



# Medical Policy Manual

**Version 2.21**

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## **Anesthesia Services**

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This information has been incorporated into the [Anesthesia Services](#) provider reference module.



## **Cardiac Rehabilitation**

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This information has been incorporated into the [Therapy Services](#) provider reference module.



## **Chiropractic Services**

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This information has been incorporated into the [Chiropractic Services](#) provider reference module.



## Clinical Trials

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This information has been incorporated into the [Clinical Trials](#) provider reference module.



## Dental Services

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This information has been incorporated into the [Dental Services](#) provider reference module.



## **Diabetes Self-Management Training Services**

This information has been incorporated into the [Diabetes Self-Management Training Services](#) provider reference module.



## **Durable and Home Medical Equipment and Supplies**

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This information has been incorporated into the [Durable and Home Medical Equipment and Supplies](#) provider reference module.



## Early and Periodic Screening Services

This information has been incorporated into the [Early and Periodic Screening, Diagnostic, and Treatment Services \(EPSDT\)/HealthWatch Services](#) provider reference module.



## **Emergency Services**

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This information has been incorporated into the [Emergency Services](#) provider reference module.



## **Evaluation and Management Services**

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This information has been incorporated into the [Evaluation and Management Services](#) provider reference module.



## **Family Planning Services**

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This information has been incorporated into the [Family Planning Services](#) provider reference module.



## **Federally Qualified Health Centers and Rural Health Clinics**

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This information has been incorporated into the [Federally Qualified Health Centers and Rural Health Clinics](#) provider reference module.



## **Genetic Testing Services**

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This information has been incorporated into the [Genetic Testing](#) and [Laboratory Services](#) provider reference modules.



## **Hearing Services**

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This information has been incorporated into the [Hearing Services](#) provider reference module.



## **Home Health Services**

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This information has been incorporated into the [Home Health Services](#) provider reference module.



## **Hospice Services**

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This information has been incorporated into the [Hospice Services](#) provider reference module.



## **Hospital Inpatient Services**

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This information has been incorporated into the [Inpatient Hospital Services](#) provider reference module.



## **Hospital Outpatient Services**

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This information has been incorporated into the [Outpatient Facility Services](#) provider reference module.



## **Injections, Vaccines, and Other Physician-Administered Drugs**

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This information has been incorporated into the [Injections, Vaccines, and Other Physician-Administered Drugs](#) and [Pharmacy Services](#) provider reference modules.

## **Laboratory Services**

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This information has been incorporated into the [Laboratory Services](#) and [Genetic Testing](#) provider reference modules.



## Lead Services

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This information has been incorporated into the [Early and Periodic Screening, Diagnostic, and Treatment Services \(EPSDT\)/HealthWatch Services](#) provider reference module.

## Mental Health and Addiction Services

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### Description of Service

The Indiana Health Coverage Programs (IHCP) offers coverage for inpatient and outpatient mental health services, including tobacco cessation and substance abuse services.

### Medical Policy

#### Psychiatric and Substance Abuse Inpatient Services

Acute psychiatric and substance abuse inpatient services are mental health interventions used to stabilize and manage people with severe symptoms and behaviors that have harmed or may result in harm to themselves or others. The following information describes presenting factors that may meet medical necessity for inpatient services:

- Current or recent serious suicide ideation, with plan and potential means with lethal intent
- Current or recent serious, violent, impulsive, and unpredictably dangerous homicidal ideation, with plan and potential means with lethal intent
- Current or recent harm to self or others, with plan and potential means with lethal intent
- Unable to care for self, due to a psychiatric condition, so that imminent life-threatening deterioration has occurred
- Acute psychotic symptoms, severely bizarre thinking, and psychomotor agitation or retardation that cannot be safely treated in a less restrictive level of care (LOC)

Depending on the patients' needs, acute psychiatric and substance abuse inpatient services often include, but are not limited to, 24-hour psychiatric and medical services, continuous monitoring, medication management, treatment planning, individual therapy, family therapy, and group therapy.

