either directly related to the mental health or substance-related disorder, or to the treatment of the disorder (for example, diabetes, cardiac or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, and seizures)
- Non-face-to-face services may include consultation on assessment, service planning and implementation with other members of the member's treatment team, the member's family and nonprofessional caregivers.
 - This consultation may be provided either in or outside the team meeting.
 - To be a billable activity, consultation must be goal-oriented, focused on addressing barriers to fulfilling the member's IICP, and documented in the clinical record in a way that reflects the complexity of the interaction.

Exclusion

The following exclusion applies to Psychiatric Assessment and Intervention:

- Medication management activities provided in a clinic setting and other services that may be reimbursed as an outpatient behavioral health service are excluded

Examples

Psychiatric Assessment and Intervention (Non-Face-to-Face) Example

A staff person met with a member yesterday at the member's home. During the visit, the staff person noticed the member had not taken any medication for the last five days. The member was agitated and insisted the staff person leave the house as he was expecting a visit from a well-known celebrity. The staff person returned to the clinic and located the team psychiatrist. The staff person reviewed the member's current status with the psychiatrist, who asked a number of questions regarding the member's mental status and the condition of his home. After reviewing the case, the psychiatrist recommended the staff person arrange for the member to come in for a medication check.

The psychiatrist may document the consultation and recommendation, and bill as non-face-to-face Psychiatric Assessment and Intervention (H2019 HW UA).

Psychiatric Assessment and Intervention (Non-Face-to-Face) Exclusion Example

A staff person met with a member yesterday at his home. During the visit, the staff person noticed the member had not taken any medication for the last five days. The member was agitated and insisted the staff person leave the house as he was expecting a visit from a well-known celebrity. The next morning during the team meeting, the staff person let the team psychiatrist know she had arranged a medication check for the member to see him the following week.

Not billable as non-face-to-face Psychiatric Assessment and Intervention because no service was provided by the physician during the meeting. The activity of assessing the member's needs and linking him to needed services may be billed as Case Management.

Psychiatric Assessment and Intervention (Face-to-Face) Example

The team psychiatrist visited a member in his home to assess his response to medication.

This face-to-face service may be billed as Psychiatric Assessment and Intervention because the activity occurred in the member's home (H2019 HW).

Psychiatric Assessment and Intervention (Face-to-Face) Exclusion Example

The team psychiatrist saw a member in his office to assess the member's response to medication.

Not billable as face-to-face Psychiatric Assessment and Intervention due to the service location of the office. Instead, this service may be billed as an outpatient behavioral health service.

Psychosocial Rehabilitation (Clubhouse Services)

Psychosocial Rehabilitation refers to services delivered through a community-based accredited clubhouse setting in which the member, with staff assistance, is engaged in operating all aspects of the program, including clerical, reception, janitorial and food services, as well as receiving other member services such as employment training, housing assistance and educational support. See the following table for the applicable billing code.

Table 12 – HCPCS Code for MRO Psychosocial Rehabilitation

Code and Modifiers	Code Description
H2017 HW	Psychosocial rehabilitation services, per 15 minutes

Service Unit Limitations

Psychosocial Rehabilitation services are included in adult service packages 3, 4, 5 and 5A. The following limitations apply:

- 1,820 units per each 180-day period of a member's MRO eligibility
- 32 units per day

See [Appendix A](#) for information regarding units and service packages.

Target Population

Psychosocial Rehabilitation services may be appropriate for members with serious mental illness and/or a co-occurring substance use disorder who have an ANSA LON of 3 or higher.

Provider Qualifications

Psychosocial Rehabilitation services must be rendered by a DMHA-certified clubhouse provider under contract with an IHCP-enrolled MRO provider. The rendering clubhouse provider must be accredited by Clubhouse International and operate in conformity with the International Standards for Clubhouse Programs. Information about accreditation and program standards is available at the [Clubhouse International website](http://clubhouse-intl.org) at clubhouse-intl.org.

A DMHA-approved MRO provider may enroll more than one rendering clubhouse Psychosocial Rehabilitation provider. A clubhouse Psychosocial Rehabilitation rendering provider may be linked to more than one DMHA-approved MRO provider.

The rendering clubhouse provider must:

- Obtain a National Provider Identifier (NPI) through the [National Plan and Provider Enumeration System](https://nppes.cms.hhs.gov) at nppes.cms.hhs.gov.
- Be accredited by Clubhouse International and have a contractual relationship with a DMHA-approved MRO provider.
- Be certified by the DMHA.
- Be enrolled with the IHCP as a rendering provider with provider specialty 613 – *MRO Clubhouse* linked to a DMHA-approved IHCP-enrolled MRO provider.

The clubhouse staff delivering services must meet appropriate federal, state and local regulations for their respective disciplines as follows:

- Licensed professional
- QBHP
- OBHP

The MRO provider with whom the clubhouse provider is contracted will bill the IHCP for the services rendered. The billing provider identified on the claim must be the MRO provider. The rendering provider identified on the claim must be the clubhouse Psychosocial Rehabilitation provider with IHCP provider specialty 613.

Program Standards

The following program standards apply to Psychosocial Rehabilitation:

- The clubhouse must function under the authority of a DMHA-approved MRO provider.
- The clubhouse must be accredited by Clubhouse International and operate in conformity with the International Standards for Clubhouse Programs.
- Psychosocial Rehabilitation services must be authorized by a physician, HSPP, LCSW, LMFT, LMHC, LCAC or APRN.
- Psychosocial Rehabilitation services must be supervised by a licensed professional or APRN.
- The member must have an IICP that is member-driven.
- Psychosocial Rehabilitation services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the IICP and be designed to facilitate community integration, employment and use of natural supports.
- Documentation requirements include a brief daily activity note, sign-in and sign-out paperwork, and total units provided. A weekly summary is required and must note progress on the IICP goals.

Exclusions

The following exclusions apply to Psychosocial Rehabilitation:

- Transitional or supported employment occurring inside or outside the clubhouse will not be reimbursed.
- Staff travel time will not be reimbursed.
- Transportation of members to any community support activities (for example, taking member to court or to Social Security office) will not be reimbursed.
- Activities purely for recreation or diversion will not be reimbursed.
- Services provided in a residential setting as defined by the DMHA will not be reimbursed.
- Services provided when the member is not present will not be reimbursed.
- Psychosocial Rehabilitation services will not be reimbursed for a member for any date of service for which AIRS (H2012 HW HB U1) is provided and reimbursed.

Skills Training and Development (Individual or Group Setting)

Skills Training and Development involves face-to-face contact with the member and/or the member's family or nonprofessional caregivers that results in the member's development of skills (for example, self-care, daily life management or problem-solving skills), in an individual or group setting, directed toward eliminating psychosocial barriers. Development of skills is provided through structured interventions for attaining goals identified in the IICP and monitoring the member's progress in achieving those skills. See the following tables for applicable billing codes.

Table 13 – HCPCS Codes for MRO Skills Training and Development (Individual Setting)

Code and Modifiers	Code Description
H2014 HW	Skills training and development, per 15 minutes; funded by state mental health agency
H2014 HW HR	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple with client present
H2014 HW HS	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple without client present

Table 14 – HCPCS Codes for MRO Skills Training and Development (Group Setting)

Code and Modifiers	Code Description
H2014 HW U1	Skills training and development, per 15 minutes; funded by state mental health agency; group setting
H2014 HW HR U1	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple with client present; group setting
H2014 HW HS U1	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple without client present; group setting

Service Unit Limitations

Skills Training and Development is limited to the following:

- 600 units for service package 3
- 750 units for service package 4
- 900 units for service package 5 and 6
- 1,000 units for service package 5A

These maximum limits include any units billed under the procedure-code-and-modifier combinations listed in Tables 13 and 14. PA is required for members requiring additional units of this service. See [Appendix A](#) for information regarding units and service packages.

Target Population

Skills Training and Development may be provided for members of all ages with an ANSA or CANS LON of 3 or higher.

Provider Qualifications

The following providers may deliver Skills Training and Development:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

The following program standards apply to Skills Training and Development:

- Skills Training and Development requires face-to-face contact with the member and/or the member's family or nonprofessional caregivers.
- Members are expected to show benefit from Skills Training and Development, with the understanding that improvement may be incremental.
- For children and adolescents, Skills Training and Development includes services to aid in the achievement of developmental milestones that would have been achieved if not for the presence of the behavioral health disorder.
- Skills Training and Development must result in demonstrated movement toward, or achievement of, the member's treatment goals identified in the IICP.
- Skills Training and Development includes monitoring the impact of training acquisition.
- Skills Training and Development must restore the member's abilities essential to independent living (for example, self-care and daily life management).
- As identified in the IICP, Skills Training and Development must provide skills training specific to illness self-management.
- Skills Training and Development may include, but is not limited to, the following types of services:
 - Skills training in food planning and preparation, money management, and maintenance of living environment
 - Training in appropriate use of community services
 - Medication-related education and training by nonmedical staff
 - Training in skills needed to locate and maintain a home; renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, locating and interviewing prospective roommates, and understanding renters' rights and responsibilities
 - Social skills training necessary for functioning in a work environment
- The member is the focus of Skills Training and Development.
- Documentation must support how the service benefits the member, including when the service is provided in a group setting and when the member is not present.
- Skills Training and Development goals are rehabilitative in nature and time limited.
- When provided in a group setting, Skills Training and Development must be provided in an age-appropriate setting for members less than 18 years of age.
- Skills Training and Development services are eligible for reimbursement when an individual is residing in a 3.1 American Society of Addiction Medicine (ASAM) substance use disorder (SUD) residential treatment facility and the individual is eligible to receive MRO services. Therefore, procedure codes H2014 and H2034 can be reimbursed for the same date of service for the same member.

Note: Only providers enrolled as CMHCs are eligible to bill for H2014 under the MRO program, and only providers enrolled as 3.1 ASAM SUD residential facilities within the IHCP are eligible to bill for H2034.

Exclusions

The following exclusions apply to Skills Training and Development:

- Skills Training and Development that is habilitative in nature (except for the developmental milestones for members less than 18 years of age that would have occurred absent the presence of emotional disturbance) is not reimbursable.
- Skill-building activities not identified in the IICP are not reimbursable.
- Activities purely for recreation or diversion are not reimbursable.
- Job coaching is not reimbursable.
- Academic tutoring is not reimbursable.
- Skills Training and Development services (H2014 HW and H2014 HW U1) are not reimbursable if delivered on the same day as AIRS or CAIRS.
- Skills Training and Development is limited to eight units (two hours) when billed for the same date of service as Psychosocial Rehabilitation (H2017 HW).
- Skills Training and Development may not be provided to professional caregivers.

Examples

Skills Training and Development (Individual Setting) Example

A member identifies that he has never signed a lease or rented his own place. He says he is scared and does not know what to say to the landlord. Per his IICP, staff works with the member on assertiveness skills needed to negotiate with the landlord and ask questions about the property and lease expectations. Staff role-played as the landlord while the member practiced assertiveness skills. After three practice sessions, the member met with the prospective landlord.

This service may be billed as Skills Training and Development (H2014 HW).

Skills Training and Development Exclusion Example

A member hoards newspapers and mail, has not taken the trash to the dumpster in four weeks, and spoiled food and dirty dishes are covering the kitchen counters. Staff goes in and cleans the apartment for him and reminds him that he is to keep the apartment clean.

Doing tasks/activities for members is not billable under Skills Training and Development.

HCBS Waiver Programs and MRO Services

A member may be enrolled in a Home- and Community-Based Services (HCBS) waiver program and also receive other IHCP services, such as MRO services, at the same time. However, a federally approved waiver requires that waiver services not duplicate services that are already available. Service duplication would most likely occur in the following two areas:

- Skills Training and Development
- Case Management

Waiver case managers are responsible for monitoring services to prevent duplication. The behavioral health service provider must coordinate the provision of services with the waiver case manager.

