List of Policy Modules

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Services
Anesthesia Services

This information has been incorporated into the Anesthesia Services provider reference module.
Cardiac Rehabilitation

Description of Service
Progressive exercise programs have demonstrated benefit in the management and rehabilitation of individuals with cardiac disease, especially following certain cardiac events. Cardiac rehabilitation programs are typically divided into three stages.

- The initial stage (Phase I) involves the most intensive supervision and occurs in an inpatient setting. A Phase I program is typically initiated during the acute convalescent period following a cardiac event.
- The second stage (Phase II) begins with an overall treatment plan, including a physician’s prescription for progressive exercise based on the individual’s clinical status and physical capacity. Phase II programs incorporate close monitoring and individualized progressive increases in the intensity of physical activity, as well as lifestyle changes, such as dietary modifications and smoking cessation. Phase II exercise programs for cardiac patients may be conducted in specialized, freestanding, cardiac rehabilitation clinics, as well as in outpatient hospital departments.
- The third stage (Phase III) is an ongoing maintenance period consisting of continued lifestyle changes and aerobic exercise. All phases of cardiac rehabilitation programs include individualized exercises and behavior-change therapy with the intention of returning the patient to an active life with minimized symptoms.

Medical Policy
Required Components
The IHCP provides reimbursement for comprehensive cardiac rehabilitation programs. Cardiac rehabilitation requires that specific components be included in the rehabilitation program.

Required components include:
- Medical evaluation
- A program to modify cardiac risk factors (e.g., nutritional counseling, assessing smoking status, history and control of diabetes or hypertension, lipid management, weight management, and any psychosocial interventions such as depression screening)
- Prescribed exercise
- Education
- Counseling
- Under the direct supervision of a physician

Phase I
Phase I reimbursement is included in the inpatient diagnosis related group (DRG); therefore, IHCP does not provide separate reimbursement for Phase I.
Phase II
IHCP reimbursement is available for cardiac rehabilitation services for Phase II when considered medically reasonable and necessary. The member must be referred by the physician and must have at least a moderate level of risk stratification. Services provided in connection with a cardiac rehabilitation program may be considered reasonable and necessary up to a maximum of 36 sessions, usually three sessions a week in a single 12-week period.

Coverage for continued participation in a cardiac rehabilitation program beyond 12 weeks requires documentation (in the member’s medical record) that fully supports the medical necessity for cardiac rehabilitation along with exit criteria, as it is covered by IHCP.

Reimbursement is not available for Phase II cardiac rehabilitation services exceeding a maximum of 24 weeks.

The members must have had one of the following preceding the initiation of the Phase II program:

- Stable angina pectoris – International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes I20.1 through I20.9 – with reduced activity tolerance substantially altering lifestyle. Stable angina is defined as exertional chest pains with a constant threshold, predictable symptoms, and the ability to adjust one’s activity and medications to avoid symptoms. Members who qualify for a Phase II cardiac rehabilitation program are expected to have a functional classification of Class II or Class III on the Canadian Cardiovascular Society Functional Classification, as follows:
  - Class I: Ordinary physical activity, such as walking and climbing stairs, does not cause angina. Angina may occur with strenuous, rapid, or prolonged exertion at work or during recreation.
  - Class II: Slight limitation of ordinary activity, including walking or climbing stairs; rapidly walking uphill; walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening; walking more than two blocks on a level surface and climbing more than one flight of ordinary stairs at a normal pace and under normal conditions.
  - Class III: Marked limitation of ordinary physical activity, such as walking one to two blocks on a level surface and climbing more than one flight in normal conditions.
  - Class IV: Inability to carry on any physical activity without discomfort; anginal syndrome may be present at rest.
- Documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months
- Coronary artery-bypass surgery
- Heart-valve repair/replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- Heart or heart-lung transplant

A routine cardiac rehabilitation visit must include at least one of the following services:

- Continuous electrocardiogram (ECG) telemetric monitoring during exercise
- ECG rhythm strip with interpretation and physician’s revision of exercise prescription
- Physician’s evaluation to assess the member’s performance, adjust medication, or other treatment changes

Other cardiac rehabilitation services may include but are not limited to the following:

- New patient comprehensive evaluation, including history, physical, and preparation of initial exercise prescription. One comprehensive evaluation is allowed and separately payable at the beginning of the program, if not already performed by the member’s attending physician, or if the evaluation performed by the member’s attending physician is not acceptable to the program’s director. An assessment performed by a nurse or other personnel does not meet this requirement.
- ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report. One is allowed at the beginning of the program and one after three months (usually at the completion of the program). Pharmacologic stress testing may be indicated in certain circumstances and would be allowed with appropriate documentation of medical necessity in the member’s medical records.

Cardiac rehabilitation programs may be provided by the outpatient department of a hospital or in a freestanding cardiac rehabilitation facility. The IHCP requires facilities rendering cardiac rehabilitation services to be:

- Staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life-support techniques and in exercise therapy for coronary disease; and
- The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary – for example, oxygen, cardiopulmonary resuscitation equipment and defibrillator.

**Phase III**

IHCP does not provide reimbursement for Phase III cardiac rehabilitation programs.

A member may progress to the maintenance (Phase III) program when the following criteria are met:

- The member has achieved a stable level of exercise tolerance without ischemia or dysrhythmia, as evidenced by an ECG.
- Symptoms of angina or dyspnea are stable at the member’s maximum exercise level.
- The member’s resting blood pressure and heart rate are within normal limits, or are stable on optimal medical therapy.
- The stress test is not positive during exercise. (A positive test in this context means an ECG with a junctional depression of greater than or equal to two millimeters, associated with slowly rising, horizontal, or down-sloping ST segment).
Prior Authorization
Prior authorization is not required for cardiac rehabilitation services.

Billing and Coding
Phase II cardiac rehabilitation services are to be billed with the appropriate Current Procedural Terminology (CPT®) procedure code, as noted below, and with an appropriate ICD-10-CM diagnosis code, as described below.

According to the ICD-10-CM coding narratives, cardiac rehabilitation that begins within four weeks of the date of the infarction should be coded as I21.01 – I21.4. Cardiac rehabilitation beginning eight weeks or more from the date of the infarction (but less than 52 weeks) should be coded as I25.2 or I25.6.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93797</td>
<td>Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)</td>
</tr>
<tr>
<td>93798</td>
<td>Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)</td>
</tr>
</tbody>
</table>

ICD-10-CM Diagnosis Codes for Phase II Cardiac Rehabilitation

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I20.8</td>
<td>Other forms of angina pectoris</td>
</tr>
<tr>
<td>I20.9</td>
<td>Angina pectoris, unspecified</td>
</tr>
<tr>
<td>I21.01</td>
<td>ST elevation (STEMI) myocardial infarction involving left main coronary artery</td>
</tr>
<tr>
<td>I21.09</td>
<td>ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall</td>
</tr>
<tr>
<td>I21.11</td>
<td>ST elevation (STEMI) myocardial infarction involving right coronary artery</td>
</tr>
<tr>
<td>ICD-10-CM Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>I21.19</td>
<td>ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall</td>
</tr>
<tr>
<td>I21.21</td>
<td>ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery</td>
</tr>
<tr>
<td>I21.29</td>
<td>ST elevation (STEMI) myocardial infarction involving other sites</td>
</tr>
<tr>
<td>I21.3</td>
<td>ST elevation (STEMI) myocardial infarction of unspecified site</td>
</tr>
<tr>
<td>I21.4</td>
<td>Non-ST elevation (NSTEMI) myocardial infarction</td>
</tr>
<tr>
<td>I22.1</td>
<td>Subsequent ST elevation (STEMI) myocardial infarction of inferior wall</td>
</tr>
<tr>
<td>I22.8</td>
<td>Subsequent ST elevation (STEMI) myocardial infarction of other sites</td>
</tr>
<tr>
<td>I22.9</td>
<td>Subsequent ST elevation (STEMI) myocardial infarction of unspecified site</td>
</tr>
<tr>
<td>I25.2</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>I25.6</td>
<td>Silent myocardial ischemia</td>
</tr>
<tr>
<td>Z48.21</td>
<td>Encounter for aftercare following heart transplant</td>
</tr>
<tr>
<td>Z48.280</td>
<td>Encounter for aftercare following heart-lung transplant</td>
</tr>
<tr>
<td>Z94.1</td>
<td>Heart transplant status</td>
</tr>
<tr>
<td>Z94.3</td>
<td>Heart and lungs transplant status</td>
</tr>
<tr>
<td>Z95.1</td>
<td>Presence of aortocoronary bypass graft</td>
</tr>
<tr>
<td>Z95.2</td>
<td>Presence of prosthetic heart valve</td>
</tr>
<tr>
<td>Z95.3</td>
<td>Presence of xenogenic heart valve</td>
</tr>
<tr>
<td>Z95.4</td>
<td>Presence of other heart-valve replacement</td>
</tr>
<tr>
<td>Z95.5</td>
<td>Presence of coronary angioplasty implant and graft</td>
</tr>
<tr>
<td>Z95.818</td>
<td>Presence of other cardiac implants and grafts</td>
</tr>
<tr>
<td>Z98.61</td>
<td>Coronary angioplasty status</td>
</tr>
<tr>
<td>Z98.89</td>
<td>Other specified postprocedural states</td>
</tr>
</tbody>
</table>

*Includes nocturnal angina

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM (for example, up to seven characters). The correct use of an ICD-10-CM code listed above does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this policy.

The appropriate revenue code for cardiac rehabilitation services is 943. All charges associated with the elements of a cardiac rehabilitation service, as noted previously in this section, including telemetry and supplies for telemetry, are to be included in this charge.

Separate reimbursements for charges for telemetry, electrodes, and so on, are not provided. One unit equals one cardiac rehabilitation visit. The number of units must be shown on the
Uniform Bill- (UB-) 04 in field 46. A stress test may be billed using revenue code 482. The date of onset or surgery must be indicated on the UB-04 in fields 31-36 with occurrence code 11. The date of the first cardiac rehabilitation session must be indicated in fields 32-35 with occurrence code 46. The total number of cardiac rehabilitation visits from the start of care, including the current claim, must be entered on the UB-04 in fields 39-41 with value code 53.

**Reasons for Denial**

Although members may meet a provider’s protocol for cardiac rehabilitation services, they must also meet the IHCP coverage criteria for medical necessity. The IHCP will deny reimbursement for reasons including but not limited to the following:

- Lack of documentation of a covered diagnosis
- Lack of documentation of the elements of a cardiac rehabilitation visit
- Duration beyond 12 weeks without documentation showing medical necessity, as indicated above
- Services determined to be not reasonable and necessary, as stated previously in this section

**Documentation Requirements**

The diagnosis of stable angina should be substantiated with a physician history and physical (H&P), a hospital-discharge summary, or a physician statement to confirm the diagnosis. The member’s medical record must contain documentation that fully supports the medical necessity for cardiac rehabilitation, as it is covered by IHCP.