Effective February 1, 2018, the IHCP expanded coverage for inpatient stays for opioid use disorder (OUD) and other substance use disorder (SUD) treatment to members 21 through 64 years of age in facilities that qualify as institutions for mental disease (IMD). Providers enrolled as psychiatric hospitals (provider type 01 and provider specialty 011) that have 17 or more beds are currently the only providers recognized as qualified IMDs. Inpatient stays are allowed to be authorized for up to 15 days in a calendar month.

**Note:** Healthy Indiana Plan (HIP) mental health inpatient coverage does not include hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders, personal comfort items, and room and board when temporary leave available. HIP substance abuse inpatient coverage does not include services and supplies for the treatment of co-dependency or caffeine addiction, personal comfort items, and room and board when temporary leave permitted.

## Admission Criteria

Members must meet medical necessity to be eligible for acute inpatient psychiatric and substance abuse inpatient services. Members must present with the following criteria at the time of admission:

- Admissions for inpatient detoxification stays may be approved using one of the following evidenced-based, peer-reviewed sources of clinical criteria:
  - Milliman Care Guidelines (MCG)
  - InterQual Criteria
  - American Society of Addiction Medicine (ASAM) Patient Placement Criteria
  - Anthem Clinical Utilization Management (UM) Guidelines
- Acute psychiatric inpatient admissions are available for members with a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:
  - Danger to the individual
  - Danger to others
  - Death of the individual
- Substance abuse inpatient admissions must be to a psychiatric facility or unit. Admissions to a general hospital floor are only appropriate when medical services are required for life support and cannot be rendered in a substance abuse treatment facility or unit. These inpatient detoxification, rehabilitation, and aftercare admissions are available for members when the following criteria have been determined:
  - Evaluation, treatment, and detoxification are based on the stated medical condition and/or primary diagnosis for inpatient admission
  - Need for safe withdrawal from alcohol and/or other drugs is indicated
  - Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting

- There is a history of recent convulsions or poorly controlled convulsive disorder

## **Plan of Care (POC)**

Each Medicaid-eligible patient admitted to an acute psychiatric facility or unit must have an individually developed plan of care (POC). For members between 22 and 65 years old in a psychiatric hospital of 16 beds or fewer, or a person 65 years old or older, a POC must be developed by the attending or staff physician. For members under 21 years old, POCs must be developed by a physician and Interdisciplinary team.

All POCs must be developed within 14 days of the admission date, regardless of the member's age. For a patient who becomes eligible for Medicaid after admission to a facility, the POC must be prepared to cover all periods for which Medicaid coverage is claimed.

The following components must be documented in each member's POC:

- Treatment objectives and goals, including an integrated program of appropriate therapies, activities, and experiences designed to meet the objectives
- At the appropriate time, a post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the member's community to ensure continuity of care when the patient returns to his or her family and community upon discharge

The POC is developed as a result of a diagnostic evaluation that includes an examination of the medical, psychological, social, and behavioral aspects of the member's presenting problem and previous treatment interventions. The POC must be reviewed and updated at least every 90 days for members between 22 and 65 years old in psychiatric hospitals with 16 beds or fewer and for members 65 years old or older.

The POC will be reviewed by the attending or staff physician to ensure that appropriate services are being provided and that they continue to be medically necessary. The attending or staff physician will also recommend necessary adjustments in the plan, as indicated by the member's overall adjustment as an inpatient. The quarterly POC must be in writing and must be part of the member's record.

The requirements for the development of a POC for all members 21 years old or younger are the same as for members who are older than age 22, as stated above, with the following exceptions:

- An Interdisciplinary Team (IDT), which will include the child and parents, legal guardians, or others to whose care or custody the individual will be released following discharge, is required to develop and direct the POC.
- This team is responsible for developing and updating POCs at least every 30 days.
- The team will be responsible for determining that the services provided were and are required on an inpatient basis and for determining adjustments that may be needed in the POC.

Recertification is required at least every 60 days. Initial evaluative examinations are exempt from prior review and authorization.