1915(i) HCBS Benefits and MRO Services

Indiana operates three 1915(i) HCBS State Plan Amendment programs that fall under the authority of CMS HCBS rules. The following sections describe the relationship between these programs and MRO services.

Child Mental Health Wraparound

The Child Mental Health Wraparound (CMHW) program provides intensive home- and community-based wraparound services to youth ages 6 through 17 with serious emotional disturbances. CMHW services are provided within a System of Care (SOC) philosophy consistent with wraparound principles and are intended to augment the youth's existing or recommended behavioral health treatment plan (for example, MRO, HCBS waiver or managed care). For additional information about this program, see the [CMHW Services](#) webpage and the [Division of Mental Health and Addiction Child Mental Health Wraparound Services](#) module.

Members may be eligible to receive MRO services at the same time that they are receiving CMHW services; however, CMHW facilitators are responsible for monitoring services to prevent duplication. The behavioral health service provider must coordinate the provision of services with the wraparound facilitator.

Behavioral and Primary Healthcare Coordination

The Behavioral and Primary Healthcare Coordination (BPHC) program provides coordination of healthcare services to adults with serious mental illness who demonstrate impairment in self-management of physical health needs due to their mental illness. See the [Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services](#) module for more information about this program.

A member may be eligible and receive services from both BPHC and MRO at the same time. The following information applies for members using MRO in conjunction with the BPHC program:

- For individuals who have an active MRO service package assignment at the time of BPHC application, the BPHC program eligibility end date will be aligned with the current MRO end date; therefore, the two application processes will be aligned. The number of BPHC units authorized will be prorated based on the time left until the MRO service package expiration, as outlined in Table 15.

For example, if an individual is determined eligible for BPHC as of Sept. 1, 2022, and the MRO service package expiration date is Oct. 12, 2022, 16 BPHC units would be approved and the BPHC expiration date will be Oct. 12, 2022.

Table 15 – BPHC Units Authorized with Active MRO Service Package

# Months Until MRO Expires	# Units of BPHC Authorized
6	48
5	40
4	32
3	24
2	16
1	8

- When BPHC and MRO service package authorizations are aligned, following the initial application and authorization process, the BPHC service will be approved for 48 units. The MRO Case Management Services (T1016 HW) will be authorized at 48 fewer units of service than would be authorized if the member was not using the BPHC service. See the [Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services](#) module for information about the BPHC renewal process.

- For individuals who are not Medicaid eligible at the time of BPHC application and, therefore, do not have an active MRO service package assignment, the MRO effective date will be set retroactively to the BPHC effective date. A total of 48 units of BPHC will be authorized and the MRO service package will be assigned based on the individual's LON, as outlined in this document, with the exception that the number of authorized MRO Case Management units (T1016 HW) will be reduced by 48 units, as outlined in Table 16.

Table 16 – MRO Case Management Units Authorized with Active BPHC

MRO Service Package	# Authorized MRO Case Management Units
3	152
4	252
5	352
5A	452

Adult Mental Health Habilitation

The Adult Mental Health Habilitation (AMHH) program provides services to adults age 19 and older with serious mental illness who may most benefit from a habilitative treatment approach, which promotes sustaining and learning skills to maintain a healthy safe lifestyle in community-based settings. See *405 IAC 5-21.6* and the [Division of Mental Health and Addiction Adult Mental Health Habilitation Services](#) module for more information about this program.

AMHH and MRO services are mutually exclusive. A member may not be served in these programs at the same time. Providers may not submit claims for MRO services and AMHH services simultaneously.

The IHCP established measures to ensure that MRO and AMHH services do not overlap each other. When MRO data is received for a member who has AMHH coverage, the AMHH benefit is ended and the MRO package starts the following day. When AMHH data is received for a member who has MRO coverage, the MRO package is ended and the AMHH service starts the following day.

Noncovered Services

While each MRO service may have its own exclusions unique to that service, the following services are considered noncovered and are not eligible for reimbursement under *any* MRO services:

- A service provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, state, local and private entities (for example, AMHH, BPHC, HCBS waiver, or outpatient behavioral health services provided through Traditional Medicaid or a managed care plan)
- A service provided as a diversion, leisure or recreational activity, unless it is an identified component of an approved respite care service
- A service that is provided in a manner that is not within the scope or limitations of the MRO service
- A service that is not documented as a covered or approved service on the member's IICP
- A service that exceeds the limits provided within the service definition, including service quantity/limit, duration and/or frequency
- Any service provided on the same day that the member is receiving inpatient or partial hospitalization

Note: MRO and AMHH services are mutually exclusive. An individual may not receive these services concurrently.

Section 3: Diagnosis and Level of Need

All Medicaid members who demonstrate a behavioral health need are eligible for outpatient behavioral health services, as described in the [Behavioral Health Services](#) module, within the coverage limitations of their particular benefit plan. However, only members with a qualifying diagnosis and level of need (LON) are also eligible for a Medicaid Rehabilitation Option (MRO) service package. Details regarding service packages may be found in [Section 4: Medicaid Rehabilitation Option Service Packages](#) of this document and in [Appendix A](#).

Qualifying Diagnosis

The behavioral health International Classification of Diseases (ICD) diagnosis codes associated with MRO services are listed in the *Medicaid Rehabilitation Option Services Codes* on the [Code Sets](#) page at in.gov/medicaid/providers. A “Y” (Yes) indicates a qualifying MRO diagnosis. A member must have at least one qualifying diagnosis from the list to be eligible for an MRO service package. Note that adults and children or adolescents have separate qualifying diagnosis lists.

The provider must enter the qualifying diagnosis for each member into the Division of Mental Health and Addiction (DMHA) Data Assessment Registry for Mental Health and Addiction (DARMHA) database for an MRO service package to be assigned.

Level of Need

In addition to a qualifying diagnosis, a member with Medicaid must also have a qualifying LON, as demonstrated by the DMHA-approved assessment tool. Currently, DMHA has approved the use of the Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA). The CANS and ANSA are comprehensive, uniform assessment tools developed to support care planning and level-of-care decision making, to facilitate quality improvement initiatives and to allow for the monitoring of outcomes of services.

Providers must enter the CANS or ANSA data for each member into the DMHA DARMHA system for an LON to be established and eligibility for an MRO service package to be determined:

- Children with an LON of 2 or higher are eligible for an MRO service package.
- Adults with an LON of 3 or higher are also eligible for an MRO service package.

Members may present with the same diagnosis but have very different LONs. Service packages are designed to meet the member’s behavioral health needs based on his or her functional assessment and resulting LON.

The IHCP Provider Healthcare Portal (Portal) displays the LON information for members covered for MRO services. The LON information is available on the eligibility benefit and coverage detail pages of the Portal. All providers can see the MRO LON on the *Benefit Details* panel when verifying member eligibility. Providers with the MRO specialty can also see detailed information for a member’s MRO LON on the *Detail Information* panel.

Level of Need Example

Two members have a diagnosis of schizophrenia. One member hears and responds to nonexistent voices, is not able to manage his own medicine or hold a job, and has moved six times in the last year. His ANSA LON is 5.

A second member has a job working at the local grocery store 20 hours per week. He has his own apartment, manages his own medications with some supervision, and performs all activities of daily living independently. He is involved with church and takes classes at the local community center. His ANSA LON is 3.

Service package 5 contains a broad array of services with a robust number of units of service available designed to meet the first member's intense LON. Service package 3 includes an assortment of services with a minimal/moderate number of units of services designed to meet the second member's lower intensity of needs.

Diagnosis and LON Exceptions

A member who does not have a qualifying diagnosis or LON necessary to access an MRO service package may submit prior authorization (PA) for medically necessary MRO services. To do so, a provider must demonstrate that the member has a significant behavioral health need that would benefit from the provision of MRO services. This process is discussed in further detail in [Section 5: Prior Authorization](#).

Section 4: Medicaid Rehabilitation Option Service Packages

An Indiana Health Coverage Programs (IHCP) member with a qualifying diagnosis and level of need (LON) may be assigned a Medicaid Rehabilitation Option (MRO) service package. The MRO service package comprises types and units of MRO services that match the needs of the majority of MRO members. A member who does not have either a qualifying diagnosis or LON necessary to access an MRO service package may submit prior authorization (PA) for individual MRO services. If a member has an MRO service package and needs additional units of a service or a service that is not included in the service package, PA may be submitted. PA processes are discussed in further detail in [Section 5: Prior Authorization](#).

Note: MRO service packages are approved for individual members and are not tied to a particular provider. The member may choose to receive approved services from any IHCP-enrolled community mental health center (CMHC), regardless of which CMHC submitted the MRO data for the service package.

Note that, although a process is in place to request PA for additional medically necessary services or units of service, treatment shall be individualized to meet each individual member's needs. Not all members need all services and/or units of services in assigned service packages.

Service package assignment is based on the member's LON. Typically, MRO service packages are assigned for 180 days. Exceptions occur when MRO is established after another program with a service package assignment is preexisting. See the [Behavioral and Primary Healthcare Coordination](#) section for details. Service packages are assigned by the IHCP claim-processing system, Core Medicaid Management Information System (CoreMMIS). All assignments for service packages and PA approvals and denials are viewable on the IHCP Provider Healthcare Portal (Portal).

Each service package contains a set of services and units of service designed to meet the member's intensity of need. More information on the services and units of service in each service package may be found in [Appendix A](#) of this document.

Service Package Assignment Process

A process has been created in CoreMMIS to assign service packages, pay claims, and track available service units. Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) assessments that are completed and entered into the Data Assessment Registry for Mental Health and Addiction Medication (DARMHA) follow this process:

1. Data Transfer

- CoreMMIS receives newly entered or updated member data from the DARMHA system every business day through a file exchange.
 - DARMHA only transmits member data if the Indiana Health Coverage Programs (IHCP) Member ID (indicated in the DARMHA as "Medicaid RID") and other required data has been entered in DARMHA by the provider.
 - If all the required data is not entered for a member, the process for assigning an MRO service package is not initiated.

2. Member Data Match

- DARMHA member data is matched to existing IHCP member data using the Member ID and date of birth (DOB).
 - Match – YES
 - After matched, a member-specific MRO file is created and stored in CoreMMIS and displayed on the Portal.

- Match – NO
 - If a match is not made, a service package is not assigned. Matches are not made if there are errors in member data submitted to DARMHA. CoreMMIS generates an *Error Report* for each provider indicating members who were not matched to the Medicaid data. Errors include:
 - 1001 – *Member ID not on file – TXN rejected*
 - 1506 – *Invalid date of birth*
 - 1600 – *Submission date is not a valid date*
 - 1603 – *MRO tool ID is invalid*
 - 1604 – *MRO provider is invalid*
 - 1609 – *Member ID ineligible*
 - 1677 – *MRO PA already exists for all/part of service dates*
 - Providers should use this report to review and correct member data entered into DARMHA. After the data is corrected, CoreMMIS accepts the member data and runs through the validation steps.