This documentation includes but is not limited to:

- Medical records confirming the diagnosis and evidence of the elements of a cardiac rehabilitation session (e.g., telemetry-monitoring strips)
- Also, the medical record must indicate the medical necessity for unusual frequency or duration of Phase II cardiac rehabilitation.
- The documentation must be specific in terms of exit criteria and/or setbacks that changed the exercise prescription.

Claims for Phase II cardiac rehabilitation must have documentation indicating the member has not reached an exit level within 12 weeks.

**Rules and Citations**

**405 IAC 5**

405 IAC 5-2-17 "Medically reasonable and necessary service" defined

IHCP Provider Bulletins

IHCP Provider Banners

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit [http://provider.indianamedicaid.com/](http://provider.indianamedicaid.com/).
Update History
January 1, 2017 – Initial Publication
Chiropractic Services

This information has been incorporated into the Chiropractic Services provider reference module.
Clinical Trials

This information has been incorporated into the Clinical Trials provider reference module.
Dental Services

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

This information has been incorporated into the Durable and Home Medical Equipment and Supplies provider reference module.
Early and Periodic Screening Services

Description of Service

The EPSDT program, referred to as HealthWatch in Indiana, is a federally mandated preventive health care program designed to improve the overall health of IHCP eligible members from birth to 21 years old. Special emphasis is given to early detection and treatment, as these efforts can reduce the risk of more costly treatment or hospitalization when detection is delayed. The objectives of the EPSDT Program are:

- To increase the number of members who are up-to-date with their childhood immunizations
- To increase the number of members receiving an initial health examination
- To increase the number of members receiving a preventive care/well visit examination
- To promote interaction between member and provider by developing and coordinating preventive services
- To encourage members to take a more active role in managing their health

Medical Policy

Initial Screening

An initial screening is performed by the EPSDT screening provider when referred by the OMPP or its designee, or upon the member’s initial request for EPSDT services. The initial screening and subsequent, periodic screenings must be performed according to the HealthWatch Periodicity and Screening Schedule (periodicity schedule) shown on Table 1.

Periodic Screening

Periodic screenings will be provided by the EPSDT screening provider in accordance with the EPSDT periodicity schedule as long as the recipient chooses to participate in the EPSDT program, or until the recipient reaches his or her twenty-first birthday.

A periodic screening shall include the following:

- A comprehensive health and developmental history, including assessment of both physical and mental health development.
- A comprehensive unclothed physical exam.
- A nutritional assessment.
- A developmental assessment.
- Appropriate vision and hearing testing.
- Dental screening.
- Health education, including anticipatory guidance.

In addition to the required procedures listed above, the periodic screening shall include administration of or referral for any other test, procedure, or immunization that is medically necessary or clinically indicated.

**HealthWatch Periodicity and Screening Schedule**

The initial screening and subsequent, periodic screenings must be performed according to the HealthWatch Periodicity and Screening Schedule (periodicity schedule) shown below. This table can be seen in greater detail at 405 IAC 5-15-8.

**HealthWatch/EPSDT Periodicity and Screening Schedule**

<table>
<thead>
<tr>
<th>AGE</th>
<th>INFANCY</th>
<th>EARLY CHILDHOOD</th>
<th>MIDDLE CHILDHOOD</th>
<th>ADOLESCENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1mo</td>
<td>2-4mo</td>
<td>6mo</td>
<td>12mo</td>
</tr>
<tr>
<td>HISTORY: INITIAL/INTERVAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEASUREMENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height and Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Circumference</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SENSORY SCREENING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>DEVELOPMENTAL BEHAVIOR ASSESSMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSICAL EXAMINATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROCEDURES - GENERAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematocrit or Hemoglobin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROCEDURES - PATIENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AT BIRTH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Sickle Cell&quot; Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug/Alcohol Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic Exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANTICIPATORY GUIDANCE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborn Infant Screen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please Consult the EPSDT-HealthWatch Program Provider Manual for immunization schedules and risk factor definitions.

**Key:**
- * = to be performed
- R = to be performed on patient
- S = subjective, by history
- O = objective, by a standard testing method

- Range during which a service may be provided, with the dot or number indicating the preferred age.
With regard to dental care, once the member has been referred for dental screening, the dental provider must follow the IHCP EPSDT Dental Periodicity Schedule shown below.

### IHCP EPSDT Dental Periodicity Schedule

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6-12 months</td>
</tr>
<tr>
<td>Clinical oral examination 1,2 to include:</td>
<td>●</td>
</tr>
<tr>
<td>Assess oral growth and development 3</td>
<td>●</td>
</tr>
<tr>
<td>Caries-risk assessment 4</td>
<td>●</td>
</tr>
<tr>
<td>Anticipatory guidance/ counseling 6</td>
<td>●</td>
</tr>
<tr>
<td>Injury prevention counseling 7</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for nonnutritive habits 8</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for speech/language development</td>
<td>●</td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for intraoral/perioral piercing</td>
<td>●</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants 9</td>
<td>●</td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td>●</td>
</tr>
<tr>
<td>Radiographic assessment 5</td>
<td>●</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride 4,5</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td>●</td>
</tr>
</tbody>
</table>

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child’s risk status/susceptibility to disease.
2. Includes assessment of pathology and injuries
3. By clinical examination
4. Must be repeated regularly and frequently to maximize effectiveness
5. Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially play objects, pacifiers, car seats; then, when learning to walk, sports and routine playing, including the importance of mouth guards
8. At first, discuss the need for additional sucking: digits vs. pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
Treatment

Any treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements for the services set out in this policy. However, if a service is not covered under the state plan, it is still available to EPSDT eligible recipients subject to prior authorization requirements of 405 IAC 5-4 if it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Recipient and Provider Participation

Any IHCP member under twenty-one (21) years of age may participate in the EPSDT program. Each recipient will be informed about the program by the office or its designee in accordance with federal regulations. Participation in EPSDT by IHCP members is voluntary.

Individual physicians, physician group practices, hospitals, or physician-directed clinics that are enrolled as Medicaid providers may provide a complete EPSDT screen.

Any enrolled IHCP provider may provide EPSDT diagnostic and/or treatment services within the scope of his or her practice upon referral from the screening provider.

Screening Referrals

HealthWatch/EPSDT providers are required to make dental, vision, hearing, and lead screening referrals when screening results indicate a problem. Providers may refer members for dental services beginning at 24 months old or as early as 12 months, if indicated in the screening.

Vision referrals must be made to an optometrist or ophthalmologist starting when objective screening methods indicate a problem is present. Newborns with hearing deficits identified under the Universal Newborn Screening Program are followed up by the Early Hearing Detection and Intervention Program (EHDI) at the Indiana State Department of Health (ISDH) and encouraged to follow up with an audiologist. Older members needing additional hearing testing should be referred for additional testing and treatment when screening results indicate a possible hearing deficit. The tables below show the schedules for dental, vision, and hearing observation and screenings.

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Subjective (S) or Required (R)</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 12 months</td>
<td>S</td>
<td>Direct referral to a dentist for medically appropriate services, if warranted by injury, disease, congenital abnormality, or other cause</td>
</tr>
<tr>
<td>12 to 24 months</td>
<td>S</td>
<td>Direct referral to a dentist, if necessary</td>
</tr>
<tr>
<td>24 months</td>
<td>R</td>
<td>Direct referral to a dentist for examination, preventive dental care, and anticipatory guidance</td>
</tr>
</tbody>
</table>
Regular dental assessments at intervals defined by the dentist (approximately every six months). The individual member’s assessment should include examination, preventive dental care, and anticipatory guidance.

### Periodicity Schedule – Vision Observation and Screening

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Recommended (S) or Objective (O)</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 3 years</td>
<td>S</td>
<td>Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality is suspected.</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>O</td>
<td>Annual objective screening test by standard testing method. If warranted, refer child to an appropriate specialist.</td>
</tr>
<tr>
<td>6, 8, 14, 16, 20 years</td>
<td>S</td>
<td>Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality is suspected.</td>
</tr>
<tr>
<td>10, 12, 18</td>
<td>O</td>
<td>Objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.</td>
</tr>
</tbody>
</table>

### Periodicity Schedule – Hearing Observation and Screening

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Subjective (S), Objective (O), or Required (R)</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>R</td>
<td>Newborn hearing screening via fully automated brain-stem response, if available</td>
</tr>
<tr>
<td>Newborn</td>
<td>R</td>
<td>All members considered to be at risk for hearing deficit should be screened at this time.</td>
</tr>
<tr>
<td>Under 12 months</td>
<td>S</td>
<td>Subjective screening by history or other infant screening, using standard testing method. Refer those at risk or suspected of a hearing deficit to a specialist, if warranted.</td>
</tr>
<tr>
<td>12 months through 3 years</td>
<td>O</td>
<td>As early as possible, perform an objective screening using standard testing method. Refer those at risk or suspected of a hearing deficit to a specialist.</td>
</tr>
</tbody>
</table>
Audiometric screening with an audiometer or audioscope (refer to audiologist, if necessary). Refer child at risk or suspected of a hearing deficit to an appropriate specialist.

Subjective screening, by history and/or other method; refer child with suspected hearing deficit to an appropriate specialist.

Objective hearing screening by a standard testing method (hearing tests are given by the Indiana Department of Education in grades one, four, seven, and 10; several schools also test kindergarten students). Do not duplicate school screenings unless a child is considered at risk and rescreening is warranted.

Providers of services who perform screening or treatment services as a result of an EPSDT screening referral shall be subject to the same limitations for such services.

**Blood Lead Screenings**

Blood lead screenings must be performed between the ages of 9 and 12 months, and again at 24-month visits. If the member is at high risk for lead exposure, the initial screening should be performed at the six-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning.

A blood lead test result equal to or greater than 5 μg/dl obtained by a capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent screenings are required for children with blood lead levels equal to or greater than 5 μg/dl.

The ISDH, through the Indiana Lead and Healthy Homes Program (ILHHP), monitors lead poisoning. Providers are required to report all results of blood lead screenings to the ISDH no later than one week after completing the examination. The ILHHP provides medical and environmental case management follow-up for children who are identified with elevated levels of lead in their blood.

**Prior Authorization**

Prior authorization is not required for screening services. Treatment services are subject to the same prior authorization requirements as the services.