One of the following professionals or combination of professionals must be active in the development of the POC planning process:

- A board certified or eligible psychiatrist
- A psychologist endorsed as a health service provider in psychology (HSPP) and a physician licensed to practice medicine or osteopathy
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases; and a psychologist endorsed as a HSPP or licensed psychologist

A professional who is qualified to make determinations regarding mental health conditions and treatments must be part of the IDT, as well. At least one of the following professionals must be active in planning and implementing the POC:

- A licensed clinical social worker (LCSW), licensed marital and family therapist (LMFT), licensed mental health counselor (LMHC), or a person holding a master's degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse or RN who has specialized training or one year's experience in treating people with mental illnesses
- An occupational therapist (OT), registered with the National Association of OTs who has specialized training or one year of experience treating people with mental illnesses
- A psychologist endorsed as a HSPP or a licensed psychologist

## **Readmission**

A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge for the same or a related condition. Same or related condition refers to the primary diagnosis code.

- If the initial admission was paid on a per diem basis, the readmission should be considered a new admission and billed accordingly. The readmission is treated as a separate stay for payment purposes, but is subject to medical review.
- If the initial admission was paid using the DRG methodology, providers should bill one inpatient claim when a member is readmitted to their facility within three days of a previous inpatient discharge (the stays should be consolidated on one claim) for the same or a related diagnosis.

If it is determined that a discharge is premature, payment made as a result of the discharge or readmission may be subject to recoupment. Additionally, post payment review of readmissions will be conducted to ensure that providers are appropriately following the readmission policies and guidelines.

## **Observation Stays**



Psychiatric and substance abuse observation stays in acute care hospitals and freestanding psychiatric hospitals are reimbursable. The observation period must last no more than three days (72 hours). If the member meets the criteria for inpatient admission prior to the end of the observation period, the member's status may be changed to inpatient at that time. IHCP members may qualify for observation status meeting both of the following criteria:

- The criteria for inpatient admission have not been met.
- The treating physician or mental health provider has determined that allowing the member to leave the facility would likely put the member at serious risk.

Observation stays are reimbursed according to outpatient mental health services.

### **Less than 24-Hour Stays**

Providers should bill any inpatient stay that is less than 24 hours as an outpatient service. Inpatient stays less than 24 hours that are billed as inpatient services will be denied or will be subject to retrospective review.

### **Outpatient Service within Three Days of an Inpatient Stay**

Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or a related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an inpatient claim only when both of the services, outpatient and inpatient, occur at the same facility.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with an explanation of benefits (EOB) code indicating that the provider should bill services on the inpatient claim. The provider should adjust the outpatient claim (complete adjustment) and resubmit one inpatient claim.

### **Reserving Beds**

Reimbursement is available for reserving beds in psychiatric hospitals; it is not available in general acute care hospitals. Hospitalization must be ordered by a physician for the treatment of an acute condition that cannot be treated in a psychiatric facility. Physician orders must be maintained in the member's file at the facility. The total length of time reimbursable per inpatient stay is 15 days. If a member requires more than 15 consecutive days, the member must be discharged from the psychiatric facility. Facilities are reimbursed for the reserved bed at one-half the regular *per diem* rate.

### **Therapeutic Leave of Absence (LOA)**

Reimbursement is available for a therapeutic LOA from psychiatric hospitals; it is not available from general acute hospitals. A LOA must be for therapeutic reasons and ordered by a physician, as indicated in the member's POC. Physician orders must be maintained in the member's file at the facility.

The total length of time available for therapeutic leaves of absence is 60 days per calendar year per member. If a member is absent from a psychiatric hospital for more than 60 days per year,

no further reimbursement will be available for reserving a bed for that member in that year. Facilities are reimbursed at one-half the regular *per diem* rate.

## **Prior Authorization for Inpatient Psychiatric and Substance Abuse Stays**

PA is required for all inpatient psychiatric admissions, rehabilitation, and substance abuse inpatient stays. PA for inpatient detoxification, rehabilitation, and aftercare for chemical dependency must include consideration of the following information:

- Review on a case-by-case basis by the appropriate PA department based on the program assignment of the member
- Treatment, evaluation, and detoxification based on the stated medical condition
- Need for safe withdrawal from alcohol or other drugs
- History of recent convulsions or poorly controlled convulsive disorder
- Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting

IHCP members must meet the following criteria for inpatient detoxification:

- Evidence of symptoms of withdrawal that require close medical monitoring or continuous observation. Three or more of the following conditions:
  - Delirium tremens
  - Hypertension of recent onset
  - Impaired or absence of gag reflex
  - Tachycardia
  - Elevated temperature
  - Diaphoresis
  - Piloerection (goose bumps)
- Or one of the following conditions:
  - Seizures
  - Hallucinations of recent onset
  - Disorientation or confusion
- History of severe withdrawal reaction, such as seizures, delirium tremens, or psychotic episode
- Intoxicated with a history of recent, severe idiosyncratic intoxication, such as violence or blackouts while under the influence



- In addition to alcohol/drug condition, member has a co-existing medical and/or psychiatric condition which requires medical and psychiatric services
- Recent history of alcohol or other drug abuse and is currently unable to control abuse outside of a restrictive 24-hour care environment that is demonstrated by documented recent failed attempts.
- Dependency or abuse must be contributing to severe social and/or emotional dysfunction in one or more life spheres, e.g., vocational, familial, or social

The facility is responsible for initiating the PA review process. Providers should contact the appropriate PA entity for the initial PA and concurrent review.

Reimbursement is available for inpatient care provided on the psychiatric unit of an acute care hospital only when the need for admission has been certified. The Division of Family and Children State Form 44697, [OMPP 1261A – Certification Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility](#) - fulfills the written certification of need requirements. The certification of need must be completed in writing at least every 60 days after admission, or as requested, to recertify that the member continues to require inpatient psychiatric hospital services.

All requests for PA will be reviewed on a case-by-case basis. The PA entity reviews each OMPP 1261A form and determines whether the requested acute inpatient services meet medical necessity. Reimbursement is denied for any days the facility cannot justify a need for inpatient care. If the provider fails to complete a telephone PA pre-certification, reimbursement will be denied from the admission to the actual date of notification.

### **Emergency Admissions**

- A telephone precertification must be completed within 48 hours of the admission date, not including Saturdays, Sundays, and legal holidays
- A completed OMPP 1261A form must be received via U.S. mail within 14 working days of the admission date, not including Saturdays, Sundays, and legal holidays

### **Non-Emergency Admissions**

- A telephone PA must be completed prior to admission
- A completed OMPP 1261A form must be received via U.S. mail within 10 working days of the admission date, not including Saturdays, Sundays, and legal holidays

When an individual applies to become an IHCP member after admission to a facility, providers must notify the PA entity in writing within 10 days of receiving a notification of IHCP eligibility. At that time, providers may request coverage for the entire period of service for which reimbursement is sought.

### **Continuation of Services after Discharge from an Inpatient Hospital**

When a member's physician determines that an inpatient hospital setting is no longer necessary, but that IHCP-covered services should continue after the recipient is discharged from inpatient hospital care, services may continue for a period not to exceed 120 hours within 30 calendar days of discharge without prior review and authorization, if the physician has specifically ordered such services in writing upon the member's discharge from the hospital. Services provided are subject to all appropriate limitations. This exemption does not apply to durable medical equipment, neuropsychological and psychological testing, or out-of-state medical services.

Prior review and authorization by the office must be obtained for reimbursement beyond the 120 hours within 30 calendar days of the discharge period. Physical, speech, respiratory, and occupational therapies may continue for a period not to exceed 30 hours, sessions, or visits in 30 calendar days without prior approval, if the physician has specifically ordered such services in writing upon the member's discharge or transfer from the hospital. Prior review and authorization must be obtained for reimbursement beyond the 30 hours, sessions, or visits in the 30 calendar day period for physical, speech, respiratory, and occupational therapies.

## Residential Substance Use Treatment

The IHCP provides coverage for short-term low-intensity and high-intensity residential treatment for OUD and other SUD treatment in settings of all sizes, including facilities that qualify as IMDs. Residential stays are allowed to be authorized with a statewide average length of 30 calendar days, based on medical necessity.

Services built into the daily per diem residential payment include:

- Individual therapy
- Group therapy
- Medication training and support
- Case management
- Drug testing
- Peer recovery supports

Specific billing instructions for residential SUD treatment are currently found in [BT201801](#).

### Prior Authorization for Residential Substance Use Treatment

PA is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria Level 3.1 (Clinically Managed Low-Intensity Residential Services) and Level 3.5 (Clinically Managed High-Intensity Residential Services). Providers are required to include all appropriate documentation demonstrating medical necessity for residential treatment with PA requests.