3. Criteria Validation

- CoreMMIS performs a validation to determine whether the member meets the criteria necessary to assign an MRO service package. All denial reasons are viewable on the Portal.
- The validation process is not initiated without all the following data fields:
 - First Name
 - Last Name
 - Medicaid RID
 - DOB
 - CANS or ANSA score
 - Diagnosis

Provider Responsibility #1

Enter accurate member data into DARMHA in a timely manner. An MRO service package is not assigned, and consequently claims are not paid, without the boldfaced data fields:

- | | |
|-----------------------|----------------------------------------|
| ✓ First Name | ✓ Diagnosis |
| ✓ Last Name | ✓ CANS or ANSA score |
| ✓ DOB | ✓ Assessment Date |
| ✓ Medicaid RID | ✓ Provider ID |
| ✓ SSN | ✓ ACT indicator (for ACT members only) |

- (a) **Assessment Date Format:** Is the CANS or ANSA assessment date a valid date?
 - YES – Move to step 3(b).
 - NO – Service package not assigned.
Denial reason 1610 – *Denied: Invalid assessment date format.*
- (b) **Qualifying LON:** Does the member’s LON qualify? (See [Appendix A](#) for qualifying CANS 2–6 and ANSA 3–5 for each MRO service.)
 - YES – Move to step 3(c).
 - NO – Service package not assigned.
Denial reason 1602 – *LON does not meet MRO services criteria.*
- (c) **Qualifying Diagnosis:** Does the member **have** a qualifying diagnosis? (See the *Medicaid Rehabilitation Option Codes* on the [Code Sets](#) page at in.gov/medicaid/providers for qualifying MRO diagnoses.)
 - YES – Move to step 3(d).
 - NO – Service package not assigned.
Denial reason 1601 – *Denied: Diagnosis code does not meet the MRO services criteria.*

(d) **Active Service Package:** Does the member have an active service package with more than 60 days (or 30 days, for youth) of authorization remaining?

- YES – Service package not assigned.
Denial reason 1600 – *Active service package already exists.*
- NO – Move to step 3(e).

Policy on Changes in LON During an Active Service Package Period

The existing assigned service package remains the same even if the LON changes during the 180 days for which the package is authorized.

- If the LON goes *up* during the authorized period, and additional services or units are necessary to meet the needs of the member, the provider may use the new LON as evidence of medical necessity when requesting PA.
- If the LON goes *down* during the authorized period, services assigned by the system are not prorated to adjust to the lower LON. However, audits are conducted to ensure that providers are only delivering medically necessary services. As such, the changed LON may be 1 source (along with other medical records) used to determine whether services are being delivered appropriately.

(e) **Current Assessment:** Is the CANS or ANSA current?

- YES – Move to step 3(f).
- NO – Service package not assigned.
Denial reason 1605 – *Denied: Assessment date does not meet MRO program services criteria.*

What is a “current” assessment?

The *assessment date* is the date upon which a provider completes the CANS or ANSA with the member. The *date of submission* is the date upon which the assessment data is received by CoreMMIS from DARMHA. DARMHA sends daily files of newly entered and updated data to CoreMMIS.

Policy on current assessment for youth:

- A CANS assessment is current if the assessment date is less than 30 days prior to the date of submission for a member not currently assigned to a service package.
- A CANS reassessment is current if the reassessment date is 30 days prior to the end of a currently assigned service package if a renewal package is being sought.

Policy on current assessment for adults:

- An ANSA assessment is current if the assessment date is less than 60 days prior to the date of submission for a member not currently assigned to a service package.
- An ANSA reassessment is current if the reassessment date is 60 days prior to the end of a currently assigned service package if a renewal package is being sought.

Provider Responsibility #2

Perform required CANS or ANSA reassessments and enter data into DARMHA within the required number of days prior to the end of a member’s service package to ensure continuity of care (**30 days for CANS or 60 days for ANSA**). If a reassessment is performed after the member’s initial service package end date, retroactive PA is not available for providers to receive reimbursement.

- (f) **Assertive Community Treatment (ACT) Criteria:** Has the ACT indicator been selected?
- YES – CoreMMIS performs the following additional checks:
 - Is the provider an ACT-certified community mental health center (CMHC)?
 - YES – Move to the next question.
 - NO – Move to step 4 to assign the service package.
Reason code 1607 – *Approved: LON and MRO service pkg assigned, but ACT service criteria not met.*
 - Does the LON supplied have two characters and match the member’s LON on file for the submission date?
 - YES – Move to step 4 to assign the service package.
 - NO (First character matches) – Move to step 4 to assign the service package.
Reason Code 1606 – *MRO LON and benefit plan assigned, but invalid ACT indicator.*
 - NO (First character does not match) – Service package not assigned.
Denial reason 1602 – *LON does not meet MRO services criteria.*
 - NO – CoreMMIS moves to step 4.

4. Service Package Assignment

- If the member meets the criteria for MRO and passes the preceding criteria validation process (3a–f), a service package is assigned for 180 days.
- For renewals, the system assigns the new package to begin the day following the end date of the previous package.
- If a member has existing units of PA available prior to a service package assignment, the system end dates the PA for these individual services and assigns the service package.

Verifying Member Eligibility for MRO Services

Providers can use the [Provider Healthcare Portal](https://in.gov/medicaid/providers) (accessible from the home page at in.gov/medicaid/providers) to verify a member’s eligibility for MRO services and to track utilization of services within the assigned service package. The system displays assigned service codes and number of units available for each member. Units of service are decremented from a member’s service package when a claim is paid.

Provider Responsibility #3

Check eligibility for IHCP and MRO services, and internally monitor service package utilization for each member.

- ✓ As is required for all IHCP service providers, MRO providers should check a member’s IHCP eligibility prior to each visit.
- ✓ In addition to this check, MRO providers should review the MRO service package assignment and available units of service prior to service delivery.

While the Portal provides service package details, it is ultimately the responsibility of the provider to track utilization.

The following steps outline the procedure for verifying a member's eligibility for MRO services and viewing details of the member's assigned service package from the Portal:

1. Click the Eligibility tab on the menu bar to access the *Eligibility Verification Request* panel.

Figure 1 – Eligibility Verification Request

2. Enter any of the following three search criteria for the member:
 - Member ID
 - Social Security number (SSN) and birth date
 - Last name, first name and birth date
3. Enter the date, or date range, for the inquiry:
 - The Effective From field is always required. If a date is not entered in this field, the Portal defaults this field to the current date. This field only accepts current and previous dates.
 - The Effective To field is optional. If a date is entered, it must be on or after the date in the Effective From field and must be within the same calendar month as that date. If a date is not entered in this field, it will default to the date in the Effective From field.
4. Click **Submit** to view the member's benefit coverage – including Medicaid Rehabilitation Option coverage, LON and service package assignment – for the date range submitted.

Figure 2 – Eligibility Verification Information

Coverage Details for			
Member ID		Birth Date	
Verification Response ID	1813400003		
Benefit Details			
Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	01/01/2017	01/31/2017
Medicaid Rehabilitation Option	Medicaid Rehabilitation Option for Adults with Level of Need = 4, Service Package 4	01/01/2017	01/31/2017
Medical Review Team	Medical Review Team procedure codes only	01/01/2017	01/31/2017

Note: If the search results do not include Medicaid Rehabilitation Option, the member has no MRO service package assigned for the dates entered.

*If the system does not find **any** coverage for the member on the dates entered, "Not Eligible" appears in the Coverage column.*

*If the system does not find any member matching the search criteria entered, it displays the message "Error: Member not found, confirm and/or revise search criteria." Select **Reset** to clear the search criteria fields.*

5. In the Coverage column, select **Medicaid Rehabilitation Option** to view details about the associated MRO services.

Note: Medicaid Rehabilitation Option appears as a hyperlink only to providers with a CMHC specialty (111). All other provider specialties see only the plan name and description; they do not have the option to click the plan and view the MRO coverage details.

6. On the *Coverage Details* page, the *Detail Information* panel provides the following information for each service included in the member's MRO coverage:
 - **Authorization Number** – The PA number associated with the service.
 - **Status** – Indicates whether the MRO service is approved or gives the reason it was denied. The following list of reasons appears in this column based on the information submitted by the MRO provider:
 - **Approved**
The MRO service is approved.
 - **Approved: LON and MRO service pkg assigned, but ACT service criteria not met.**
Providers requesting an ACT service package for MRO members must be ACT certified. The PA vendor must have a copy of the certificate on file.
 - **MRO, LON and benefit plan assigned, but invalid ACT indicator.**
For the ACT service package to be assigned, the LON supplied must be an ACT LON that matches the member's LON for the submission date.
 - **Denied: Diagnosis code does not meet the MRO services criteria.**
The diagnosis code submitted must be an approved MRO diagnosis code and be valid for the CANS or ANSA.
 - **LON does not meet the MRO services criteria.**
LON for a CANS must be greater than 1 and the LON for an ANSA must be greater than 2.
 - **Active service package already exists.**
An MRO service package is effective for 180 days. A new assessment (CANS or ANSA) may be submitted within the required time frame (30 days for CANS and 60 days for ANSA) prior to the end of a service package. If eligible, the start date is the day after the old service package expires.
 - **Denied: Invalid assessment date format.**
The CANS or ANSA assessment date must be submitted in the correct format.
 - **Denied: Assessment date does not meet MRO program services criteria.**
The CANS or ANSA assessment must be completed within 30 or 60 days of the date of submission.
 - **Provider** – Practitioner or entity that requested the PA.
 - **Code** – Procedure code and modifiers used for service.
 - **Description** – Description of the procedure code.
 - **Service Dates** – The effective date range of the MRO service package. (Services rendered prior to the start date or after the end date are not considered for reimbursement.)
 - **Units Authorized** – The number of units that are allowable for this service.
 - **Units Used** – The number of units of this service that have been used.

Note: The information displayed in the MRO coverage details is based on paid claims only.

- **Amount Authorized** – This field is not populated for MRO services.
- **Amount Used** – This field is not populated for MRO services.

Figure 3 – Detail Information for an MRO Service Package

Coverage Details for

from 11/02/2017 to 11/02/2017

Back to Eligibility Verification Request

Benefit Details

Coverage	Description
Medicaid Rehabilitation Option	Medicaid Rehabilitation Option for Adults with Level of Need = 4, Service Package 4

Detail Information

Total Records: 5

Authorization Number	Status	Provider	Code	Description	Service Dates	Units Authorized	Units Used	Amount Authorized	Amount Used
X100100100	APPROVED	PSYCHIATRIC CENTER	H0031 HW	MH HEALTH ASSESS BY NON-MD	08/10/2017 - 02/06/2018	1	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H0004 HW	ALCOHOL AND/OR DRUG SERVICES	08/10/2017 - 02/06/2018	32	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H0004 HW U1	ALCOHOL AND/OR DRUG SERVICES	08/10/2017 - 02/06/2018	48	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H2035 HW	A/D TX PROGRAM, PER HOUR	08/10/2017 - 02/06/2018	32	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H2017 HW	PSYSOC REHAB SVC, PER 15 MIN	08/10/2017 - 02/06/2018	1820	-	-	-

MRO Agency Contact Information

Contact information for the agency where a member receives MRO services is available to providers through the eligibility verification process. This information is accessible through each of the IHCP Eligibility Verification System (EVS) options: the Portal, Interactive Voice Response (IVR) system and 270/271 electronic transaction.

When date and prior authorization parameters have been established, a provider can view or hear the following contact details in each of the EVS options:

- MRO agency name
- Agency phone number
- Agency fax number (if on file)
- Agency email address (if on file)
- Agency type
- Date agency information received

If no contact information is found, providers will receive a No Agency Found response.

Figure 4 shows where this information appears in the Portal.

Figure 4 – Waiver-MRO Program Agency information on the Portal

Waiver MRO Program Agency					
Waiver MRO Agency Name	Agency Phone	Agency Fax	Email Address	Agency Type	Date Agency Information Received
Provider Name	1-317-XXX-XXXX			MRO	06/10/2021

For details about where to find this information on the 270/271 transaction, see the *270/271 Health Care Eligibility Benefit Inquiry and Response Transactions Companion Guide*, accessible from the [IHCP Companion Guides](#) page at in.gov/medicaid/providers.

Section 5: Prior Authorization

This section outlines the prior authorization (PA) guidelines for Medicaid Rehabilitation Option (MRO) services provided beyond the assigned MRO service package. For more information about general PA, see *Indiana Administrative Code 405 IAC 5* and the [Prior Authorization](#) module. Indiana Health Coverage Programs (IHCP) providers are responsible for reading and understanding portions of the IAC and the [IHCP provider reference modules](#) that apply to their areas of service.