**Billing and Coding**

For further billing information, see the [EPSDT Services](#) provider reference module. For a list of billing codes, see the [EPSDT/HealthWatch Codes](#) on the [Code Sets/Tables](#) webpage.
Rules and Citations

405 IAC 5
- 405 IAC 5-15: Early and Periodic Screening, Diagnosis, and Treatment Services

IHCP Provider Bulletins
- BT201427 BMI to be required component of EPSDT screening

IHCP Provider Banners
- BR201640 IHCP clarifies lead screening requirements for children

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
Emergency Services

This information has been incorporated into the Emergency Services provider reference module.
Evaluation and Management Services

This information has been incorporated into the Evaluation and Management Services provider reference module.
Family Planning Services

This information has been incorporated into the Family Planning Services provider reference module.
Federally Qualified Health Centers and Rural Health Clinics

This information has been incorporated into the Federally Qualified Health Centers and Rural Health Clinics provider reference module.
Genetic Testing Services

This information has been incorporated into the Genetic Testing and Laboratory Services provider reference modules.
Hearing Services

This information has been incorporated into the Hearing Services provider reference module.
Home Health Services

This information has been incorporated into the Home Health Services provider reference module.
Hospice Services

This information has been incorporated into the Hospice Services provider reference module.
Hospital Inpatient Services

Description of Service
“Inpatient” is defined as a patient required to be admitted to the hospital to treat a condition requiring close monitoring or skilled professional management. Inpatient hospital services may be covered when determined to be medically reasonable and necessary for the services to be performed only in an inpatient hospital setting.

Medical Policy
Inpatient Acute Care Hospital Admissions
Inpatient hospital services are covered by IHCP when such services are provided or prescribed and documented by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition, subject to the following limitations:

- Reimbursement for inpatient hospital services is available only when it is determined to be medically reasonable and necessary for the services to be performed only in an inpatient hospital setting.
  - Reimbursement will be denied for any days of the hospital stay during which the inpatient hospitalization is found not to have been medically necessary.
- If an inpatient procedure requires prior authorization, and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.
- The recipient's medical condition, as described and documented in the medical record by the primary or attending physician, must justify the intensity of service provided.
- Reimbursement shall not be made for any hospital services not covered by the IHCP.
- Reimbursement is not available for reserving a bed during a therapeutic leave of absence from an acute care hospital.

Prior Authorization for Inpatient Acute Care Hospital Admissions
Prior authorization is required for all non-emergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. 405 IAC 5-33 provides criteria for acute care hospital admissions for both adult and pediatric recipients. Below are the criteria for acute care hospital admissions for day of admission.

Acute Care Hospital Admission Criteria for Adults
Severity of Illness Criteria
- Sudden onset of unconsciousness or disorientation (coma or unresponsiveness);
- Pulse rate:
  - less than fifty (50) per minute; or
  - greater than one hundred forty (140) per minute;
- Blood pressure:
  - systolic less than ninety (90) or greater than two hundred (200) millimeters mercury; or
• diastolic less than sixty (60) or greater than one hundred twenty (120) millimeters mercury;
• Acute loss of sight or hearing;
• Acute loss of ability to move body part;
• Persistent fever equal to or greater than one hundred (100) (p.o.) or greater than one hundred one (101) (R) for more than five (5) days;
• Active bleeding;
• Severe electrolyte/blood gas abnormality, including any of the following:
  o Na < 123 mEq/L
  o Na > 156 mEq/L
  o K < 2.5 mEq/L
  o K > 6.0 mEq/L
  o CO₂ combining power (unless chronically abnormal) < 20 mEq/L
  o CO₂ combining power (unless chronically abnormal) > 36 mEq/L
  o Blood pH < 7.30
  o Blood pH > 7.45;
• Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, or breathe); must also meet intensity of service criterion simultaneously in order to certify; do not use for back pain;
• EKG evidence of acute ischemia; must be suspicion of a new MI; or
• Wound dehiscence of evisceration.

Intensity of Service
• Intravenous medications and/or fluid replacement (does not include tube feedings);
• Surgery or procedure scheduled within twenty-four (24) hours requiring:
  o general or regional anesthesia; or
  o use of equipment, facilities, or procedure available only in a hospital;
• Vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
• Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
• Treatment in an intensive care unit;
• Intramuscular antibiotics at least every eight (8) hours; and
• Intermittent or continuous respirator use at least every eight (8) hours

Criteria of appropriateness of day of care
• Medical services:
  o procedure in operating room that day;
  o scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation;
  o cardiac catheterization that day;
  o angiography that day;
  o biopsy of internal organ that day;
• thoracentesis or paracentesis that day;
• invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day;
• any test requiring strict dietary control for the duration of the diet;
• new or experimental treatment requiring frequent dose adjustments under direct medical supervision;
• close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record); or

- Postoperative day for any procedure covered listed below:
  • procedure in operating room that day;
  • cardiac catheterization that day;
  • angiography that day;
  • biopsy of internal organ that day;
  • thoracentesis or paracentesis that day;
  • invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day

- Nursing/life support services:
  • respiratory care–intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB) at least three (3) times daily;
  • parenteral therapy–intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications);
  • continuous vital sign monitoring, at least every thirty (30) minutes, for at least four (4) hours;
  • IM and/or SC injections at least twice daily;
  • intake and output measurement;
  • major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains); or
  • close medical monitoring by nurse at least three (3) times daily, under doctor’s orders.

- Patient condition:
  • within twenty-four (24) hours before day of review inability to void or move bowels (past twenty-four (24) hours) not attributable to neurologic disorder;
  • within forty-eight (48) hours before day of review:
    - transfusion due to blood loss;
    - ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report;
    - fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally), if patient was admitted for reasons other than fever;
    - coma–unresponsiveness for at least one (1) hour;
    - acute confusional state, not due to alcohol withdrawal;
    - acute hematologic disorders, significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis yielding signs or symptoms; or
    - progressive acute neurologic difficulties; and
within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

**Acute Care Hospital Admission Criteria for Pediatrics**

**Severity of Illness**

- Sudden onset of unconsciousness (coma or unresponsiveness) or disorientation;
- Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, or urinate);
- Acute loss of sight or hearing;
- Acute loss of ability to move body part;
- Persistent fever (> one hundred (100) degrees orally or > one hundred one (101) degrees rectally) for more than ten (10) days;
- Active bleeding;
- Wound dehiscence or evisceration;
- Severe electrolyte/acid-base abnormality, including any of the following:
  - Na < 123 mEq/L
  - Na > 156 mEq/L
  - K < 2.5 mEq/L
  - K > 6.0 mEq/L
  - CO2 combining power (unless chronically abnormal) <20 mEq/L
  - CO2 combining power (unless chronically abnormal) > 36 mEq/L
  - Arterial pH < 7.30
  - Arterial pH > 7.45;
  - Hematocrit < thirty percent (30%);
- Pulse rate outside following ranges (optimally a sleeping pulse for < twelve (12) years old):
  - 2–6 years old 70–200/minute
  - 7–11 years old 60–180/minute
  - 12 years old 50–140/minute
- Blood pressure outside following ranges:
  - Systolic/Diastolic
    - 2–6 years old 75–125 mm Hg/ 40–90 mm Hg
    - 7–11 years old 80–130 mm Hg/ 45–90 mm Hg
    - < 12 years old 90–200 mm Hg/ 60–120 mm Hg
- Need for lumbar puncture, where this procedure is not done routinely on an outpatient basis;
- Any conditions not responding to outpatient, including emergency room:
  - seizures;
  - cardiac arrhythmia;
  - bronchial asthma or croup;
  - dehydration;
  - encopresis (for clean-out); or
  - other physiologic problem (specify);
- Special pediatric problems:
o child abuse;
o noncompliance with necessary therapeutic regimen; or
o need for special observation or close monitoring of behavior, including
  calorie intake in cases of failure to thrive.

Intensity of Service

- Surgery or procedure scheduled within twenty-four (24) hours requiring:
  - general or regional anesthesia; or
  - use of equipment, facilities, or procedure available only in a hospital;
- Treatment in an intensive care unit;
- Vital sign monitoring every two (2) hours or more often (may include telemetry or
  bedside cardiac monitor);
- Intravenous medications and/or fluid replacement (does not include tube
  feedings);
- Chemotherapeutic agents that require continuous observation for life-threatening
  toxic reaction;
- Intramuscular antibiotics at least every eight (8) hours; and
- Intermittent or continuous respirator use at least eight (8) hours.

Criteria of appropriateness of day of care

- For medical services, the following documented criteria will be used for continued
  stay reviews; at least one (1) of the criteria must be met for the continued stay to
  be recertified:
  o Procedure in operating room that day.
  o Procedure scheduled in operating room the next day, requiring
    preoperative consultation or evaluation.
  o If day being reviewed is the day of admission, any procedure listed below
    (cardiac catheterization through gastrointestinal endoscopy) scheduled
    for the day after admission unless that procedure is usually done at that
    facility on a same-day basis.
  o Cardiac catheterization that day.
  o Angiography that day.
  o Biopsy of internal organ that day.
  o Thoracentesis or paracentesis that day.
  o Invasive CNS diagnostic procedure, for example, lumbar puncture,
    cisternal tap, ventricular tap, or pneumoencephalography, that day.
  o Gastrointestinal endoscopy that day.
  o Any test requiring strict dietary control for the duration of the diet.
  o New or experimental treatment requiring frequent dose adjustments
    under direct medical supervision.
  o Close medical monitoring by a doctor at least three (3) times daily
    (observations must be documented in record).
  o Postoperative day for any procedure covered below:
    - Procedure in operating room that day
    - Cardiac catheterization that day
    - Angiography that day
- Biopsy of internal organ that day
- Thoracentesis or paracentesis that day
- Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day
- Gastrointestinal endoscopy that day

- Nursing/life support services shall be as follows:
  - Respiratory care–intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB), at least three (3) times daily, Bronkosol with oxygen, oxyhoods, or oxygen tents.
  - Parenteral therapy–intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications).
  - Continuous vital sign monitoring, at least every thirty (30) minutes for at least four (4) hours.
  - IM and/or SC injections at least twice daily.
  - Intake and/or output measurement.
  - Major surgical wound and drainage care, for example, chest tubes, T-tubes, hemovacs, or Penrose drains.
  - Traction for fractures, dislocations, or congenital deformities.
  - Close medical monitoring by nurse at least three (3) times daily, under doctor's orders.

- Patient condition:
  - within twenty-four (24) hours on or before day of review, inability to void or move bowels, not attributable to neurologic disorder–usually a post-op;
  - within forty-eight (48) hours on or before day of review:
    - transfusion due to blood loss;
    - ventricular fibrillation or ECG evidence of acute ischemia as stated in progress note or in ECG report;
    - fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally) if patient was admitted for reason other than fever;
    - coma–unresponsiveness for at least one (1) hour;
    - acute confusional state, including withdrawal from drugs and alcohol;
    - acute hematologic disorders–significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis–yielding signs of symptoms; or
    - progressive acute neurologic difficulties; and
  - within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

Inpatient Psychiatric Admissions
The IHCP reimburses for inpatient psychiatric services provided to eligible individuals between 22 and 65 years old only in certified psychiatric hospitals with 16 beds or less. 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. For more information, please see the Mental Health and Addiction Services policy module.

**Inpatient Rehabilitation Admission**

Per CMS, inpatient rehabilitation is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IHCP provides reimbursement for inpatient rehabilitation services when such services are prior authorized and determined to be medically necessary.