## Outpatient Mental Health and Substance Abuse Services

Outpatient mental health services are interventions intended to reduce or alleviate symptoms, improve level of functioning, and prevent further or recurrent deterioration. After clients are assessed, a determination is made as to what forms of therapy will most likely be beneficial. Common interventions of outpatient treatment include individual, family, couple, and group counseling.

Therapy is a collaborative process; therefore, the client is expected to be active and cooperative when establishing the treatment plan. Treatment plans include specific goals, methods to accomplish goals, and methods to measure the progress of treatment goals. Measurable goals are also necessary to determine when improvement or deterioration of a client's functioning has occurred. Treatment plans must be reviewed and updated on a regular basis to reflect continued needs and identify the client's new goals.

**Note:** Healthy Indiana Plan (HIP) mental health outpatient treatment does not include self-help training or other related forms of non-medical self-care, marriage counseling, hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders. HIP substance abuse outpatient treatment does not include services or supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction.

### Outpatient Mental Health Services

The IHCP covers outpatient mental health services provided by a licensed medical doctor, doctor of osteopathy, psychologist endorsed as a health service provider in psychology (HSPP), psychiatric hospitals, psychiatric wings of acute care hospitals, and outpatient mental health facilities. Reimbursement is also available for services provided by mid-level practitioners when services are supervised by a physician or a HSPP.

Mid-level practitioners who are eligible to provide outpatient mental health services must have obtained one of the following credentials:

- Advanced practice nurse who is a licensed RN with a master's degree in nursing, with a major in psychiatric or mental health nursing from an accredited school of nursing
- Independent practice school psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed psychologist
- Master's degree in social work, marital and family therapy, or mental health counseling
- Licensed clinical addiction counselors (LCAC)



These mid-level practitioners cannot be separately enrolled as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or a HSPP enrolled in the IHCP.

The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and supervising the treatment plan. The physician, psychiatrist, or HSPP must be available for emergencies. They are responsible for seeing the member during the intake process or reviewing the medical information obtained by the mid-level practitioner within seven days of the intake process. Also, the physician, psychiatrist, or HSPP must see the member or review the medical information and certify medical necessity on the basis of medical information provided by the mid-level practitioner at intervals not to exceed 90 days. Both reviews must be documented in writing; co-signatures alone are not sufficient.

The IHCP requires written evidence of physician or HSPP involvement and personal evaluation to document the member's acute medical needs. If practicing independently, a physician or a HSPP must order therapy in writing.

### **Prior Authorization for Outpatient Visits**

Prior authorization is required for mental health services provided in an outpatient or office setting that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time.

**Note:** For Hoosier Healthwise Package C members, the IHCP covers thirty (30) office visits per member, per rolling calendar year. The IHCP may cover an additional twenty (20) visits with PA for a maximum of 50 visits per year.

### **Partial Hospitalization**

The IHCP reimburses for partial hospitalization services under the following conditions:

- Partial hospitalization programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measureable and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.
- Partial hospitalization programs must have the ability to reliably contract for safety. Consumers with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.
- Services may be provided for consumers of all ages who are not at imminent risk to harm to self or others. Consumers who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. Consumers

must have a diagnosed or suspected behavioral health condition and one (1) of the following:

- A short-term deficit in daily functioning.
- An assessment of the consumer indicating a high probability of serious deterioration of the consumer's general medical or behavioral health.
- Partial hospitalization services must be ordered and authorized by a psychiatrist.
- A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twenty four (24) hours following admission to the program.
- A psychiatrist must actively participate in the case review and monitoring of care.
- Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or a HSPP must appear in the consumer's clinical record.
- At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.
- For consumers under eighteen (18) years of age, documentation of active psychotherapy must appear in the consumer's clinical record, including a minimum of one (1) family encounter per five (5) business days of episode of care.
- Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.
- Programs must not mix consumers receiving partial hospitalization services with consumers receiving outpatient behavioral health services.