PA Contractor

On behalf of the Family and Social Services Administration (FSSA), the fee-for-service (FFS) PA contractor reviews all MRO PA requests for IHCP members on a case-by-case basis. The decision to authorize, modify or deny a PA request is based on medical necessity, all applicable IACs, PA guidelines, and IHCP bulletins and banner pages.

PA requests may be submitted electronically or by mail or fax, using the *Indiana Health Care Programs Prior Authorization Request Form* (universal PA form), available on the [Forms](#) page at in.gov/medicaid/providers (for contact information, see the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers).

See the [PA Submission](#) section for details.

Allowable PA Scenarios for MRO Services

For the majority of members receiving MRO services, the assigned MRO service packages provide a sufficient number of services and units of services to meet their needs. However, for members who require additional medically necessary services not included in the service package, or additional units of services assigned in the service package, a PA request is required. Under the following four scenarios, an MRO service provider is required to submit a PA request to the FFS PA contractor to be reimbursed for additional medically necessary services or units of service.

- Scenario 1:** A member exhausts all units of a service included in their MRO service package and requires additional units of that medically necessary service.
- Scenario 2:** A member requires a medically necessary MRO service not assigned in their MRO service package.
- Scenario 3:** A member does not have a qualifying MRO diagnosis or level of need (LON), and has a significant behavioral health need that requires a medically necessary MRO service.
- Scenario 4:** A member is newly eligible to the Medicaid program or a member without an MRO package had a lapse in their Medicaid eligibility and was determined Medicaid-eligible for a retroactive period. In this case, a retroactive request for PA is appropriate for MRO services.

Note: For all the scenarios presented, MRO service providers are required to submit documentation that supports medical necessity.

Retroactive PA Policy

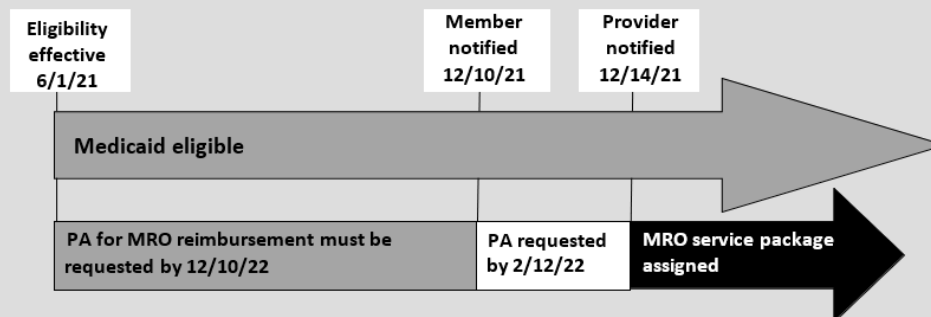
Requests for retroactive PA are not authorized except where a member:

- Is newly eligible for Medicaid or other IHCP program that covers MRO services
- Had a lapse in their Medicaid eligibility and was determined Medicaid eligible for a retroactive period

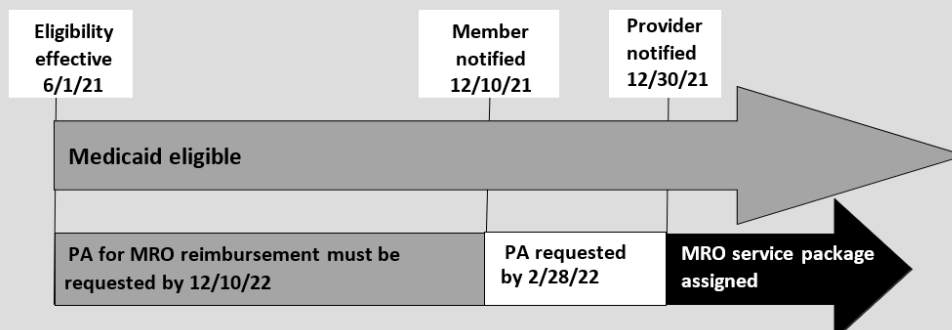
Retroactive PA requests must be made within 12 months of the date when the member's caseworker entered the eligibility information or 60 days of the provider receiving notice of a member's eligibility. Clinical notes documenting dates of service, services and duration of services must be submitted with retroactive PAs.

Scenario 4 (Retroactive PA) Examples

A member submits a Medicaid application on Sept. 1, 2021. On Dec. 10, 2021, the member's caseworker enters the eligibility information and notifies the member that she is Medicaid-eligible retroactive to June 1, 2021. The member has an appointment with her behavioral health provider on Dec. 14, 2021, and tells the provider that she is now eligible for Medicaid. Her provider completes an Adult Needs and Strengths Assessment (ANSA) and submits the ANSA score, a qualifying diagnosis and IHCP Member ID (RID) to the Data Assessment Registry for Mental Health and Addiction Medication (DARMHA) on Dec. 14, 2021. An MRO service package is assigned for 180 days. If the member's provider delivered MRO services between June 1, 2021, and Dec. 10, 2021, PA must be submitted within 12 months of Dec. 10, 2021, (by Dec. 10, 2022) to receive reimbursement. If her provider delivered services between Dec. 10, 2021, and Dec. 14, 2021, PA must be submitted within 60 days of Dec. 14, 2021, (by Feb. 12, 2022) to receive reimbursement.



A member submits a Medicaid application on Sept. 1, 2021. On Oct. 20, 2021, his provider completes an ANSA and submits the ANSA information to DARMHA with a qualifying diagnosis. On Dec. 10, 2021, the member is notified that he is Medicaid-eligible retroactive to June 1, 2021. A service package is not assigned because the provider has not yet entered a RID into DARMHA to trigger the member's data be sent to CoreMMIS. The member has an appointment on Dec. 30, 2021, during which he tells his provider that he is now eligible for Medicaid. The member's provider enters the member's RID in DARMHA. An MRO service package is assigned. If the provider delivered services between June 1, 2021, and Dec. 10, 2021, PA must be submitted within 12 months of Dec. 10, 2021 (by Dec. 10, 2022), to receive reimbursement. If the provider delivered services between Dec. 10, 2021, and Dec. 30, 2021, PA must be submitted within 60 days of Dec. 30, 2021, (by Feb. 28, 2022) to receive reimbursement.



Lapse in Medicaid Eligibility

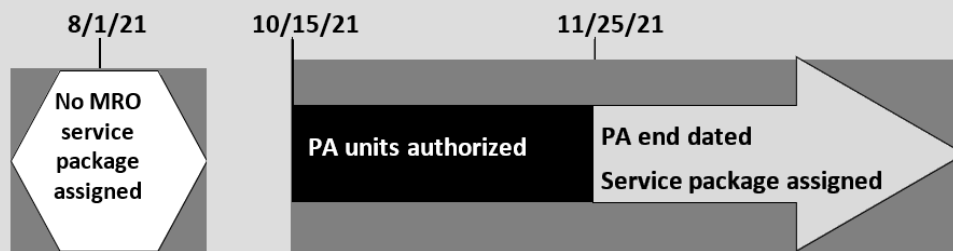
Retroactive PA is also available for members who experience a lapse in Medicaid eligibility. For example, a member is assigned service package 4 for 180 days. On day 40 of the service package, the member loses Medicaid eligibility. The MRO service package remains open for the 180-day period. On day 90, the member's Medicaid eligibility is reinstated with a retroactive period back to day 40. Medicaid is reopened with retroactive period, resulting in no lapse in eligibility. The provider may submit claims without requesting retroactive PA.

PA and Service Package Assignment

For members who did not qualify for a service package but who received PA for a medically necessary MRO service (scenario 3), if, at a later date within the PA period, they are reassessed and the resulting LON now qualifies them for an MRO service package, the provider would submit a system update to end date the existing PAs so that a service package can be assigned.

PA and Service Package Assignment Example

On Aug. 1, 2021, a provider completes an ANSA for a member, who is assessed as LON 2. No MRO service package is assigned. The provider submits a PA request for 50 units of Skills Training and Development on Oct. 12, 2021, and the request is authorized by the FFS PA contractor on Oct. 15, 2021, for 50 units of Skills Training and Development for 90 days. On Nov. 25, 2021, the provider completes another ANSA for this member, and she is assessed as LON 3. The provider enters this data into DARMHA, and service package 3 is assigned for 180 days. The PA for the remaining units of Skills Training and Development is end dated, as this service is now available under the member's MRO service package.

**PA Submission**

Providers may request PA on behalf of the IHCP member. For scenarios 1, 2 and 3 in the [Allowable PA Scenarios for MRO Services](#) section, the provider is responsible for submitting new PA requests up to 30 days before the current authorization period expires to ensure service authorization and reimbursement are not interrupted. For scenario 4, retroactive eligibility, a request for PA may be made retroactively.

PA requests and system updates to existing authorizations may be initiated with the FSSA PA contractor from the Portal or via fax, mail, telephone or 278 electronic transaction, as described in the [Prior Authorization](#) module:

- On the Portal, PA requests and system updates are submitted from the *Care Management* page. Only the requesting MRO provider for the original PA (or a delegate of that provider) may submit a system update to an existing authorization via the Portal; all other MRO providers must submit a system update via paper or fax.
- For PA requests and system updates submitted by mail or fax, providers **must** use the *Indiana Health Coverage Programs Prior Authorization Request Form* (universal PA form) and the *Prior Authorization – System Update Request Form*. The form must be submitted to the FFS PA contractor. Providers should retain photocopies of the completed forms for their records. All

necessary PA forms for MRO services can be found on the [Forms](#) page at in.gov/medicaid/providers. Providers are responsible for using these forms to ensure accurate, timely PA review and claim processing.

When submitting a system update request to modify an existing MRO benefit package for a member, providers must include the member's primary ICD-10 diagnosis code on the request. Requests received without the primary diagnosis code could be suspended for up to 30 days, until the provider submits this information.

MRO providers can view authorization numbers in the Portal when verifying coverage details for members receiving MRO services. Only MRO providers will see a hyperlink for the MRO benefit plan on the *Eligibility Verification* page. That link will take those users to the *Coverage Details* page, where PA information for the requested dates is displayed (see [Figure 3](#)).

Provider Responsibility #4

Request PA for additional services or additional units of service required for a member on a timely basis.

- The FFS PA contractor reviews PA requests on behalf of the IHCP.
- Use the current PA process and request form for MRO PA requests.

PA Policy Requirements

An Individualized Integrated Care Plan (IICP) and progress notes, including the necessity and effectiveness of therapy, must be attached to the PA request, and a copy must be available for audit purposes.

For MRO PA requests submitted by mail, the PA form must be signed (handwritten or rubber stamp) by one of the following practitioners:

- Physician (doctor of medicine or doctor of osteopathic medicine)
- Health service provider in psychology (HSPP)
- Advanced practice registered nurse (APRN)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed clinical addiction counselor (LCAC)

MRO PA requests submitted via the Portal must be submitted from the account of one of the preceding provider types or specialties, or must include a physician's order, signed and dated by the physician, as an attachment.

Each PA submission is reviewed on a case-by-case basis. MRO services are subject to PA as found in *405 IAC 5-21*.

PA Decision

A PA decision is represented by the following responses in the decision letter sent to the provider and member:

- Approved – The service request has been authorized.
- Modified – A modified PA request is an approved PA that has been changed in some way.

- Suspended – The PA request is suspended; additional information is required to complete review. This is not an appealable decision.
- Pending – The PA request is pending; the PA is being held for required documentation.
- Denied – If the PA request is denied, the provider is not reimbursed by the IHCP for any dates of service applicable.