**Prior Authorization for Inpatient Rehabilitation Admission**

Prior authorization is required for all inpatient rehabilitation admissions. Prior to admission to a physical rehabilitation unit, an assessment of the patient’s total rehabilitative potential must be completed and documented in the medical record. Also, a written plan of care, cooperatively developed by the therapist or psychologist and the attending physician, is required for all rehabilitation services.

Prior to admission to a physical rehabilitation unit, the member’s total rehabilitation potential must be evaluated. Documentation in the medical record must include the member’s condition, IHCP criteria, and level of care necessary in the rehabilitation unit.

The following conditions must be met for reimbursement for physical rehabilitation admission:

- The patient is medically stable.
- The patient is responsive to verbal or visual stimuli.
- The patient has sufficient mental alertness to participate in the program.
- The patient's premorbid condition indicates a potential for rehabilitation.
- The expectation for improvement is reasonable.
- The criteria listed in 405 IAC 5-32 are met.

Per 405 IAC 5-32, the following criteria shall demonstrate the inability to function independently with demonstrated impairment. The following criteria contains the evaluation necessary to determine the member’s ability or inability to function independently.

**Severity of Illness Criteria**

- Cognitive function (attention span, memory, or intelligence).
- Communication (aphasia with major receptive or expressive dysfunction).
- Continence (bladder or bowel).
- Mobility (transfer, walk, climb stairs, or wheelchair).
- Pain management (pain behavior limits functional performance).
• Perceptual motor function (spatial orientation or depth or distance perception).
• Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis).

Intensity of Service Criteria
• Multidisciplinary team evaluation at least every two (2) weeks.
• Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
  o Occupational therapy.
  o Speech therapy.
• Participation in a rehabilitation program under the direction of a qualified physician.
• Skilled rehabilitative nursing care or supervision required at least daily.

Discharge Criteria
• Evidence in record that patient has achieved stated goals.
• Medical complications preclude intensive rehabilitative effort.
• Multidisciplinary therapy no longer needed.
• No additional functional improvement is anticipated.
• Patient's functional status has remained unchanged for fourteen (14) days.

Inpatient Surgical Admission
Admission Indicators for Surgical Procedures
• Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG but is subject to retrospective review for medical necessity.
• Criteria for determining the medical necessity for inpatient admission includes the following information:
  o Technical or medical difficulty during the outpatient procedure as documented in the medical record
  o Presence of physical or mental conditions, which make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel a necessity
  o Performance of another procedure simultaneously, which itself requires hospitalization
  o Likelihood of another procedure, which would require hospitalization following the initial procedure

Prior Authorization for Inpatient Surgical Admission
Prior authorization is required for all surgical procedures typically performed on an outpatient basis, when performed on an inpatient basis, require PA.
Dental Admissions
Any one of the following is an inpatient dental admission indicator:
- Mental incapacitation such that the recipient’s ability to cooperate with procedures is impaired, including intellectual disability, organic brain disease, and behavioral problems associated with uncooperative, but otherwise healthy children
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the recipient’s ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication
- The need for oral surgery, listed in 405 IAC 5-19-17; or in extreme cases of facial trauma, pathology, or deformity
- Periodontal surgery only in cases of drug-induced periodontal hyperplasia
- Elective oral surgery when recipient is unable to cooperate with or tolerate the procedure

Prior Authorization for Dental Admissions
Prior authorization is required for all dental admissions.

Inpatient Burn Admissions
The following criteria list below for hospitalization for adults and children with burns are to be used for reference in determining IHCP appropriate inpatient burn admissions.

Hospitalization for Adults with Burns (Age 10 and Over)
First Degree
- Superficial
- Damage is limited to the epidermis
- Erythema appears
- Between 10 and 20 percent of total body surface (TBS) area – Minor Burn

Second Degree
- Deep partial thickness burns of eyes, ears, face, hands, feet, or perineum; or
- Burns complicated by fractures or respiratory damage;
- Electrical burns; and
- All burns in poor-risk patients
- Involvement of less than 15 percent TBS area – Minor Burn
- Involvement of 15 to 25 percent TBS area – Moderate Burn
- Involvement of more than 25 percent TBS area – Major Burn

Third Degree
- Minor Burn: Full thickness burns covering less than 3 percent of the body
  - Excluding the eyes, ears, face, hands, feet or perineum –
  - Or
• Moderate Burn: Full thickness burns covering greater than 3 percent and less than 10 percent TBS area
  o Including the eyes, ears, face, hands, feet, or perineum
  **Or**
• Major Burn: Full thickness burns of more than 10 percent of the TBS

**Admission Indicators**
The admission may be approved without referral for physician review if **one** of the following is present (recent onset):

• Loss or damage of skin ≥ 15 percent of TBS area
• High-voltage burn with devitalized skin, fat, or muscle
• Second- or third-degree burns of one of the following: face, hands, perineal region, encircling neck or extremities, anterior or posterior neck or limbs
• T ≥ 104.0° F
• T ≥ 102.0° F and one of the following:
  o White blood cells (WBC) ≥ 18,000/cu.mm
  o WBC ≥ 15,000/cu.mm with ≥ 7 percent bands
• T ≥ 100.5° F and **one** of the following:
  o Absolute neutrophil count ≤ 500/cu.mm
  o WBC ≤ 1,500/cu.mm
• Admission for an invasive procedure which necessitates an inpatient setting **and** is scheduled for the same day as admission

**And one** of the following treatments is being provided (at least daily):

• Post surgery or procedure care ≤ three days and at least **two** of the following:
  o IV fluids ≥ 100 mL/h
  o IV or IM analgesics
  o IV or IM anti-emetics
  o Graft or wound care
• Burn therapy with at least **three** of the following:
  o IV electrolyte (K, Ca, Mg, P)
  o IV fluids ≥ 100 mL/h
  o IV plasma expanders
  o O2 ≥ 28 percent (4L) or hyperbaric
  o Total parenteral nutrition (TPN)

**Or** at least **three** of the following treatments are being provided:

• Blood or blood products
• Complex burn, graft, or wound care
• IV fluids ≥ 100 mL/h
• Restorative PT or OT at least 2x/24h
• TPN
• IV or IM corticosteroids at least 3x/24h
• IV or IM diuretics at least 2x/24h
• IV or IM analgesics at least 4x/24h
• IV or IM anti-emetics at least 4x/24h
• IV or IM anti-infectives at least 3x/24h

Hospitalization for Children with Burns (Age 10 and Under)
First Degree
• Superficial
• Damage is limited to the epidermis
• Erythema appears
• Minor Burn: Between 10 and 20 percent area

Second Degree
• Deep partial thickness burns of eyes, ears, face, hands, feet, or perineum; or
• Burns complicated by fractures or respiratory damage;
• Electrical burns; and
• All burns in poor-risk patients
• Minor Burn: Involvement of less than 10 percent TBS area
• Moderate Burn: Involvement of 10 to 20 percent TBS area
• Major Burn: Involvement of more than 20 percent TBS area

Third Degree
• Major Burn: Full thickness burns covering 2 percent of the body
  • Excluding the eyes, ears, face, hands, feet or perineum
  • Or
• Major Burn: Full thickness burns covering greater than 1 percent and less than 10 percent TBS area
  • Including the eyes, ears, face, hands, feet, or perineum

Admission Indicators
The admission may be approved without referral for physician review if one of the following is present (recent onset):
• Electrical burns with devitalized skin, fat, or muscle
• First-degree burns covering 40 percent of TBS
• Second-degree burns covering 15 percent of TBS
• Second-degree burns covering face, genitalia, hands, or feet
• Third-degree burns covering 5 percent or more of TBS
And at least one of the following treatments is being provided at least daily
• Post surgery or procedure care ≤ two days
• IV electrolytes
• Burn therapy with at least two of the following:
  • IV fluids ≥ 30 mL/kg/24h
PV plasma expanders
02> 28 percent (4L)
Or at least three of the following treatments are being provided:
- Blood or blood products
- Complex burn, graft, or wound care
- PT
- IV fluids ≥ 30 mL/kg/24h
- IV plasma expanders
- TPN or enteral feeding
- IV or IM corticosteroids at least 3x/24h
- IV diuretics at least 2x/24h
- IV or IM analgesics at least 4x/24h
- IV or IM anti-emetics at least 4x/24h
- IV or IM anti-infectives at least 3x/24h
- Inpatient Dental Admission

Prior Authorization for Inpatient Burn Admissions
Prior authorization is required for inpatient hospitalizations for the immediate treatment of burns, except those with an admit of type 1 (emergency) or type 5 (trauma).

Hospital Inpatient Readmissions
Readmission is the term used when patients are admitted into the hospital, acute care or other, following a previous admission and discharge for the same or a related diagnosis.

Readmissions are subject to medical review to determine if the previous discharge was premature. Reviews are conducted based on statistical data sets for readmissions. If the discharge was premature and payment made, the readmission or discharge may be subject to recoupment. For payment purposes, readmissions within three days after discharge will be treated as the same admissions, while readmissions after three days will be treated as separate stays but are subject to medical review.

Out-Of-State Services
All out-of-state services require Prior Authorization (see 405 IAC 5-5-1). The following services are exceptions:
- Emergency services
- Recipients of the adoption assistance program placed outside of Indiana
- Services that are provided by designated cities listed in 405 IAC 5-5-2(a) (3)-(4).

Long Term Acute Care (LTAC) Hospitals
LTAC hospitals are designed to provide specialized acute care for patients that require especially long recovery periods. These patients are usually in acute-care facilities. Their medical conditions have stabilized, but they continue to require an acute level-of-care (LOC). A lesser LOC, such as a SNF or sub-acute care facility, is not appropriate.
Federal regulations for LTAC hospitals require average inpatient stays greater than 25 days. Medicare program criteria are used to qualify a facility as a LTAC hospital. Patients are generally discharged to home with or without home care services, to acute inpatient rehabilitation hospitals, sub-acute rehabilitation programs, or to SNFs. LTAC hospitals are licensed by state acute care licensing standards and are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

**Admission Criteria**

Before admission to a LTAC hospital, assessment of the patient’s current medical status and discharge goals must be provided to the appropriate PA vendor for PA purposes. This information should also be documented in the medical record. Each PA request is reviewed for medical necessity on an individual, case-by-case basis.

The proposed admission needs to be to a facility that meets the definition of a LTAC hospital in 405 IAC 1-10.5-2(s), which states, “LTC hospital means a freestanding general acute care hospital licensed under Indiana Code IC 16-21 that:

- Is designated by the Medicare program as a long-term hospital; or
- Has an average inpatient length of stay greater than twenty-five (25) days as determined using the same criteria used by the Medicare program to determine whether a hospital’s average length of stay is greater than twenty-five (25) days.”

The Indiana Code goes on to state: “Freestanding does not mean a wing or specialized unit within a general acute care hospital.” However, LTC hospitals may be licensed hospitals that operate as separate entities within a host hospital.