The following exclusions apply for partial hospitalization services:

- Consumers at imminent risk of harm to self or others are not eligible for services.
- Consumers who concurrently reside in a group home or other residential care setting are not eligible for services.
- Consumers who cannot actively engage in psychotherapy are not eligible for services.
- Consumers with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services.
- Consumers who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services

### **Prior Authorization for Partial Hospitalization**

Prior authorization is required for partial hospitalization services subject to medical necessity.

## Testing Services (Neuropsychological and Psychological)

The IHCP covers neuropsychology and psychology testing. A physician or HSPP must oversee all testing services, as well as interpretation and reporting. The following practitioners may only administer neuropsychological and psychological testing under the direction supervision of a physician or HSPP:

- A licensed psychologist
- A licensed independent practice school psychologist
- A person holding a master's degree in a mental health field and one (1) of the following
  - A certified specialist in psychometry (CSP)
  - Two-thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed

A cosignature by the physician or HSPP is required for services rendered by one of the practitioners listed above.

### Prior Authorization for Testing Services

Prior authorization is required for all neuropsychology and psychology testing, subject to medical necessity.

## Screening and Brief Intervention Services

The IHCP provides coverage for screening and brief intervention (SBI) services. SBI identifies and intervenes with individuals who are at risk for substance abuse related problems or injuries. SBI services use established systems, such as trauma centers, emergency rooms, community clinics, and school clinics, to screen patients who are at risk for substance abuse and, if necessary, provide the patients with brief interventions or referrals to appropriate treatment.

## Bridge Appointments

The IHCP provides coverage for bridge appointments, which are follow-up appointments after inpatient hospitalization for behavioral health issues, when no outpatient appointment is available within seven days of discharge. The goal of the bridge appointment is to provide proper discharge planning while establishing a connection between the member and the outpatient treatment provider.

During the bridge appointment, the provider should ensure at minimum that:

- The member understands the medication treatment regimen as prescribed.
- The member has ongoing outpatient care.
- The family understands the discharge instructions for the member.
- Barriers to continuing care are addressed.
- Any additional questions from the member or family are answered.

The following conditions must be met for bridge appointments to be reimbursed:

- Appointments must be conducted face-to-face in an outpatient setting on the day of discharge from an inpatient setting.
- Appointments must be a minimum of 15 minutes long.
- The member must have one or more identified barriers to continuing care, such as:
  - Special needs
  - Divorce or custody issues
  - Work conflicts
  - Childcare problems
  - Inability to schedule within seven days
  - History of noncompliance
  - Complex discharge plans
- The member must have one of the ICD diagnosis codes listed on the Diagnosis Codes for Bridge Appointments tables in *Mental Health and Addiction Services Codes* on the [Code Set](#) pages at indianamedicaid.com. Bridge appointments may be appropriate for members with psychiatric diagnoses not listed; however, documentation must be maintained in the member's chart, indicating the reason the bridge appointment service was necessary.

The appointment must be conducted by a qualified mental health provider, defined as:

- A licensed psychologist
- A licensed independent practice school psychologist
- A licensed clinical social worker (LCSW)
- A licensed marital and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A person holding a master's degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse (APN) who is a licensed, registered nurse holding a master's degree in nursing, with a major in psychiatric or mental health nursing from an accredited school of nursing

## Medicaid Rehabilitation Option (MRO)

For all coverage and billing information around Medicaid Rehabilitation Option (MRO) services, please see the [Medicaid Rehabilitation Option Services](#) provider reference module.

## Annual Depression Screening

The IHCP covers annual depression screening. Providers are expected to use validated standardized tests for the screening. These tests include, but are not limited to, the Patient Health Questionnaire (PHQ), Beck Depression Inventory, Geriatric Depression Scale, and Edinburgh Postnatal Depression Scale (EPDS)

## Smoking Cessation

Smoking cessation refers to a course of treatment designed to assist individuals in decreasing or stopping the use of tobacco products.

### Smoking Cessation Products

Reimbursement is available to pharmacy providers for smoking cessation products under the following conditions:

- When prescribed by a licensed practitioner within the scope of his or her license under Indiana law.
- Over-the-counter smoking cessation products must be prescribed by licensed practitioners.
  - A licensed practitioner must prescribe all smoking cessation products for use, along with counseling.
- Tobacco dependence pharmacotherapy will be available for up to 180 days per member per calendar year.
- Pharmacies should bill for reimbursement according to the normal procedures.