Providers can also obtain the PA status from the Portal, via 278 electronic transaction or through a telephone-based authorization inquiry on the Interactive Voice Response (IVR) system. See the [PA Status Information](#) page at in.gov/medicaid/providers for equivalent status responses on the Portal, 278 transaction or IVR system. For more information about using these tools, see the [Prior Authorization](#), [Electronic Data Interchange](#) and [Interactive Voice Response System](#) modules.

PA Exceptions and Limitations

Granting PA confirms medical necessity but is valid only if a member is eligible for Medicaid on the date services are rendered. PA is not a guarantee of payment, and member eligibility should be verified by the provider before services are rendered.

Providers should also determine if the member has third-party liability (TPL) coverage and if PA from the third-party carrier is necessary. As the IHCP is the payer of last resort, claims must be submitted to the third-party carrier before they are submitted to the IHCP.

Note: If a member has other health insurance, and a service that is covered by Medicaid requires PA, the provider must obtain PA from both sources prior to rendering services.

The IHCP does not reimburse providers for any IHCP service requiring PA unless PA is obtained prior to services being rendered. The exception to this rule is when a PA request qualifies for retroactive eligibility, provided that the member's aid category covers MRO services.

Any authorization of a service by the FFS PA contractor is limited to authorization for payment of IHCP-allowable charges. It is not an authorization of the provider's estimated fees. PA is not a guarantee of payment.

Section 6: Clinical Record Documentation Requirements

The documentation required to support billing for Medicaid Rehabilitation Option (MRO) services must:

- Focus on recovery
- Emphasize member strengths
- Reflect progress toward the goals included in the Individualized Integrated Care Plan (IICP)
- Be updated with every member encounter that billing is submitted for reimbursement
- Note actual time used in delivering the service
- Reflect start and end times of service
- Be written and signed by the provider rendering services and cosigned as necessary
- Include the date of service rendered (including month, day and year) in the documentation

See [Section 2: Medicaid Rehabilitation Option Services](#) of this document for complete service definitions, provider qualifications, program standards, target population and exclusions (for example, activities that are not reimbursable or services that are not reimbursable on the same day).

Note: For documentation requirements related to outpatient behavioral health services that are not specific to the MRO program, such as crisis intervention and peer recovery, see the [Behavioral Health Services](#) module.

General Documentation Requirements

For individuals participating in any MRO service, documentation must be provided for each encounter and must include:

- Type of service being provided
- Name and qualifications of the staff providing the service
- Location or setting where the service was provided
 - *Clinic setting* is an outpatient, office-based environment and does not refer to a billing mechanism.
 - *Community setting* is a nonclinical, office-based, noninstitutional (institutions include jail, psychiatric residential treatment facility [PRTF], state-operated facility [SOF]) setting.
 - *Residential setting* is any setting in which a member resides or sleeps.
 - *School setting* is a formal education environment.
 - *Acute care setting* is inpatient or partial hospitalization.
- Focus of the session or service delivered to or on behalf of the member
- Individual symptoms or issues addressed during the session
- Duration of the service (actual time spent with the member)
- Start and end time of the service
- Member's IICP goals being addressed during the session

- Progress made toward the member's recovery goals
- Date of service rendered (including month, day and year)

The content of the documentation must support the amount of time billed. In addition to the requirements listed in this section, specific requirements for selected service types are reflected in the following sections.

Group Setting Documentation Requirements

For individuals participating in MRO services in a group setting (applicable to Addiction Counseling, Behavioral Health Counseling and Therapy, Medication Training and Support, and Skills Training and Development), documentation must be provided for each encounter and must include:

- All items listed in the [General Documentation Requirements](#) section
- Focus of the group or session
- Member's level of activity in the group session
- How the service benefits the member and assists the member in reaching his/her recovery goals
- Progress toward the individual member's recovery goals as found in his or her IICP

Simply noting whether or not the member was present in the group does not constitute adequate documentation.

Services Without the Member Present Documentation Requirements

For MRO services provided without the member present (applicable to Addiction Counseling, Behavioral Health Counseling and Therapy, Medication Training and Support, and Skills Training and Development), documentation must be provided for each encounter and must include:

- All items listed in the [General Documentation Requirements](#) section
- Who attended the session and his or her relationship with the member
- How the service benefits the member and assists the member in reaching his or her recovery goals
- Progress toward the individual member's recovery goals as found in his or her IICP

Simply noting that the member was not present does not constitute adequate documentation.

Service-Specific Documentation Requirements

The following MRO services have additional documentation requirements as described in this section.

AIRS Documentation

Adult Intensive Rehabilitation Services (AIRS) is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured rehabilitative services to maintain the member on an outpatient basis. AIRS is curriculum-based and designed to alleviate emotional or behavior problems with the goal of transitioning to a less restrictive level of care, reintegrating the member into the community, increasing social connectedness beyond a clinical setting and/or employment. For a complete definition of this service, see the [Adult Intensive Rehabilitative Services](#) section.

Documentation requirements for AIRS include a weekly review with details of daily activities and update of progress providing details of services provided each day per the following:

- All items listed in the [General Documentation Requirements](#) section
- All requirements noted in the [Group Setting Documentation Requirements](#) section (if delivered in a group setting)
- Member's goals and a transitional plan to reintegrate the member into the community

Note: Providers may opt to use daily documentation versus a weekly review summary as long as there is consistency across the agency in which method is used. A daily review note requires all the same documentation elements as noted for weekly review.

Behavioral Health Level of Need Redetermination Documentation

Behavioral Health Level of Need Redetermination services are associated with the Division of Mental Health and Addiction (DMHA)-approved assessment tool – Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA) – required to determine level of need (LON), assign an MRO service package and make changes to the member's IICP. For a complete definition of this service, see the [Behavioral Health Level of Need Redetermination](#) section.

Documentation requirements for Behavioral Health Level of Need Redetermination services include:

- Notation of face-to-face contact with the member (required to bill this service)
- Notation of face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, if applicable, and done in addition to the face-to-face contact with the member
- Type of reassessment being completed (CANS or ANSA)
- Name and qualifications of the staff providing the reassessment
- Location or setting where the reassessment was completed
- Duration of the reassessment (actual time spent)
- Start and end time of the reassessment

Behavioral Health Level of Need Redetermination Documentation Example

The member was seen in her home on May 1, 2022, from 10 a.m. to 10:55 a.m. by [Name], an other behavioral health professional (OBHP). Together, they contacted the member's mother over the telephone to obtain information and completed her ANSA reassessment. Time spent was 55 minutes. The ANSA reassessment and LON results dated May 1, 2022, are located in the assessment section of this medical record.

CAIRS Documentation

Child and Adolescent Intensive Resiliency Services (CAIRS) is a time-limited, nonresidential service provided in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an IICP. CAIRS is designed to alleviate emotional or behavioral problems, with a goal of reintegrating the child into the community setting. CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS is curriculum-based, with goals that include reintegration into age-appropriate community settings (for example, school and activities with pro-social peers). For a complete definition of this service, see the [Child and Adolescent Intensive Resiliency Services](#) section.

Documentation requirements for CAIRS include a weekly review with details of daily activities and update of progress, providing details of services provided each day per the following:

- All items listed in the [General Documentation Requirements](#) section
- All requirements noted in the [Group Setting Documentation Requirements](#) section (if delivered in a group setting)
- Member's goals and a transitional plan to reintegrate the child into the school setting and a less restrictive level of care

Note: Providers may opt to use daily documentation versus a weekly review summary as long as there is consistency across the agency in which method is used. A daily review note requires all the same documentation elements as noted for weekly review.

CAIRS Documentation Example

The member participated in CAIRS provided at her school on March 3, 4 and 5, 2022. Her IICP goals related to improving her self-esteem, appropriate expression of feelings and appropriate classroom behavior were addressed this week. On March 3, the member participated for two hours (3–5 p.m.) in a group focused on building self-esteem with [Name], a qualified behavioral health professional (QBHP). The member identified three things she does well.

On March 4, the member participated in a one-hour group (8–9 a.m.) focused on communication skills and a two-hour group (3–5 p.m.) focused on constructive expression of feelings with [Name], an OBHP. The member was able to verbalize situations where assertiveness was appropriate, but was unable to maintain eye contact when verbalizing her wishes.

The member identified two situations this week where she threw tantrums, and she recognized the importance of using words to express her feelings. On March 5, the member participated in a three-hour psycho-educational group (3–6 p.m.) focused on appropriate classroom behavior with [Name], a licensed clinical social worker (LCSW). The member was able to sit quietly in class and speak when called on by the teacher three out of five days this week. The member will increase her time an hour a week in the regular classroom progressively over the next four weeks.

Psychosocial Rehabilitation (Clubhouse Services) Documentation

Psychosocial Rehabilitation (also known as Clubhouse Services) refers to services delivered through a community-based, accredited clubhouse in which the member, with staff assistance, is engaged in operating all aspects of the program as well as receiving other member services, such as employment training, housing assistance and educational support. For a complete definition of Psychosocial Rehabilitation, see the [Psychosocial Rehabilitation \(Clubhouse Services\)](#) section in Section 2 of this document.

Documentation must be provided for each encounter and must reflect:

- All items listed in the [General Documentation Requirements](#) section
- A brief daily activity note
- Sign-in and sign-out paperwork
- Total units provided

A weekly summary is also required and must note progress on the IICP goals.

Section 7: Billing and Reimbursement Requirements for MRO Services

This section outlines Medicaid Rehabilitation Option (MRO) billing guidelines, claim format and necessary billing-related information. Moreover, explanation of actual time spent conducting service versus time billed, modifiers and other helpful billing-related items are included, with examples. For general information about billing, see *Indiana Administrative Code 405 IAC 1* and the [Claim Submission and Processing](#) module.

Indiana Health Coverage Programs (IHCP) providers are responsible for reading and understanding portions of the IAC and the [IHCP provider reference modules](#) that apply to their areas of services.

MRO Claim Completion

Community mental health centers (CMHCs) can bill MRO services using the *CMS-1500* paper claim form, the Portal professional claim or the 837P electronic transaction.

Each detail line identifies services billed using Healthcare Common Procedure Coding System (HCPCS) codes and service dates. Each date of service must be billed as a separate detail line. The procedure code description defines the unit of service.

Modifier HW must be used to denote MRO services; other service-specific modifiers may also be required, as described in this module.

Rendering and Billing Providers

Provider IDs are assigned to all IHCP-enrolled providers, including individual rendering practitioners as well as billing groups. The Provider IDs (and associated National Provider Identifiers [NPIs]) of the rendering practitioners are linked to the Provider ID/NPI of the participating billing group (the CMHC). The group Provider ID/NPI is used for billing and incorporates all the individual provider services on the group Remittance Advice (RA).

MRO services that are rendered by practitioners who meet the qualifications to deliver the service but who are **not** individually enrolled in the IHCP must be billed using the NPI of a supervising practitioner for the rendering provider on the claim. Modifiers that identify the qualifications of the individual who rendered the service (also known as *midlevel modifiers*) should **not** be used when billing MRO services.

The following instructions must be followed when billing claims to the IHCP for MRO services:

- The CMHC billing group's NPI must be entered as the billing provider for the claim (field 33a of the *CMS-1500* claim form).
- Each detail line of the claim must include the NPI of the rendering or supervising practitioner (field 24J of the *CMS-1500* claim form).

When multiple staff members (regardless of the type of provider) deliver the same service on the same date, they must add time and bill those services on the same claim form and on one detail line. Billing separate detail lines for the same service and the same date of service causes the claim to be denied as exact duplicates.

MRO Services Provided at an FQHC or RHC

IHCP reimbursement for MRO services is available only when the services are billed by an IHCP-enrolled CMHC (provider type 11, specialty 111). MRO services are not reimbursed when billed under the federally qualified health center (FQHC) or rural health clinic (RHC) provider specialties (provider type 08, specialties 080 and 081).