The patient must be admitted directly from an acute care facility or be readmitted from a NF or rehabilitation facility. No PA will be approved for requests for initial admission directly from a NF, from a physician’s office, or from home.

The following documentation must be included with requests for admission to a LTAC hospital and must be available for review by the PA Department or SUR Department, as applicable:

- A signed statement from the referring physician indicating medical necessity for transfer to a LTAC hospital.
- The following information must accompany a request for approval and an evaluation by the requesting facility:
  - Diagnosis and premorbid conditions. If the patient is currently in an acute care hospital, the diagnosis at discharge should be included if it has changed from the time of admission.
  - Information about where the patient is being admitted from, if not hospitalized
  - Neurological assessment
  - Complete listing of long- and short-term goals
  - Discharge plan with two options, depending on the member’s condition
  - Potential date of admission
  - Projected date of discharge
  - History of any previous rehabilitation therapies
All the following situations apply to the patient’s status and current requirements before admission to the LTAC hospital:

- The patient is medically stable.
- The initial diagnostic workup is completed.
- There are no major surgical procedures planned.
- The patient has a prognosis requiring a prolonged stay in an acute setting, and there is a reasonable expectation for improvement in the status of his or her medical condition.
- The patient requires interactive physician direction with daily on-site assessment.
- The patient requires significant ancillary services dictated by complex, acute medical needs. Examples include but are not limited to full service and STAT laboratory, radiology, and respiratory care services.
- There is a patient-centered, outcome-focused, interdisciplinary approach requiring a physician directed professional team that includes intensive case management to move the patient efficiently through the continuum of care.
- Education for the patient and family must be provided to manage the patient’s present and future healthcare needs.

During the PA process, the medical director may help determine whether the admission is medically necessary. Admissions requested for categories not specified in the following sections will be reviewed for medical necessity and intensity of service on a case-by-case basis.

**Respiratory**

The patient must meet two or more of the following requirements for admission and continued stay:

- Requires ventilator assistance and has failed attempts to be extubated or maintain adequate ventilation, oxygenation, or functional level after extubation
- Requires one or more of the following IV medications daily:
  - Bronchodilators
  - Corticosteroids
  - Diuretics
  - Antiviral agents
  - Anti-tuberculosis agents
  - Antiprotozoal agents
  - Chemotherapy
  - Antibiotics
  - Antifungal agents
  - Anticoagulation medications
• Requires frequent monitoring of tissue oxygenation (for example, pulse oximetry), frequent RT treatments, or suctioning or inhalation medications

**Impaired Skin Integrity**
Impaired skin integrity means the patient has stage three or stage four decubitus wounds, infected necrotic skin conditions, surgical wounds, or burns. The patient must meet each of the following requirements for admission or continued stay:

- The patient has non-healing wounds that have failed to improve while receiving home care, SNF, or acute hospital care.
- The patient requires complex dressing changes using daily whirlpool, debridement, frequent intramuscular or IV analgesics or antifungals, frequent positioning, or hyperbaric treatments.
- The patient requires more than one of the following IV medications at least daily:
  - Antiviral agent
  - Antibiotics
  - Antifungal agent
  - IV plasma expanders
  - IV electrolytes
  - Total parenteral nutrition (TPN)

**Cardiac**
Cardiac care is required if the member is unable to maintain adequate circulation related to mechanical or electrical dysfunction of the cardiovascular system. The patient must meet each of the following requirements for admission or continued stay:

- The patient requires frequent monitoring of tissue oxygenation (for example, pulse oximetry) and continuous telemetry.
- The patient requires management of hemodynamic instability, cardioversion or valsalva maneuver, temporary pacemaker, or monitoring of a functional permanent pacemaker, monitoring for drug toxicity, defibrillation, pulmonary artery catheterization and arterial monitoring, and monitoring of electrolyte imbalance.
- The patient requires two or more of the following medications intravenously to maintain cardiovascular integrity:
  - Anticoagulants
  - Anti-anginal agents
  - Anti-arrhythmics
  - Antibiotics
  - Alpha/beta-adrenoreceptor blocking agents
  - Antihypertensives
  - Beta blockers
  - Calcium channel blockers
  - Cardiac glycosides
  - Corticosteroids
  - Diuretics
  - Intropic agents
  - Mucarinic receptor antagonists
  - Sodium channel blockers
Continued Stay Criteria
All of the following are required to be documented for review of a continued stay in the LTAC hospital:

- Multidisciplinary team evaluation at least weekly
- Evidence of participation in a rehabilitation-therapy program
- Continued daily on-site direction of a qualified physician
- Continued skilled nursing care or supervision required
- Continued need for acute LOC, as evidenced by continuing to meet the admission criteria category requirements

Documentation Requirements for Continued Stay
Concurrent review for approval of additional days must be received by the PA department at least 48 hours before the last approved day, including:

- Completed IHCP Prior Authorization Request Form
- A summary of the current discharge plans
- Documentation of family or friend participation in the discharge planning process
- A neurological assessment update, if appropriate
- Documentation of the member's cooperation, participation, or progress

Discharge Criteria
Continued length of stay will not be authorized without the medical director’s review when any of the following conditions occur:

- There is evidence in the patient record that the patient has achieved stated goals.
- Medical complications require readmission to an inpatient acute facility.
- Multidisciplinary services are no longer needed.
- No additional improvement is anticipated.
- Patient’s progress towards goals has remained unchanged for seven days.

Prior Authorization for LTAC
Prior authorization is required for LTAC hospital admissions according to the criteria listed above.

Prior Authorization
In addition to prior authorization information set forth at 405 IAC 5-3, general prior authorization requirements for hospital services can be found in 405 IAC 5-17-2. These requirements include:

- Prior authorization is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-
section deliveries, newborns stays, and inpatient hospital admissions covered by Medicare do not require PA.

- Prior authorization is required for all Medicaid covered rehabilitation, burn, and psychiatric inpatient stays that are reimbursed under the level of care methodology described in 405 IAC 1-10.5 as well as substance abuse stays that are reimbursed under the DRG methodology also described at 405 IAC 1-10.5.
- Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG, but will be subject to retrospective review for medical necessity.

Criteria for determining the medical necessity for inpatient admission shall include the following:

- Technical or medical difficulties during the outpatient procedure as documented in the medical record.
- Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or skilled medical personnel a necessity.
- Performance of another procedure simultaneously, which itself requires hospitalization.
- Likelihood of another procedure following the initial procedure, which would require hospitalization.

Days that are not prior authorized under the level of care methodology as required by 405 IAC 5-17 will not be covered by Medicaid.

PA must be obtained for all admissions within 48 hours, excluding Saturdays, Sundays, and legal holidays. Concurrent review is necessary beyond the approved days.

**Billing and Coding**
For further billing information, see the Inpatient Hospital Services provider reference module. For a list of billing codes, please see the Inpatient Hospital Services Codes on the Code Sets/Tables webpage.

**Rules and Citations**

405 IAC 1
- 405 IAC 1-10.5-2 – Definitions
- 405 IAC 1-10.5-3 – Reimbursement for Inpatient Hospital Services
- 405 IAC 1-10.5 – Reimbursement for Inpatient Hospital Services

405 IAC 5
- 405 IAC 5-3-13 – Services requiring prior authorization
- 405 IAC 5-17 – Hospital Services
- 405 IAC 5-32 – Rehabilitation Unit
- 405 IAC 5-33 – Acute Care Hospital Admission

IHCP Provider Bulletins
IHCP Provider Banners

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
Hospital Outpatient Services

This information has been incorporated into the Outpatient Facility Services provider reference module.
Injections, Vaccines, and Other Physician-Administered Drugs

This information has been incorporated into the Injections, Vaccines, and Other Physician-Administered Drugs and Pharmacy Services provider reference modules.
Laboratory Services

This information has been incorporated into the Laboratory Services and Genetic Testing provider reference modules.
Lead Services

Description of Service
Screening for blood lead toxicity is a federal requirement for all children enrolled in Medicaid.

Medical Policy
Verbal Risk Assessment
The following questions should be asked at each well child visit:
1. Is your child living in or regularly visiting, or has your child lived in or regularly visited, a house or child care center built before 1978?
2. Does your child have a sibling or playmate who has or who has had lead poisoning?
3. Does your child frequently come in contact with an adult who works in an industry or has a hobby using lead (battery factory, steel smelter, stained glass)?
4. Is your child a recent immigrant or a member of a minority group?
5. Does anyone in your family use ethnic or folk remedies or cosmetics?

If the answer to any question is positive, a child is considered at high risk for high doses of lead exposure, and a blood lead level test must be obtained immediately regardless of the child’s age.

Subsequent verbal risk assessments can change a child’s risk category. If, as a result of a verbal risk assessment a previously low risk child is re-categorized as high risk, that child must be given a blood lead level test.

Prior Authorization for Verbal Risk Assessment
Prior authorization is not required for screening services. Individual treatment services may require prior authorization.

Blood Lead Screenings
Blood lead screenings must be performed between the ages of 9 and 12 months, and again at 24-month visits. If the member is at high risk for lead exposure, the initial screening should be performed at the six-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning.

A blood lead test result equal to or greater than 5 μg/dl obtained by a capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent screenings are required for children with blood lead levels equal to or greater than 5 μg/dl.

The ISDH, through the Indiana Lead and Healthy Homes Program (ILHHP), monitors lead poisoning. Providers are required to report all results of blood lead screenings to the ISDH no later than one week after completing the examination. The ILHHP provides medical and
environmental case management follow-up for children who are identified with elevated levels of lead in their blood.

Prior Authorization for Blood Lead Screenings
Prior authorization is not required for screening services. Individual treatment services may require prior authorization.

Comprehensive Environmental lead testing
The Indiana Health Coverage Programs (IHCP) will cover initial and follow-up comprehensive environmental lead investigation services for IHCP members with a confirmed elevated blood lead level (EBLL). EBLL is defined by the Centers for Disease Control (CDC) as a blood level of 5 mcg/dL or higher.

Services are limited to one unit, per member, per 12 month rolling calendar year.

Prior Authorization for Comprehensive Environmental Lead Testing
Prior authorization is not required for initial and follow up comprehensive environmental lead testing.

Prior Authorization
Prior authorization is not required for screening services. Individual treatment services may require prior authorization.

Billing and Coding
For further billing information, see the EPSDT Services provider reference module. For a list of billing codes, see the EPSDT/HealthWatch Codes on the Code Sets/Tables webpage.

Rules and Citations
405 IAC 5
- 405 IAC 5-15; Early and Periodic Screening, Diagnosis, and Treatment Services

IHCP Provider Bulletins
- BT201709 IHCP to Cover HCPCs Code T1029- Comprehensive Environmental Lead Investigation

IHCP Provider Banners
- BR201641 IHCP Encourages Providers to Review Reporting Processes for Submitting Lead Screening Information
- BR201640 IHCP Clarifies Lead Screening Requirements for Children
- BR201636 IHCP Reminds Providers Lead Screening is Required for Children
Note: For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit http://provider.indianamedicaid.com/.