Only patients who agree to participate in smoking cessation counseling will receive prescriptions for smoking cessation products. The prescribing practitioner may request the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in smoking cessation treatment. A prescription for smoking cessation products will serve as documentation the prescribing practitioner has prescribed or obtained assurance from the patient counseling will concomitantly occur with the receipt of smoking cessation products.

Products covered by Indiana Medicaid include, but are not limited to, the following:

- Sustained release bupropion products
- Varenicline tartrate tablets (Chantix)
- Nicotine replacement drug products (patch, gum, inhaler)

### Smoking Cessation Counseling

Counseling services must be prescribed by a licensed practitioner within the scope of his or her license under Indiana law. Reimbursement is available for smoking cessation counseling services rendered by the following licensed practitioners participating in the Indiana Medicaid program:

- A physician
- A physician's assistant
- A nurse practitioner
- A registered nurse
- A psychologist
- A pharmacist
- A dentist
- An optometrist
- A clinical social worker
- Marital and family counselors
- Mental health counselors
- Licensed clinical addiction counselors

Counseling must be provided as follows: A minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) per member per calendar year. Providers must bill counseling in 15-minute increments.

**Note:** For Hoosier Healthwise (HHW), providers of smoking cessation treatment services must obtain the PMP certification.

## Opioid Treatment Program (OTP) Services

The IHCP provides coverage for services provided within an Opioid Treatment Program (OTP). The following services are considered part of a bundled daily payment within an OTP:

- Oral medication administration, direct observation, daily
- Methadone, daily
- Drug testing, monthly
- Specimen collection and handling, monthly
- Pharmacologic management, daily
- One hour of case management, per week
- Group or individual psychotherapy, as required by DMHA
- Hepatitis A, B, and C testing, as needed
- Pregnancy testing, as needed
- One office visit every 90 days

- Tuberculous testing, as needed
- Syphilis testing, as needed
- Complete blood count, as needed

**Note:** The daily bundled rate for OTP services is only billable for individuals who are receiving daily methadone maintenance treatment. If a member is using an alternative medication for treatment, such as Suboxone or Vivitrol, the medication, along with any related services rendered, should be billed separately.

A psychiatric diagnostic evaluation with medical services, as well as psychotherapy services over and above the therapy covered under the bundled rate, may be rendered and billed separately from the daily bundled rate.

These services are available to members enrolled in all IHCP progress, except for those with the following benefit plans:

- Individuals eligible for Family Planning Eligibility Program only
- Individuals eligible for Package E – Emergency Services only
- Individuals eligible for Medicare Savings Programs only – Qualified Medicare Beneficiary (QMB)-only, Specified Low Income Medicare Beneficiary (SLMB)-only, or Qualified Individual (QI)

Individuals who are aged 18 and older seeking OTP services must meet the following medical necessity criteria:

- Must be addicted to an opioid drug
- Must have been addicted for at least one year before admission to the OTP
- Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria

Individuals under the age of 18 seeking OTP services must meet the following medical necessity criteria:

- Must be addicted to an opioid drug
- Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period preceding admission
- Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria

The following individuals are exempt from the one-year addiction requirement:

- Members released from a penal institution – if the individual seeks OTP services within six months of release
- Pregnant women
- Previously treated individuals – if the individual seeks OTP services within two years after treatment discharge

The IHCP recognizes the following credentials, under the direction of a physician or health services provider in psychology (HSPP), for individuals rendering individual, group, or family counseling services in an OTP setting:

- A licensed psychologist
- A licensed clinical social worker (LCSW)
- A licensed marriage and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A licensed clinical addiction counselor (LCAC)
- A physician assistant
- A nurse practitioner
- A clinical nurse specialist
- An individual credentialed in addiction counseling by a nationally recognized credentialing body approved by the Division of Mental Health and Addiction (DMHA)\*

\*The Medication Assisted Treatment Specialist (MATS) credential is not currently recognized by DMHA and will not be allowed by the IHCP.