Because a number of FQHC and RHC facilities are operated by CMHCs, the IHCP allows such facilities to enroll separately as both an FQHC or RHC and also a CMHC, for the purposes of MRO billing. Any MRO services provided at the facility must be billed under the CMHC Provider ID, and following the normal MRO billing procedures, as described in this module.

The *Non Reimbursable Costs* section of the FQHC cost report has been updated to include a line for MRO services. FQHC providers must include nonreimbursable costs associated with MRO services provided at their facility in all cost reports. This information is used for calculating prospective payment reimbursement rates.

MRO Services Provided Along With Other Services

For fee-for-service (FFS) members, MRO services may be billed on the same claim with other IHCP-covered services. For managed care members, MRO services must be billed separately and submitted to the IHCP FFS claim-processing unit rather than to the member's MCE. Each IHCP provider number identifies all the programs for which a provider is qualified to deliver services and that were elected during the enrollment process. In addition, *CoreMMIS* adjudicates claims line by line, which allows a mixed-program claim, as long as the claim is billed under the same provider number. However, mixing program billing on the same claim significantly complicates the RA claim reconciliation, and it is easier to reconcile RA claim transactions if MRO billing is separate from IHCP clinical billing, especially if different departments are responsible for those functions.

MRO Reimbursement

For a CMHC provider to receive reimbursement for the delivery of MRO services, a member must have an assigned MRO service package or prior authorized service units. The service package assignment process is dependent upon reliable, accurate data submitted by the provider via the Data Assessment Registry for Mental Health and Addiction (DARMHA). Providers have the responsibility of ensuring that data and claims are submitted accurately and timely.

Provider Responsibility #5

Submit MRO claims for reimbursement on a timely basis.

- ✓ Units of MRO services, as displayed in the IHCP Provider Healthcare Portal (Portal), are decremented based on adjudicated claims.
- ✓ Timely submission of claims ensures that the data accessible on the Portal accurately reflects remaining units of service for each member.
- ✓ Failure to submit claims in a timely manner may place the provider at risk for nonpayment.

Reimbursement Rate

Each detail line of the professional claim is individually priced at the IHCP-allowed rate for the procedure billed. The IHCP-allowed rate is the lower of the submitted charge or the IHCP maximum fee for that procedure. MRO services are reimbursed at **100%** of the IHCP Professional Fee Schedule amount for all allowable rendering practitioners. The Professional Fee Schedule is accessible from the [IHCP Fee Schedules](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers.

The Family and Social Services Administration (FSSA) sets the rate for each procedure code.

Facility Fees

No facility fees are paid for MRO services.

Time Documentation

Staff must document actual time spent delivering services in a 24-hour period within the member's clinical record. When services are provided in group settings, it is appropriate to bill for each member in the group for the time spent in the group.

For billing purposes, a provider agency must total actual time delivering the same MRO service on the same day by all provider types for each member. Minutes of service do not have to be consecutive to be billed together.

Time Billing and Documentation Examples

A member receives five minutes of MRO Case Management from a case manager, four minutes of MRO Case Management from a second case manager and nine minutes of MRO Case Management from a third case manager on the same day. The member's clinical record notes that three staff members provided Case Management on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time spent that may be billed is 18 minutes.

$$5 \text{ minutes} + 4 \text{ minutes} + 9 \text{ minutes} = 18 \text{ minutes of Case Management}$$

A member receives nine minutes of Skills Training and Development, Individual, from a licensed clinical social worker (LCSW) and 15 minutes of Skills Training and Support, Individual, from a master's level practitioner on the same day. The member's clinical record notes that two staff members provided Skills Training and Development, Individual, on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time that may be billed is 24 minutes. Even though the two staff members have different provider qualifications, they must add their time spent with the member together.

$$9 \text{ minutes} + 15 \text{ minutes} = 24 \text{ Minutes of Skills Training and Development, Individual}$$

Rounding Minutes to Units

Providers may round the total actual time each day, as described previously, to the nearest whole unit when calculating reimbursement. Providers should refer to the HCPCS code for each service for information on the unit increment that is used for each service.

15-Minute Unit

If staff delivers a service for eight or more minutes, or the total daily minutes for the service add up to eight or more minutes, the provider may round up to one 15-minute unit. If staff delivers a service for seven minutes or less, or the total daily minutes for the service add up to seven minutes or less, the provider rounds down to zero units and therefore may not bill for the service. Providers must add actual time together (as described in the [Time Documentation](#) section) before rounding.

15-Minute Unit Example

A member receives five minutes of MRO Case Management from one case manager, four minutes of MRO Case Management from a second case manager and nine minutes of MRO Case Management from a third case manager on the same day. The member's clinical record notes that three staff members provided MRO Case Management on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time spent may be listed as 18 minutes; however, only **one** 15-minute unit can be billed because the three additional minutes ($18-15=3$) are not enough to round up to a second unit ($3 < 8$).

5 minutes + 4 minutes + 9 minutes = 18 minutes of MRO Case Management;

18 minutes of MRO Case Management = One 15-minute unit (T1016 HW)

A member receives nine minutes of Skills Training and Development, Individual, from an LCSW and 15 minutes of Skills Training and Support, Individual, from a master's level on the same day. The member's clinical record notes that two staff members provided Skills Training and Development, Individual, on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time that may be billed is 24 minutes. Two 15-minute units can be billed because the nine additional minutes ($24-15=9$) may be rounded up to a second unit. (Note: Even though the two staff members have different provider qualifications, they must add their time spent with the member together.)

9 minutes + 15 minutes = 24 minutes of Skills Training and Development, Individual;

24 minutes of Skills Training and Development = Two 15-minute units (H2014 HW)

One-Hour (60 Minutes) Unit

If staff delivers a service for 45 or more minutes (meaning the total number of minutes of a particular service delivered to a member on one day adds up to 45 or more minutes), the provider rounds up to the one-hour unit. If staff delivers a service for 44 minutes or less (meaning all the minutes for the day for one service add up to a total of 44 minutes or less), the provider rounds down to zero units and therefore may not bill for this service.

One-Hour Unit Examples

A member receives 48 minutes of AIRS from a staff person who has less than a bachelor's degree. For billing purposes, 48 minutes of service is greater than the 44-minute threshold, and the provider may round up to one one-hour unit.

48 minutes > 44-minute threshold = provider may bill for one 60-minute unit of AIRS H2012 HW HB U1

A member receives 25 minutes of Addiction Counseling, Individual, from an LCSW. For billing purposes, 25 minutes of service is less than the 44-minute threshold. The provider must round down to zero and may not bill for this service.

25 minutes < 44 minutes = provider may not bill for Addiction Counseling, Individual, services rendered

A member receives 20 minutes of CAIRS from a staff person who has less than a bachelor's degree and 25 minutes of CAIRS from a second staff person with less than a bachelor's degree on the same day. The provider totals the actual time delivering the service to 45 minutes. For billing purposes, 45 minutes of service is greater than the 44-minute threshold, and the provider may round up to one 60-minute unit.

20 minutes + 25 minutes = 45 minutes;

45 minutes > 44 minutes threshold = provider may bill for one 60-minute unit of CAIRS H2012 HW U1 HA

A member receives 80 minutes of Addiction Counseling, Group, from a licensed mental health counselor (LMHC). For billing purposes, 80 minutes is greater than the 44-minute threshold for one one-hour unit of service, but it does not qualify for a second one-hour unit of service.

80 minutes = 60 minutes (one unit of service) + 20 minutes;

20 minutes < 44-minute threshold = provider may bill for one 60-minute unit of Addiction Counseling, Group, and may not bill the additional 20 minutes of services rendered H0005 HW

Place of Service Codes

MRO services can be rendered in the following locations with the place of service (POS) code listed:

- 11 – Office
- 12 – Home
- 23 – Emergency room – hospital
- 31 – Skilled nursing facility
- 32 – Nursing facility
- 53 – CMHC (such as therapy)
- 99 – Other unlisted facility (such as employment or a community place)

Note: The MRO provider must ensure that the service provided is not already included in the nursing home or inpatient per diem rate.

Procedure Codes and Modifiers for MRO Services

When billing for MRO services, the appropriate HCPCS codes and modifiers must be placed in field 24D of the CMS-1500 claim form (or in the equivalent field of the electronic claim). For details about billing each MRO service, see the [MRO Service Requirements](#) section of this document.

Modifiers for MRO Services

The HW modifier is always required for MRO services. The following table shows other modifiers that may be appropriate for MRO claims.

Table 17 – MRO Service Modifiers

Modifier	Service Description
HW	Funded by state mental health agency
U1	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
UA	Non-face-to-face encounter
HA	Child/adolescent program
HB	Adult program

Note: Modifiers that identify the qualifications of the individual who rendered the service, such as modifier SA or HE, should not be used when submitting MRO claims. The use of these modifiers results in the denial of the MRO claim.

HCPCS Codes

The following table lists the HCPCS code associated with each MRO service.

Table 18 – MRO HCPCS Codes

HCPCS Code	Associated MRO Service
H0004	Behavioral Health Counseling and Therapy
H0005	Addiction Counseling (Group Setting)
H0031	Behavioral Health Level of Need Redetermination
H0034	Medication Training and Support
H2012	AIRS and CAIRS
H2014	Skills Training and Development
H2017	Psychosocial Rehabilitation
H2019	Psychiatric Assessment and Intervention
H2035	Addiction Counseling (Individual Setting)
T1016	Case Management

MRO members are also eligible for *non-MRO* services, including, but not limited to, crisis intervention (H2011), intensive outpatient treatment (IOT) (procedure codes H0015 or S9480, or revenue codes 905 or 906), peer recovery services (H0038), and other outpatient behavioral health services as described in the [Behavioral Health Services](#) module.

Third-Party Liability Requirements

To ensure that the IHCP does not pay for services covered by other insurance sources, federal regulations (*Code of Federal Regulations 42 CFR 433.139*) require that the IHCP be the payer of last resort. With some exceptions, providers are required to bill all liable third parties before submitting a claim to the IHCP. This activity is commonly referred to as *cost avoidance*.

All MRO services are exempt from third-party liability (TPL) cost avoidance editing. MRO codes can be billed directly to the IHCP, even if other insurance exists for the member.

Managed Care Considerations

Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise programs require all enrolled members be linked with a managed care entity (MCE). MRO services are carved out of IHCP managed care programs. MRO claims for managed care members are submitted to the IHCP fee-for service PA contractor for processing.

Healthy Indiana Plan

MRO services are available to qualifying HIP members enrolled in *HIP State Plan* or *HIP Maternity*.

Most members enrolled in *HIP State Plan – Basic* are required to pay a \$4 copayment for outpatient services and for most MRO services. Certain services such as preventive care and services allowed without the member present are exempt from copayments.

Members enrolled in *HIP State Plan – Basic* will owe a separate \$4 copayment for each distinct service rendered, even if they are rendered on the same date. If the same distinct service is rendered multiple times on a single date, or if more than one unit of a distinct service is rendered on a single date, only one \$4 copayment will be owed.

Service activities on behalf of the member that do not involve the member being present do not have the \$4 copayment applied. For a list of the exempt procedure codes for MRO, see the *Medicaid Rehabilitation Option Services Codes* on the [Code Sets](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers.

Mailing Address for MRO Claims

Electronic claim submissions through the Portal or 835 transaction are preferred. However, paper claims for MRO services can be submitted to the standard medical/professional claim address listed in the [IHCP Quick Reference Guide](https://in.gov/medicaid/providers), available at in.gov/medicaid/providers.

Additional Addresses and Telephone Numbers

Providers should direct questions about filing claims to Customer Assistance toll-free at 800-457-4584. Additional addresses and telephone numbers are provided on the [IHCP Quick Reference Guide](https://in.gov/medicaid/providers) available at in.gov/medicaid/providers.