Update History
April 1, 2017- Initial Publication
Mental Health and Addiction Services

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.
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

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.
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,
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 codependency 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:
  o Special needs
  o Divorce or custody issues
  o Work conflicts
  o Childcare problems
  o Inability to schedule within seven days
  o History of noncompliance
  o 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 buproprion 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 meeting 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

This information has been incorporated into the Obstetrical and Gynecological Services provider reference module.
Oncology Services

This information has been incorporated into the Oncology Services provider reference module.
Out-of-State Services

This information has been incorporated into the Out-of-State Providers provider reference module.
Podiatry Services

Description of Service
Podiatry is a specialized practice focusing on the study and care of the foot and related structures, including its anatomy, pathology, and medical and surgical treatment.

Medical Policy
Office Visits
The IHCP covers podiatric office visits, subject to the following restrictions:

- Reimbursement is limited to one (1) office visit, per 12 months.
- Reimbursement for a new patient office visit is limited to one (1) office visit, per member, per provider, within the last three (3) years.

Reimbursement is not available for the following types of extended or comprehensive office visits:
- New patient, comprehensive
- Established patient, detailed
- Established patient, comprehensive

A new patient is “one who has not received professional services from the provider or another provider of the same specialty who belongs to the same practice within the last three years.”

Routine Foot Care Restrictions
The IHCP covers routine foot care only if a medical doctor or doctor of osteopathy has seen the patient for treatment or evaluation of a systemic disease during the six-month period prior to rendering routine foot care services.

The IHCP may provide reimbursement for a maximum of six (6) routine foot care services per year only when the member:

- Has a systemic disease of sufficient severity that unskilled performance of the procedure would be hazardous; and
- The systemic condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet.

Routine foot care includes the following:

- Cutting or removal of corns, calluses, or warts (including plantar warts)
- Trimming of nails, including mycotic nails
- Treatment of fungal (mycotic) infection of the toenail is routine foot care only when:
  - Clinical evidence of infection of the toenail is present; and
  - Compelling medical evidence exists documenting that the member has either marked limitation of ambulation requiring active treatment of the foot or, in the
case of non-ambulatory members, has a condition that is likely to result in significant medical complications in the absence of such treatment.

Prior Authorization for Routine Foot Care
PA for routine foot care is not required. However, no more than six visits per year are covered. The patient must have been seen by an MD or doctor of osteopathy for treatment or evaluation of the systemic disease during the six-month period prior to the rendering of routine foot care services.

Doppler Evaluations
The IHCP may provide reimbursement for ultrasonic measurement of blood flow (Doppler evaluation) providing prior authorization has been obtained for the proposed medical procedure and is subject to the following limitations:

- There is a preoperative diagnosis of diabetes mellitus, peripheral vascular disease, or peripheral neuropathy.
- The measurement is for preoperative podiatric evaluation.
- The measurement cannot be used for routine screening.
- The measurement cannot be used as an evaluation of routine foot care procedures, including such services as removal or trimming of corns, calluses, and nails.
- The preoperative Doppler evaluation is limited to one per year.

Surgical Procedures
The IHCP may reimburse for the following podiatric surgical procedures without PA:

- Drainage of skin abscesses of the foot
- Drainage or injections of a joint or bursa of the foot
- Surgical cleansing of the skin
- Trimming of skin lesions of the foot, other than those identified as included in routine foot care services
- The IHCP allows surgical procedures other than those mentioned above, performed within the scope of the podiatrist’s license, subject to PA, as specified in 405 IAC 5-26. For covered, paid claims, the IHCP pays 100 percent of the IHCP allowance for the major procedure and 50 percent of the IHCP allowance for subsequent procedures.

Second Opinions
Podiatrists may be required to obtain a confirmatory consultation, in accordance with the guidelines for consultations and second opinions at 405 IAC 5-8-4, to establish medical necessity for the following podiatric surgical procedures:

- Bunionectomy procedures
- All surgical procedures involving the foot
A confirmatory consultation is required regardless of the surgical setting in which the surgery is performed, including ambulatory surgical centers, hospitals, clinics, or offices.

Laboratory or X-Ray Services
The IHCP may reimburse for laboratory or X-ray services provided by a podiatrist only if the services are rendered by or under the personal supervision of the podiatrist. Services ordered by a podiatrist, but performed by a laboratory or X-ray facility, will be billed directly to the IHCP by the laboratory or X-ray facility. The podiatrist may be reimbursed for handling or conveyance of a specimen sent to an outside laboratory in accordance with 405 IAC 5-18. Reimbursement is not available for comparative foot x-rays, unless prior authorized. The IHCP may reimburse for the following lab and X-ray services billed by a podiatrist:

- Cultures for foot infections and mycotic (fungal) nails for diagnostic purposes
- Sensitivity studies for treatment of infection processes
- Medically necessary pre-surgical testing

All services provided by the podiatrist must be performed within the scope of practice for podiatric medicine. Reimbursement for other surgical procedures performed within the scope of the podiatrist's license may be available, subject to the PA requirements of 405 IAC 5-3.

Orthopedic or Therapeutic Footwear
The IHCP may reimburse when a podiatrist renders orthotic services covered by Medicare for all eligible members receiving Medicare and Traditional Medicaid. With a physician’s written order, the IHCP may provide reimbursement for the following for members of all ages:

- Corrective features built into shoes such as heels, lifts, wedges, arch supports, and inserts
- Orthopedic footwear, such as, shoes, boots, and sandals
- Orthopedic shoe additions

If a member currently has a brace, the IHCP covers the shoes and supportive devices if providers document continued medical necessity. The IHCP also provides coverage for therapeutic shoes for members with severe diabetic foot disease.

Prior Authorization
PA is required for the following services:

- Hospital stays, as outlined in 405 IAC 5-17
- When a podiatrist prescribes or supplies corrective features built into shoes, such as heels, lifts, and wedges, for a recipient under 21 years old
- When a podiatrist fits or supplies orthopedic shoes for a recipient with severe diabetic foot disease, subject to the restrictions and limitations outlined in 405 IAC 5-19
- Comparative foot X-rays
Billing and Coding
For further billing information, see the Podiatry Services provider reference module. For a list of billing codes, see the Podiatry Services Codes on the Code Sets/Tables webpage.

Rules and Citations
405 IAC 5

IHCP Provider Bulletins
- BT201320 Update regarding reduction in reimbursement for podiatry services

IHCP Provider Banners
- BR201728 IHCP establishes a Podiatry Services Code Set

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
July 11, 2017 – Created a podiatry services code set
Radiology Services

This information has been incorporated into the Radiology Services provider reference module.
Surgical Services

This information has been incorporated into the Surgical Services provider reference module.
Telemedicine and Telehealth Services

This information has been incorporated into the Telemedicine and Telehealth Services provider reference module.
Therapy Services

Description of Service

The IHCP covers therapy services for its members. Therapy services, as described in this policy, encompass physical, speech, and occupational therapy, among others.

Medical Policy

Habilitative Therapy

Habilitative therapy refers to therapy addressing chronic medical conditions where further progress is not expected. Habilitative therapy services include physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services provided to members for the purpose of maintaining their level of functionality but not the improvement of functionality. Although the development of a habilitation therapy plan is considered part of rehabilitative services, the services furnished under a habilitation therapy plan are not skilled therapy.

IHCP policy regarding the coverage of habilitative therapy services makes the following distinction based on the member’s age:

- Habilitative therapy services are not covered for members 21 years of age and older.
- Habilitative therapy services are covered for members under 21 years of age on a case-by-case basis.

Educational services, including but not limited to the remediation of learning disabilities, are not considered habilitative therapy services and remain noncovered by the IHCP.

Prior Authorization for Habilitative Therapy

Habilitative therapy services are subject to prior authorization.

Rehabilitative Therapy

Rehabilitative therapy refers to the federal definition outlined in Code of Federal Regulations 42 CFR 440.130(d) and includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services provided to members.

IHCP policy regarding the coverage of rehabilitative therapy services makes the following distinction based on the member’s age:

- For members 21 years of age and older, rehabilitative therapy services are covered for no longer than two years from the initiation of the therapy unless there is a significant change in the member’s medical condition requiring longer therapy.
• For members under 21 years of age, rehabilitative therapy services are covered when it is determined to be medically necessary.

Physical Therapy

Physical Therapy (PT) is the evaluation of, administration of, or instruction in physical rehabilitative and habilitative techniques and procedures to evaluate, prevent, correct, treat, alleviate, and limit physical disability, pathokinesiological function, bodily malfunction, pain from injury, disease, and any other physical disability or mental disorder.

Physical therapy must be performed by a licensed physical therapist or certified physical therapist's assistant under the direction supervision of a licensed physical therapist or physician for reimbursement (the consultation can be either face to face or by telephone).

Payment for the following services is included in the Medicaid allowance for the modality provided by the licensed therapist and may not be billed separately to Indiana Medicaid:

• Assisting members in preparation for and, as necessary, during and at the conclusion of treatment
• Assembling and disassembling equipment
• Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient
• Following established procedures pertaining to the care of equipment and supplies
• Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas
• Transporting:
  o Patients
  o Records
  o Equipment
  o Supplies
• Performing established clerical procedures’

Evaluations and reevaluations are limited to three (3) hours of service per member evaluation.

Effective February 1, 2017, the following provider types may order physical therapy services:

• Physician
• Chiropractor
• Dentist
• Nurse practitioner
• Physician assistant
• Podiatrist
• Psychologist
Prior Authorization for Physical Therapy
For all prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.

Occupational Therapy
The practice of occupational therapy (OT) means the therapeutic use of everyday life occupations and occupational therapy services to:

- Aid individuals or groups to participate in meaningful roles and situations in the home, school, the workplace, the community, or other settings
- Promote health and wellness through research and practice
- Serve individuals or groups who are well but have been or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.

Occupational therapy must be performed by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist. An evaluation must be performed by a licensed occupational therapist in order for reimbursement to be made.

Evaluations and reevaluations are limited three (3) hours of service per evaluation.

Effective February 1, 2017, the following provider types may order occupational therapy services:
- Physician
- Chiropractor
- Nurse practitioner
- Optometrist
- Physician assistant
- Podiatrist
- Psychologist

The following occupational therapy services are not covered by the IHCP:
- General strengthening exercise programs
- Passive range of motion services (as the only or primary modality of therapy)
- Occupational therapy psychiatric services

Prior Authorization for Occupational Therapy
For all prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.
Speech Pathology

Speech pathology services are provided for IHCP members with speech, hearing, and/or language disorders. These services include diagnostic, screening, preventive, or corrective services.

The speech pathology service must be rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. A registered speech-language pathology aide may provide services.

Evaluations and reevaluations are limited three (3) hours of service per evaluation.