### **Prior Authorization for OTP Services**

Prior authorization (PA) is not required for OTP services. However, providers must maintain documentation demonstrating medical necessity, that the coverage criteria are met, as well as the individual's length of treatment, in the member's records.

### **Prior Authorization**

Prior authorization is not required for the following services:

- Screening and brief intervention services
- Smoking cessation
- Opioid Treatment Program (OTP) services

Prior authorization is required for the following services:

- Inpatient psychiatric and substance abuse stays

- Outpatient mental health services that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time
- Partial hospitalization services
- Neuropsychology and psychology testing

## Billing and Coding

For further billing information, see the [Mental Health and Addiction Services](#) provider reference module. For a list of billing codes, see the *Mental Health and Addiction Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 1-8-2 – Hospital and ambulatory surgical center reimbursement for outpatient services
- 405 IAC 1-10.5-3 – Perspective reimbursement methodology
- 405 IAC 5-2-19 – “Outpatient services” defined
- 405 IAC 5-3 – Prior authorization
- 405 IAC 5-2-17 – “Medically reasonable and necessary service” defined
- 405 IAC 5-20-1 – Reimbursement limitations
- 405 IAC 5-20-4 – Individually developed plan of care
- 405 IAC 5-20-6 – Emergency admissions
- 405 IAC 5-20-8 – Outpatient mental health services
- 405 IAC 5-21 – Community mental health rehabilitation services
- 405 IAC 5-25 – Physician services
- 405 IAC 5-29 – Services not covered by Medicaid
- 405 IAC 5-37 – Smoking cessation treatment policy
- 440 IAC 5.2-2-3 – Assertive community treatment services
- 405 IAC 5-2-19 – Outpatient Services Defined
- 405 IAC 5-3 – Prior Authorization
- 405 IAC 5-20-8 – Outpatient Mental Health Services
- 405 IAC 5-21.5 – Medicaid Rehabilitation Option Services

### [IHCP Provider Bulletins](#)

- [BT201801](#) IHCP enhances coverage for substance use treatment
- [BT201755](#) IHCP issues revised reimbursement policy and billing guidance for OTP-specific services
- [BT201744](#) IHCP to enroll OTPs under a designated provider type and cover OTP-specific services
- [BT201149](#) The IHCP to cover bridge appointments
- [BT201023](#) Medicaid Rehabilitation Option program updated code set and modifier information

## [IHCP Provider Banners](#)

- [BR201730](#) IHCP to reimburse for certain procedures rendered by LCACs
- [BR200923](#) Screening and brief intervention services

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## **Update History**

January 1, 2017 – Initial Publication; revised tobacco dependence treatment; revised criteria for inpatient detoxification admissions; added coverage of annual depression screening

August 17, 2017 – Added coverage for OTP services

August 25, 2017 - Added LCAC to list of mid-level practitioners for outpatient mental health services

February 1, 2018 – Expanded coverage for inpatient stays in IMDs

March 1, 2018 – Added coverage for residential substance use treatment

## **Obstetrical and Gynecological Services**

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This information has been incorporated into the [Obstetrical and Gynecological Services](#) provider reference module.



## **Oncology Services**

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This information has been incorporated into the [Oncology Services](#) provider reference module.



## **Out-of-State Services**

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This information has been incorporated into the [Out-of-State Providers](#) provider reference module.



## **Podiatry Services**

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This information has been incorporated into the [Podiatry Services](#) provider reference module.



## **Radiology Services**

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This information has been incorporated into the [Radiology Services](#) provider reference module.



## **Surgical Services**

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This information has been incorporated into the [Surgical Services](#) provider reference module.



## **Telemedicine and Telehealth Services**

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This information has been incorporated into the [Telemedicine and Telehealth Services](#) provider reference module.

## **Therapy Services**

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This information has been incorporated into the [Therapy Services](#) provider reference module.



## **Transplant Services**

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This information has been incorporated into the [Surgical Services](#) provider reference module.



## **Transportation Services**

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This information has been incorporated into the [Transportation Services](#) provider reference module.

## **Traumatic Brain Injury Program**

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This information has been incorporated into the [Therapy Services](#) provider reference module.



## **Vision Services**

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This information has been incorporated into the [Vision Services](#) provider reference module.