Appendix A: MRO Service Packages

Tables 19 and 20 identify the services and unit allotment included in the Medicaid Rehabilitation Option (MRO) service package for each level of need (LON). The LON is determined by the intake assessment, which includes the following:

- A biopsychosocial assessment
- Diagnosis by a supervising practitioner as defined in the [MRO Treatment Plan Supervision Standards](#) section:
 - Physician
 - Advanced practice registered nurse (APRN)
 - Health service provider in psychology (HSPP)
 - Licensed clinical social worker (LCSW)
 - Licensed marriage and family therapist (LMFT)
 - Licensed mental health counselor (LMHC)
 - Licensed clinical addiction counselor (LCAC)
- Functional assessment using the Child and Adolescent Needs and Strengths (CANS) for children and adolescents, or the Adult Needs and Strengths Assessment (ANSA) for adults

Note: Individuals receiving an LON of 0 or higher are eligible for outpatient behavioral health services, including crisis intervention, intensive outpatient treatment (IOT) and peer recovery services. In addition, adults receiving an LON of 3 or higher, and children or adolescents receiving an LON of 2 or higher, are also eligible for the Medicaid Rehabilitation Option (MRO) services identified in the service package for their LON.

For most people receiving MRO services, the service packages, including the amount and duration of services, should match their assigned LON. For those few individuals with unusual circumstances, an exceptions process is established. The exceptions process may be used to request a different service or a different level of intensity of a service than what is in the LON service package to which a member is assigned.

Table 19 – Authorized Services – Adults

Authorized Services – Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
0	N/A	Outpatient behavioral health services only (see the Behavioral Health Services module) – <i>No MRO services authorized</i>	N/A
1	N/A	Outpatient behavioral health services only (see the Behavioral Health Services module) – <i>No MRO services authorized</i>	N/A
2	N/A	Outpatient behavioral health services only (see the Behavioral Health Services module) – <i>No MRO services authorized</i>	N/A
3	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	H2035 HW H2035 HW HR H2035 HW HS H0005 HW H0005 HW HR H0005 HW HS	Addiction Counseling, Individual Setting Addiction Counseling, Individual Setting, Family/Couple with Member Present Addiction Counseling, Individual Setting, Family/Couple without Member Present Addiction Counseling, Group Setting Addiction Counseling, Group Setting, Family/Couple with Member Present Addiction Counseling, Group Setting, Family/Couple without Member Present	32 hours
	H0004 HW H0004 HW HR H0004 HW HS	Behavioral Health Counseling and Therapy, Individual Setting Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple without Member Present	32
	H0004 HW U1 H0004 HW HR U1 H0004 HW HS U1	Behavioral Health Counseling and Therapy, Group Setting Behavioral Health Counseling and Therapy, Group Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Group Setting, Family/Couple without Member Present	48
	H0031 HW	Behavioral Health Level of Need Redetermination	1 redetermination
	T1016 HW	Case Management	200
		<div> <i>Note: See the Behavioral and Primary Healthcare Coordination section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.</i> </div>	

Authorized Services – Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
3	H0034 HW	Medication Training and Support, Individual Setting	60
	H0034 HW HR	Medication Training and Support, Individual Setting, Family/Couple with Member Present	
	H0034 HW HS	Medication Training and Support, Individual Setting, Family/Couple without Member Present	
	H0034 HW U1	Medication Training and Support, Group Setting	
	H0034 HW HR U1	Medication Training and Support, Group Setting, Family/Couple with Member Present	
	H0034 HW HS U1	Medication Training and Support, Group Setting, Family/Couple without Member Present	
	H2017 HW	Psychosocial Rehabilitation	1,820 (32 per day)
	H2014 HW	Skills Training and Development, Individual Setting	600
	H2014 HW HR	Skills Training and Development, Individual Setting, Family/Couple with Member Present	
	H2014 HW HS	Skills Training and Development, Individual Setting, Family/Couple without Member Present	
	H2014 HW U1	Skills Training and Development, Group Setting	
	H2014 HW HR U1	Skills Training and Development, Group Setting, Family/Couple with Member Present	
	H2014 HW HS U1	Skills Training and Development, Group Setting, Family/Couple without Member Present	
4	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	H2035 HW	Addiction Counseling, Individual Setting	32 hours
	H2035 HW HR	Addiction Counseling, Individual Setting, Family/Couple with Member Present	
	H2035 HW HS	Addiction Counseling, Individual Setting, Family/Couple without Member Present	
	H0005 HW	Addiction Counseling, Group Setting	
	H0005 HW HR	Addiction Counseling, Group Setting, Family/Couple with Member Present	
	H0005 HW HS	Addiction Counseling, Group Setting, Family/Couple without Member Present	
	H2012 HW HB U1	Adult Intensive Rehabilitative Services (AIRS)	270 hours – limited to 90 consecutive days
	H0004 HW	Behavioral Health Counseling and Therapy, Individual Setting	48
	H0004 HW HR	Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple with Member Present	
	H0004 HW HS	Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple without Member Present	
	H0004 HW U1	Behavioral Health Counseling and Therapy, Group Setting	60
	H0004 HW HR U1	Behavioral Health Counseling and Therapy, Group Setting, Family/Couple with Member Present	
	H0004 HW HS U1	Behavioral Health Counseling and Therapy, Group Setting, Family/Couple without Member Present	

Authorized Services – Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
4	H0031 HW	Behavioral Health Level of Need Redetermination	1 redetermination
	T1016 HW	Case Management <i>Note: See the Behavioral and Primary Healthcare Coordination section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.</i>	300
	H0034 HW H0034 HW HR H0034 HW HS H0034 HW U1 H0034 HW HR U1 H0034 HW HS U1	Medication Training and Support, Individual Setting Medication Training and Support, Individual Setting, Family/Couple with Member Present Medication Training and Support, Individual Setting, Family/Couple without Member Present Medication Training and Support, Group Setting Medication Training and Support, Group Setting, Family/Couple with Member Present Medication Training and Support, Group Setting, Family/Couple without Member Present	104
	H2017 HW	Psychosocial Rehabilitation	1,820 (32 per day)
	H2014 HW H2014 HW HR H2014 HW HS H2014 HW U1 H2014 HW HR U1 H2014 HW HS U1	Skills Training and Development, Individual Setting Skills Training and Development, Individual Setting, Family/Couple with Member Present Skills Training and Development, Individual Setting, Family/Couple without Member Present Skills Training and Development, Group Setting Skills Training and Development, Group Setting, Family/Couple with Member Present Skills Training and Development, Group Setting, Family/Couple without Member Present	750
	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	H2035 HW H2035 HW HR H2035 HW HS H0005 HW H0005 HW HR H0005 HW HS	Addiction Counseling, Individual Setting Addiction Counseling, Individual Setting, Family/Couple with Member Present Addiction Counseling, Individual Setting, Family/Couple without Member Present Addiction Counseling, Group Setting Addiction Counseling, Group Setting, Family/Couple with Member Present Addiction Counseling, Group Setting, Family/Couple without Member Present	32 hours
5	H2012 HW HB U1	Adult Intensive Rehabilitative Services (AIRS)	270 hours – limited to 90 consecutive days

Authorized Services – Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
5	H0004 HW H0004 HW HR H0004 HW HS	Behavioral Health Counseling and Therapy, Individual Setting Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple without Member Present	48
	H0004 HW U1 H0004 HW HR U1 H0004 HW HS U1	Behavioral Health Counseling and Therapy, Group Setting Behavioral Health Counseling and Therapy, Group Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Group Setting, Family/Couple without Member Present	60
	H0031 HW	Behavioral Health Level of Need Redetermination	1 redetermination
	T1016 HW	Case Management <i>Note: See the Behavioral and Primary Healthcare Coordination section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.</i>	400
	H0034 HW H0034 HW HR H0034 HW HS H0034 HW U1 H0034 HW HR U1 H0034 HW HS U1	Medication Training and Support, Individual Setting Medication Training and Support, Individual Setting, Family/Couple with Member Present Medication Training and Support, Individual Setting, Family/Couple without Member Present Medication Training and Support, Group Setting Medication Training and Support, Group Setting, Family/Couple with Member Present Medication Training and Support, Group Setting, Family/Couple without Member Present	104
	H2014 HW H2014 HW HR H2014 HW HS H2014 HW U1 H2014 HW HR U1 H2014 HW HS U1	Skills Training and Development, Individual Setting Skills Training and Development, Individual Setting, Family/Couple with Member Present Skills Training and Development, Individual Setting, Family/Couple without Member Present Skills Training and Development, Group Setting Skills Training and Development, Group Setting, Family/Couple with Member Present Skills Training and Development, Group Setting, Family/Couple without Member Present	900
	H2019 HW H2019 HW UA	Psychiatric Assessment and Intervention (Face-to-Face, Non-Face-to-Face, authorized health care professional [AHCP], physician)	25
	H2017 HW	Psychosocial Rehabilitation	1,820 (32 per day)

Authorized Services – Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
5A	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	H2035 HW H2035 HW HR H2035 HW HS H0005 HW H0005 HW HR H0005 HW HS	Addiction Counseling, Individual Setting Addiction Counseling, Individual Setting, Family/Couple with Member Present Addiction Counseling, Individual Setting, Family/Couple without Member Present Addiction Counseling, Group Setting Addiction Counseling, Group Setting, Family/Couple with Member Present Addiction Counseling, Group Setting, Family/Couple without Member Present	50 hours
	H0004 HW H0004 HW HR H0004 HW HS	Behavioral Health Counseling and Therapy, Individual Setting Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple without Member Present	48
	H0004 HW U1 H0004 HW HR U1 H0004 HW HS U1	Behavioral Health Counseling and Therapy, Group Setting Behavioral Health Counseling and Therapy, Group Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Group Setting, Family/Couple without Member Present	60
	H0031 HW	Behavioral Health Level of Need Redetermination	1 redetermination
	T1016 HW	Case Management <i>Note: See the Behavioral and Primary Healthcare Coordination section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.</i>	500
	H0034 HW H0034 HW HR H0034 HW HS H0034 HW U1 H0034 HW HR U1 H0034 HW HS U1	Medication Training and Support, Individual Setting Medication Training and Support, Individual Setting, Family/Couple with Member Present Medication Training and Support, Individual Setting, Family/Couple without Member Present Medication Training and Support, Group Setting Medication Training and Support, Group Setting, Family/Couple with Member Present Medication Training and Support, Group Setting, Family/Couple without Member Present	104
	H2019 HW H2019 HW UA	Psychiatric Assessment and Intervention (Face-to-Face, Non-Face-to-Face, authorized health care professional [AHCP], physician)	100
	H2017 HW	Psychosocial Rehabilitation	1,820 (32 per day)

Authorized Services – Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
5A	H2014 HW	Skills Training and Development, Individual Setting	1,000
	H2014 HW HR	Skills Training and Development, Individual Setting, Family/Couple with Member Present	
	H2014 HW HS	Skills Training and Development, Individual Setting, Family/Couple without Member Present	
	H2014 HW U1	Skills Training and Development, Group Setting	
	H2014 HW HR U1	Skills Training and Development, Group Setting, Family/Couple with Member Present	
	H2014 HW HS U1	Skills Training and Development, Group Setting, Family/Couple without Member Present	

Table 20 – Authorized Services – Children/Adolescents

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
0	N/A	Outpatient behavioral health services only (see the Behavioral Health Services module) – <i>No MRO services authorized</i>	N/A
1	N/A	Outpatient behavioral health services only (see the Behavioral Health Services module) – <i>No MRO services authorized</i>	N/A
2	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	T1016 HW	Case Management	100
3	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	H2035 HW	Addiction Counseling, Individual Setting	32 hours
	H2035 HW HR	Addiction Counseling, Individual Setting, Family/Couple with Member Present	
	H2035 HW HS	Addiction Counseling, Individual Setting, Family/Couple without Member Present	
	H0005 HW	Addiction Counseling, Group Setting	
	H0005 HW HR	Addiction Counseling, Group Setting, Family/Couple with Member Present	
	H0005 HW HS	Addiction Counseling, Group Setting, Family/Couple without Member Present	