Group therapy is covered in conjunction with, not in addition to, regular individual treatment. Indiana Medicaid will not pay for group therapy as the only or primary means of treatment.

Speech pathology must be ordered in writing by a physician (doctor of medicine or doctor of osteopathy).

Prior Authorization for Speech Therapy/Pathology

For all prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.

Respiratory Therapy

Respiratory therapy services will be reimbursed only when performed by a licensed respiratory therapist or a certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic. The equipment necessary for rendering respiratory therapy will be considered part of the provider’s capital equipment.

Respiratory therapy must be ordered in writing by a physician (doctor of medicine or doctor of osteopathy).

Prior Authorization for Respiratory Therapy

Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection may be provided without prior authorization for a period not to exceed fourteen (14) hours on fourteen (14) calendar days.

For all other prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.
Hippotherapy

The IHCP covers hippotherapy for physical therapy. To be covered, services must be provided by a licensed physical therapist and should be billed using the appropriate CPT® codes. Services must be ordered by a physician and included in the patient’s plan of care.

Prior Authorization for Hippotherapy

Prior authorization requirements for physical therapy apply to hippotherapy.

Note: HIP Basic members are limited to 60 physical therapy, occupational therapy, speech pathology services, and pulmonary rehabilitation combined visits annually. HIP Plus members are limited to 75 physical therapy, occupational therapy, speech pathology services, and pulmonary rehabilitation combined visits annually.

Applied Behavior Analysis (ABA) Therapy

Applied Behavior Analysis (ABA) therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

An initial course of ABA therapy is subject to prior authorization and is covered when all of the following criteria are met:

- A diagnosis of ASD has been made by a qualified healthcare provider as described in the ‘Provider Requirements’ outlined below;
- The individual has completed a comprehensive diagnostic evaluation by a qualified healthcare provider. The evaluation must utilize a standardized assessment tool and include a referral for ABA services.
- The individual is no older than twenty (20) years of age;
- The goals of the intervention are appropriate for the individual’s age and impairment; and,
- Documentation is provided which describes the individual-specific treatment plan that is developed by a licensed or certified behavior analyst and includes all of the following:
  - Addresses the identified behavioral, psychological, family and medical concerns; and,
  - Measurable short-term, intermediate, and long-term goals based on standardized assessments relative to age-expected norms and that address the behaviors and impairments for which the intervention is to be applied (Note: this should include baseline measurements, progress to date and anticipated timeline for achievement based on both the initial assessment and subsequent interim assessments over the duration of the intervention);
  - Identifies plans for parent/guardian training and school transition; and
Documents that ABA services will be delivered by an appropriate provider who is licensed or certified as a Behavior Analyst (see “Provider Requirements” below).

Continuation of ABA therapy is subject to prior authorization and may be covered when all of the following criteria are met:

- The individual has met criteria for an initial course of ABA
- The individual-specific treatment plan will be updated and submitted as outlined below
- For each goal in the individual-specific treatment plan, the following is documented:
  - Developmental testing is done no later than 2 months after the initial course of ABA treatment has begun in order to establish a baseline in the areas of social skills, communication skills, language skills, and adaptive functioning; and
  - Progress to date; and
  - Anticipated timeline for achievement of the goals based on both the initial assessment and subsequent interim assessments over the duration of the intervention; and
- The individual-specific treatment plan includes age and impairment appropriate goals and measures of progress:
  - The treatment plan should include measures of the progress made with social skills, communication skills, language skills and adaptive functioning. Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning must be documented.
- The treatment plan must also identify and describe plans for parent/guardian training and school transition.

Reimbursement is not available when the following services do not meet medical necessity criteria, nor qualify as ABA therapy services:

- ABA components that focus on recreational or educational outcomes are not covered.
- Therapy services rendered when measurable functional improvement is not expected or documented;
- Services that are duplicative, such as services rendered under an individualized educational program (IEP);
- Services performed by an RBT in the home or school setting.

Prior Authorization for ABA Therapy

Prior authorization is required for the initial course of ABA therapy and may be approved for up to six (6) months. ABA therapy services shall not exceed a total duration of three (3) years.

Documentation supporting the PA request is required, and must include the following:

Initial Course of ABA

- An individual specific treatment plan, including:
o Identification of the individuals behavioral, psychological, family and medical concerns; and,

o Measurable goals based on standardized assessments that address the behaviors and impairments for which the intervention is to be applied (Note: this should include, for each goal, baseline measurements and anticipated timeline for achievement based on the initial assessment); and,

o The number of hours per week being requested, including justification for the specific number of hours based on the individual’s needs.

o Plans for parent/guardian training and school transition.

• Documentation that ABA services will delivered by an appropriate provider who is licensed or certified as a Behavior Analyst (see ‘Provider Requirements’ below).

Continuation of ABA

• Documentation that the member has been approved for the initial course of ABA based on the criteria above;

• An individual specific treatment plan must be updated and submitted up to 6 months. The treatment plan must include:
  
o Age and impairment appropriate goals, including baseline measures for each goal;
  
o Measureable progress to date;
  
o Anticipated timeline for achievement of each goal;
  
o Plans for parent/guardian training and school transition.

• Documentation that ABA services will delivered by an appropriate provider who is licensed or certified as a Behavior Analyst (see ‘Provider Requirements’ below).

Treatment plans must include measures and progress specific to language skills, communication skills, social skills and adaptive functioning. The individual treatment plan must include justification and supporting documentation for the number of hours being requested. The number of hours must give consideration to the child’s age, school attendance requirements, and other daily activities. The treatment plan must include a clear schedule of services planned, and that all identified interventions are consistent with ABA techniques.

In addition, for members 13 through 20 years of age, the treatment plan must include measures of the specific behaviors or deficits targeted and also include assessments of social, communication, and language skills, as well as adaptive functioning and developmental status.

Provider Requirements
For purposes of the initial diagnosis and comprehensive diagnostic evaluation, a qualified provider includes any of the following:

- Licensed physician;
- Licensed Health Service Provider in Psychology (HSPP);
- Licensed pediatrician;
- Licensed psychiatrist; or
- Other behavioral health specialist with training and experience in the diagnosis and treatment of autism spectrum disorder.

ABA therapy services must be delivered by an appropriate provider that is licensed or board certified as a Behavior Analyst, including Bachelor-level (BCaBA), Master’s (BCBA) and doctoral level (BCBA-D) behavior analysts. ABA therapy services may also be provided by a credentialed Registered Behavior Technician (RBT). Services performed by a BCaBA or RBT must be under the direct supervision of a BCBA, BCBA-D, or HSPP).

Services performed by RBTs under the supervision of a BCBA, BCBA-D, or HSPP will be reimbursed at 75% of the rate on file. Providers must bill the appropriate modifier (U1, U2, or U3) to indicate who is providing the services rendered.

Services rendered by a non-approved provider will not be reimbursed.

An IHCP ABA Prior Authorization Checklist is available for providers. Voluntary use of this tool should help providers prepare comprehensive requests for ABA therapy and reduce suspensions for requests for additional information.

Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure, increasing vascular flow and improving oxygenation of body tissue. Originally developed for the treatment of decompression sickness, hyperbaric oxygen is adjunctive treatment for the management of select non-healing wounds, treatment of carbon monoxide poisoning, and other conditions.

The following table provides reimbursable conditions for hyperbaric oxygen therapy:

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<th>ICD-10-CM Codes</th>
<th>Limitations</th>
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<td>Inflammatory conditions of jaw</td>
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<td>Irradiation cystitis</td>
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<td>---------------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Acute carbon monoxide intoxication</td>
<td>T58.01XA-T58.94XS,</td>
<td></td>
</tr>
<tr>
<td>Decompression illness</td>
<td>T70.3XXA -T70.3XXS</td>
<td></td>
</tr>
<tr>
<td>Gas embolism</td>
<td>T79.0XXA-T79.0XXS</td>
<td></td>
</tr>
<tr>
<td>Gas gangrene</td>
<td>A48.0</td>
<td></td>
</tr>
<tr>
<td>Acute traumatic peripheral ischemia</td>
<td>S35.511A-S35.513S, S45.001A-S45.099S, S55.001A- S55.999S, S65.001A-S65.999S, S75.001A S75.999S, S85.001A-S85.999S, S95.001A-S95.999S,</td>
<td>Adjunctive treatment to be used in combination with accepted standards and therapeutic measures</td>
</tr>
<tr>
<td>Complications of reattached extremity or body part</td>
<td>T87.0X1-T87.2</td>
<td></td>
</tr>
<tr>
<td>Crush injuries and suturing of severed limbs</td>
<td>S07.0XXA- S07.9XXS, S17.0XXA-S17.0XXS, S28.0XXA-S28.229S, S38.001A-S38.1XXS, S57.00XA-S57.82XS, S67.00XA-S67.92XS, S77.00XA-S77.22XS, S97.00XA-S97.82XS,</td>
<td>An adjunctive treatment when loss of function, limb or life is threatened</td>
</tr>
<tr>
<td>(Meleney Ulcers) Progressive necrotizing infections</td>
<td>M72.6</td>
<td>Other types of cutaneous ulcers are not covered</td>
</tr>
<tr>
<td>Acute peripheral arterial insufficiency</td>
<td>I74.2-I74.5</td>
<td></td>
</tr>
<tr>
<td>Compromised skin grafts</td>
<td>T86.820-T86.829</td>
<td>Preparation and preservation</td>
</tr>
<tr>
<td>Chronic Refractory Osteomyelitis</td>
<td>M86.30-M86.9</td>
<td>Use when unresponsive to conventional medical and surgical management</td>
</tr>
<tr>
<td>Osteoradionecrosis</td>
<td>M27.8</td>
<td>Adjunct to conventional treatment</td>
</tr>
<tr>
<td>Soft tissue radionecrosis</td>
<td>T66.XXXA-T66.XXXS</td>
<td>Adjunct to conventional treatment</td>
</tr>
<tr>
<td>Cyanide poisoning</td>
<td>T65.0X1A-T65.0X4S, T57.3X1A-T57.3X4S</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Actinomycosis</td>
<td>A42.0-A42.9</td>
<td>Only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment</td>
</tr>
<tr>
<td>Acute cerebral edema</td>
<td>G93.6</td>
<td></td>
</tr>
</tbody>
</table>

Reimbursement is not available for hyperbaric oxygen therapy for the following conditions:

- Topical application of oxygen
- Cutaneous, decubitus, and stasis ulcers
- Chronic peripheral-vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle-cell crisis
- Acute thermal and chemical pulmonary damage, including smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral-vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome, including Pick’s, Alzheimer’s, and Korsakoff’s disease
- Tetanus
- Systemic-aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic diseases
Treatment may include multiple sessions, which may be administered over a duration ranging from less than one week to two months, the average being two to four weeks. Claims submitted for treatment sessions lasting more than a two-month period will be suspended for submission of documentation to support medical necessity of continued therapy.