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
3	H0004 HW	Behavioral Health Counseling and Therapy, Individual Setting	32
	H0004 HW HR	Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple with Member Present	
	H0004 HW HS	Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple without Member Present	
	H0004 HW U1	Behavioral Health Counseling and Therapy, Group Setting	48
	H0004 HW HR U1	Behavioral Health Counseling and Therapy, Group Setting, Family/Couple with Member Present	
	H0004 HW HS U1	Behavioral Health Counseling and Therapy, Group Setting, Family/Couple without Member Present	
	H0031 HW	Behavioral Health Level of Need Redetermination	1 redetermination
	T1016 HW	Case Management	200
	H0034 HW	Medication Training and Support, Individual Setting	60
	H0034 HW HR	Medication Training and Support, Individual Setting, Family/Couple with Member Present	
	H0034 HW HS	Medication Training and Support, Individual Setting, Family/Couple without Member Present	
	H0034 HW U1	Medication Training and Support, Group Setting – <i>For members 12 years of age and older</i>	
	H0034 HW HR U1	Medication Training and Support, Group Setting, Family/Couple with Member Present – <i>For members 12 years of age and older</i>	
	H0034 HW HS U1	Medication Training and Support, Group Setting, Family/Couple without Member Present – <i>For members 12 years of age and older</i>	
	H2014 HW	Skills Training and Development, Individual Setting	600
	H2014 HW HR	Skills Training and Development, Individual Setting, Family/Couple with Member Present	
	H2014 HW HS	Skills Training and Development, Individual Setting, Family/Couple without Member Present	
	H2014 HW U1	Skills Training and Development, Group Setting	
	H2014 HW HR U1	Skills Training and Development, Group Setting, Family/Couple with Member Present	
	H2014 HW HS U1	Skills Training and Development, Group Setting, Family/Couple without Member Present	
4	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	H2035 HW	Addiction Counseling, Individual Setting	32 hours
	H2035 HW HR	Addiction Counseling, Individual Setting, Family/Couple with Member Present	
	H2035 HW HS	Addiction Counseling, Individual Setting, Family/Couple without Member Present	
	H0005 HW	Addiction Counseling, Group Setting	
	H0005 HW HR	Addiction Counseling, Group Setting, Family/Couple with Member Present	
	H0005 HW HS	Addiction Counseling, Group Setting, Family/Couple without Member Present	

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
4	H0004 HW H0004 HW HR H0004 HW HS	Behavioral Health Counseling and Therapy, Individual Setting Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple without Member Present	48
	H0004 HW U1 H0004 HW HR U1 H0004 HW HS U1	Behavioral Health Counseling and Therapy, Group Setting Behavioral Health Counseling and Therapy, Group Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Group Setting, Family/Couple without Member Present	60
	H0031 HW	Behavioral Health Level of Need Redetermination	1 redetermination
	T1016 HW	Case Management	300
	H2012 HW HA U1	Child and Adolescent Intensive Rehabilitative Services (CAIRS) – <i>For members 5 through 18 years of age</i>	252 hours – limited to 90 consecutive days
	H0034 HW H0034 HW HR H0034 HW HS H0034 HW U1 H0034 HW HR U1 H0034 HW HS U1	Medication Training and Support, Individual Setting Medication Training and Support, Individual Setting, Family/Couple with Member Present Medication Training and Support, Individual Setting, Family/Couple without Member Present Medication Training and Support, Group Setting – <i>For members 12 years of age and older</i> Medication Training and Support, Group Setting, Family/Couple with Member Present – <i>For members 12 years of age and older</i> Medication Training and Support, Group Setting, Family/Couple without Member Present – <i>For members 12 years of age and older</i>	104
	H2014 HW H2014 HW HR H2014 HW HS H2014 HW U1 H2014 HW HR U1 H2014 HW HS U1	Skills Training and Development, Individual Setting Skills Training and Development, Individual Setting, Family/Couple with Member Present Skills Training and Development, Individual Setting, Family/Couple without Member Present Skills Training and Development, Group Setting Skills Training and Development, Group Setting, Family/Couple with Member Present Skills Training and Development, Group Setting, Family/Couple without Member Present	750

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
5 and 6	N/A	Outpatient behavioral health services (see the Behavioral Health Services module)	N/A
	H2035 HW H2035 HW HR H2035 HW HS H0005 HW H0005 HW HR H0005 HW HS	Addiction Counseling, Individual Setting Addiction Counseling, Individual Setting, Family/Couple with Member Present Addiction Counseling, Individual Setting, Family/Couple without Member Present Addiction Counseling, Group Setting Addiction Counseling, Group Setting, Family/Couple with Member Present Addiction Counseling, Group Setting, Family/Couple without Member Present	32 hours
	H0004 HW U1 H0004 HW HR U1 H0004 HW HS U1	Behavioral Health Counseling and Therapy, Group Setting Behavioral Health Counseling and Therapy, Group Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Group Setting, Family/Couple without Member Present	60
	H0004 HW H0004 HW HR H0004 HW HS	Behavioral Health Counseling and Therapy, Individual Setting Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple with Member Present Behavioral Health Counseling and Therapy, Individual Setting, Family/Couple without Member Present	48
	H0031 HW	Behavioral Health Level of Need Redetermination	1 redetermination
	T1016 HW	Case Management	400
	H2012 HW HA U1	Child and Adolescent Intensive Rehabilitative Services (CAIRS) – <i>For members 5 through 18 years of age</i>	252 hours – limited to 90 consecutive days
	H0034 HW H0034 HW HR H0034 HW HS H0034 HW U1 H0034 HW HR U1 H0034 HW HS U1	Medication Training and Support, Individual Setting Medication Training and Support, Individual Setting, Family/Couple with Member Present Medication Training and Support, Individual Setting, Family/Couple without Member Present Medication Training and Support, Group Setting – <i>For members 12 years of age and older</i> Medication Training and Support, Group Setting, Family/Couple with Member Present – <i>For members 12 years of age and older</i> Medication Training and Support, Group Setting, Family/Couple without Member Present – <i>For members 12 years of age and older</i>	104

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted			
Level of Need	MRO Procedure Code and Modifiers	Service Description	Units
5 and 6	H2014 HW	Skills Training and Development, Individual Setting	900
	H2014 HW HR	Skills Training and Development, Individual Setting, Family/Couple with Member Present	
	H2014 HW HS	Skills Training and Development, Individual Setting, Family/Couple without Member Present	
	H2014 HW U1	Skills Training and Development, Group Setting	
	H2014 HW HR U1	Skills Training and Development, Group Setting, Family/Couple with Member Present	
	H2014 HW HS U1	Skills Training and Development, Group Setting, Family/Couple without Member Present	

Appendix B: MRO Acronyms

ACT – Assertive Community Treatment

AMHH – Adult Mental Health Habilitation

AHCP – authorized health care professional

APRN – advanced practice registered nurse

AIRS – Adult Intensive Rehabilitation Services

ANSA – Adult Needs and Strengths Assessment

BPHC – Behavioral and Primary Healthcare Coordination

CAIRS – Child and Adolescent Intensive Resiliency Services

CANS – Child and Adolescent Needs and Strengths

CMHC – community mental health center

CMS – Centers for Medicare & Medicaid Services

CoreMMIS – Core Medicaid Management Information System

DARMHA – Data Assessment Registry for Mental Health and Addiction Medication

DMHA – Division of Mental Health and Addiction

DOB – date of birth

DOS – date of service

DSM – Diagnostic and Statistical Manual of Mental Disorders

FFS – fee-for-service

FQHC – federally qualified health center

FSSA – Family and Social Services Administration

HCPCS – Healthcare Common Procedure Coding System

HIP – Healthy Indiana Plan

HIPAA – Health Insurance Portability and Accountability Act

HSPP – health service provider in psychology

IAC – Indiana Administrative Code

IC – Indiana Code

ICD – International Classification of Diseases

IHCP – Indiana Health Coverage Programs

IICP – Individualized Integrated Care Plan

IOT – intensive outpatient treatment
LAC – licensed addiction counselor
LCAC – licensed clinical addiction counselor
LCSW – licensed clinical social worker
LMFT – licensed marriage and family therapist
LMHC – licensed mental health counselor
LON – level of need
LPN – licensed practical nurse
MA – medical assistant
MRO – Medicaid Rehabilitation Option
NOS – not otherwise specified
NPI – National Provider Identifier
OBHP – other behavioral health professional
OMPP – Office of Medicaid Policy and Planning
PA – prior authorization
PRTF – psychiatric residential treatment facility
QBHP – qualified behavioral health professional
RA – Remittance Advice
RHC – rural health clinic
RID – IHCP member identification number, also known as Member ID
RN – registered nurse
SSN – Social Security number
TPL – third-party liability

Appendix C: MRO Definitions

Adult Mental Health Habilitation (AMHH) refers to services defined under *Indiana Administrative Code 405 IAC 5-21.6*.

Behavioral and Primary Healthcare Coordination (BPHC) refers to services defined under *405 IAC 5-21.8*.

Detoxification services refer to services defined under *440 IAC 9-2-4*.

Division of Mental Health and Addiction (DMHA) assessment tool refers to a state-designated, member-appropriate instrument for provider assessment of member functional impairment. The DMHA assessment tool is the Child and Adolescent Needs and Strengths (CANS) for children and the Adult Needs and Strengths Assessment (ANSA) for adults.

Level of need (LON) refers to a recommended intensity of behavioral health services, based on a pattern of a member's and family's needs, as assessed using a standardized assessment instrument. The assessment instrument used to determine level of need is the Child and Adolescent Needs and Strengths (CANS) for children and the Adult Needs and Strengths Assessment (ANSA) for adults.

Licensed professional means any of the following persons:

- Licensed physician (including licensed psychiatrist)
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed psychologist
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *Indiana Code IC 25-23.6-10.5*

Medicaid Rehabilitation Option (MRO) refers to medical or remedial services recommended by a physician, advanced practice registered nurse (APRN) or other licensed professional, within their scope of practice, designed to assist in the rehabilitation of a member's optimum functional ability in daily living.

Other behavioral health professional (OBHP) means any of the following persons:

- An individual with an associate or bachelor degree, and/or equivalent behavioral health experience, meeting minimum competency standards set forth by the behavioral health service provider and supervised by a licensed professional or qualified behavioral health professional (QBHP)
- A licensed addiction counselor (LAC), as defined under *IC 25-23.6-10.5*, supervised by a licensed professional or QBHP

Outpatient behavioral health refers to services described in the [Behavioral Health Services](#) module, as opposed to services covered under the MRO benefit plan. (These services were previously referred to as "Clinic Option" services.)

Qualified behavioral health professional (QBHP) means any of the following persons:

- An individual who is under the supervision of a licensed professional (as defined previously) or an advanced practice registered nurse (APRN) and who has had at least two years of clinical experience treating persons with mental illness, such experience occurring after the completion of a master's degree or doctoral degree in any of the following disciplines:
 - Psychiatric or mental health nursing from an accredited university, plus a license as registered nurse (RN) in Indiana
 - Pastoral counseling from an accredited university
 - Rehabilitation counseling from an accredited university
- An individual who is under the supervision of a licensed professional (as defined previously) or an APRN; is eligible for and working toward licensure; and has completed a master's or doctoral degree, or both, in any of the following disciplines:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology from an accredited university
 - Mental health counseling from an accredited university
 - Marital and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional (as defined previously) or an APRN
- An authorized health care professional (AHCP), defined as follows:
 - 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*.
 - A nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to *IC 25-23-1*.

Rehabilitative refers to the federal definition of rehabilitative, as defined under *Code of Federal Regulations 42 CFR 440.130(d)*.