Hyperbaric therapy shall be clinically practical and shall not be a replacement for other standard successful therapeutic measures.

**Prior Authorization**

**For physical therapy, occupational therapy, respiratory therapy, and speech pathology**

Prior authorization is required for all therapy services. The following criteria must be met for PA of physical therapy, occupational therapy, respiratory therapy, and speech pathology when it is provided outside the exceptions stated below:

- Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. Therapy must be ordered by a qualifying provider (see individual policy sections for qualifying providers).
- A current plan of treatment, developed 60 to 90 days from the date of the PA submission, must include clearly stated and measurable goals and progress.
- Therapies must be provided by a qualified therapist or a qualified assistant under direct supervision of a therapist, as appropriate.
- Therapy must be of such a level of complexity and sophistication and the condition of the member must be such that the judgment, knowledge, and skills of a qualified therapist are required.
- Therapy must be medically necessary.
- Therapy for diversional, recreational, vocational purposes, or avocational purposes, for the remediation of learning disabilities, or for developmental activities which can be conducted by nonmedical personnel is non-covered.
- One hour of therapy must include a minimum of 45 minutes of direct care with the member. Only one hour per day, per type of therapy may be approved.
- Therapies which duplicate other services provided to a patient will not be authorized (e.g., nursing services).

For the following situations, PA is not required:

- Initial evaluations
- Emergency respiratory therapy
- Any combination of therapy, ordered in writing prior to a recipient’s discharge from inpatient hospital care, may continue for a period not to exceed 30 hours/sessions/visits in 30 calendar days
• Deductible and copayment for services covered by Medicare Part B
• Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators
• Therapy services provided by a nursing facility or large private or small intermediate care facility for individuals with intellectual disabilities (ICF/IID), which are included in the facility’s per diem rate

For physical therapy, occupational therapy, respiratory therapy, and speech pathology in the home health setting
The following criteria must be met for PA of physical therapy, occupational therapy, respiratory therapy, and speech pathology when it is provided by a home health agency:

• Therapy must be provided by an appropriately licensed, certified, or registered therapist employed or contracted by the agency
• Ordered or prescribed in writing by a physician
• Provided in accordance with a written plan of treatment developed cooperatively between the therapist and the attending physician
• Medically necessary
• Provided in accordance with all other PA requirements for physical therapy, occupational therapy, respiratory therapy, and speech pathology

Billing and Coding
For further billing information, see the Therapy Services provider reference module. For a list of billing codes, see the Therapy Services Codes on the Code Sets/Tables webpage.

Rules and Citations
405 IAC 5

• 405 IAC 5-22-6 Prior Authorization; exceptions
• 405 IAC 5-16 Home Health Agency and Clinic Services
• 405 IAC 5-16-4 Rehabilitation center services; limitations
• 405 IAC 5-17-4 Physical rehabilitation services
• 405 IAC 5-22 Nursing and Therapy Services
• 405 IAC 5-22-8 Certified Physical Therapist ‘s Assistants
• 405 IAC 5-32-1 Rehabilitation Unit

IHCP Provider Bulletins

• BT201627 IHCP Revises Coverage Policies for Therapy Services
• **BT201126** Removal of Physical, Speech, and Occupational Therapy Services Limitations
• **BT201690** IHCP Expands Provider Types Allowed to Order Physical and Occupational Therapy Services
• **BT201736** IHCP Revises Policy Regarding Robotic Therapy

**IHCP Provider Banners**

• **BR201737** IHCP makes Applied Behavioral Analysis PA Checklist available
• **BR201338** Prior authorization no longer required when billing for initial evaluations for speech therapy

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

**Update History**

January 1, 2017 – Initial Publication

February 1, 2017 – Expanded list of provider types allowed to order physical and occupational therapy

June 13, 2017 – Removed separate policy language around robotic therapy

September 12, 2017 – Added reference to IHCP ABA PA Checklist
Transplant Services

This information has been incorporated into the Surgical Services provider reference module.
Transportation Services

This information has been incorporated into the Transportation Services provider reference module.
**Traumatic Brain Injury Program**

**Description of Service**

Traumatic brain injury (TBI) is an injury sustained after birth from physical trauma, an anoxia or hypoxic episode, allergic conditions, toxic substances, or other acute medical clinical incidents resulting in psychological, neurological or anatomical changes in brain functions. Traumatic brain injury does not include:

- Strokes that can be treated in nursing facilities providing routine rehabilitation services;
- Spinal cord injuries for which there are no known or obvious injuries to the intracranial central nervous system;
- Progressive dementias and other mentally impairing conditions;
- Depression and psychiatric disorders in which there is no known or obvious central nervous system damage;
- Intellectual disability and birth defect related disorders of long standing nature; or
- Neurological degenerative, metabolic, and other medical conditions of a chronic, degenerative nature.

Each brain injury is unique. A brain injury may be mild, with a brief change in mental status, moderate, with a loss of consciousness, or severe, causing a prolonged coma. Mild, moderate and severe brain injuries can lead to long-term symptoms and the potential for permanent disability. The outcome following a brain injury depends on several factors including:

- Nature and severity of the brain injury
- Type and degree of any resulting impairments and disabilities
- Overall health of the patient
- Family support
- Quality of the rehabilitation care

TBI services are provided based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function.
Medical Policy
Reimbursement of TBI Services

The IHCP provides reimbursement for TBI services when the services are provided in compliance with all IHCP guidelines, including obtaining prior authorization, for members who have been determined to meet eligibility.

Reimbursement for TBI services is determined based upon the member’s level of need in each of the ten (10) domains listed below and the total score of the 10 domains. Based upon the domain total the member will fall within one (1) of four (4) levels of service reimbursement categories which are described in the Level of Service section of this policy.

Domains

<table>
<thead>
<tr>
<th>Domains</th>
<th>Level of Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential</td>
<td>• Low: basic residential services</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate assist with residential living</td>
</tr>
<tr>
<td></td>
<td>• High: significant assistance with residential needs</td>
</tr>
<tr>
<td>Case Management</td>
<td>• Low: minimal logistical assistance</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate coordination of care and family engagement</td>
</tr>
<tr>
<td></td>
<td>• High: significant management of complex medical and social issues</td>
</tr>
<tr>
<td>Medical Management</td>
<td>• Low: routine medical care</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate basic medical services and care delivery</td>
</tr>
<tr>
<td></td>
<td>• High: significant and complex medical services</td>
</tr>
<tr>
<td>Speech/Language Therapy</td>
<td>• Low: maintenance services for speech and language skills</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate frequency of speech therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive speech therapy for language, speech, and receptive skills</td>
</tr>
<tr>
<td>Productive Activity/Physical Therapy</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional staff</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional staff</td>
</tr>
<tr>
<td>Service Type</td>
<td>Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td></td>
</tr>
<tr>
<td>Vocational Therapy</td>
<td></td>
</tr>
<tr>
<td>Neuro-cognitive Therapy</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health/Psychiatric</td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td></td>
</tr>
</tbody>
</table>

### Scoring of Domains

<table>
<thead>
<tr>
<th>Scoring of the Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>An assessment is utilized to review each case based upon ten domains of service and the intensity of service within each discipline as well as services provided to that member during the review process. Services will be rated on a 1 to 3 scale, e.g.</td>
</tr>
<tr>
<td>1------------2-----------3</td>
</tr>
<tr>
<td>Low</td>
</tr>
</tbody>
</table>

### Level of Services Reimbursement Categories

The goal of TBI rehabilitation is re-integration into the community. The member’s ability to live at home and/or in the community is related to the severity of the illness (SI) and intensity of services (IS). The member’s needs must be balanced with the resources available in the recovery environment. These resources include:

- Physical health care needs
- Behavioral health care needs
- Cognitive Impairments
- Safety needs, and
- Other support needs
The IHCP has developed four (4) levels of service reimbursement categories utilizing the ten domains of service, identifying the severity of the illness and the intensity of services required by each member. The four levels of service are described below.

Level I – Intense NeuroRehabilitation/NeuroBehavioral Programming

Level I is assigned to members who require immediate admission into a TBI program in order to receive intensive therapy and may be appropriate for up to the first four (4) months of intervention. Members requiring additional days after the first four (4) months for level 1 services will be reviewed on a case-by-case basis.

Members must demonstrate needs in the following areas:

Cognitive/Behavioral Needs
- Cognition – memory, impulsivity, poor judgment, lack of initiation, poor problem solving, poor social skills which significantly impact safety and well being
- Unwanted behaviors – including demonstration of, frequency and intensity of high risk behaviors secondary to the brain injury
- Non-compliance with traditional therapies due to cognitive/behavioral barriers.
- Crisis intervention and ultra-high risk support

Safety Needs
- Supervision – may require additional one on one supervision for behaviors
- Environment – may require durable, secure, highly supervised living environment to decrease risk to self or others.

Physical Health Care Needs
- Medical needs requiring daily nursing availability to ensure safety/wellbeing
- Medication management
- Coordination of physician specialists and/or any orthotic/prosthetic devices
- Pharmacological intervention through psychiatrist consults and medically necessary therapeutic interventions in all of the areas listed below.
- Residential

Other Needs
- Transportation/Escort
- Interagency communication/coordination
- Family/Caregiver Training
• Available continuum of treatment/environmental options to practice skill acquisition and simulate discharge environment.
• Begin discharge planning as part of the program to match home community based services in Indiana

Requires therapeutic interventions in the following areas
• Residential
• Case Management
• Medical Management
• Speech Language Therapy
• Productive Activity/Physical Therapy
• Occupational Therapy
• Rehabilitation Therapy
• Vocational Therapy
• Neuro-cognitive Therapy
• Mental/Behavioral Health

Level I may be appropriate for up to the first 4 months of intervention.

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>30</td>
<td>$ 567</td>
</tr>
<tr>
<td>Level I</td>
<td>28 – 29</td>
<td>$ 541</td>
</tr>
<tr>
<td>Level I</td>
<td>26 – 27</td>
<td>$ 509</td>
</tr>
</tbody>
</table>

Members at level 1 will have a total domain score between 26 and 30.

**Level II – Active NeuroRehabilitation/NeuroBehavioral Step-Down Program**

Level II offers individualized support needed at any time, specifically during times of crisis, and a member may require or be provided additional residential and programmatic support. The team may change the intensity of assistance from time to time, while taking advantage of certain “therapeutic windows”. Regardless of the setting or type of program, rehabilitation interventions are intended to help members practice strategies to remain free from harm and attain personal goals that are durable over time. Discharge planning efforts continue to be geared toward exploring and securing living environments, therapeutic services, and productive activities that match the needs and desires of the member with a focus on returning to the home community.

Level II members’ have made progress in active rehabilitation and exhibit the following needs:
• Training in self-management of behavioral, cognitive, and/or medical/physical challenges

• Continues to require specialized therapeutic intervention in the following areas although at a reduced frequency and duration
  
  o Residential
  o Case Management
  o Medical Management
  o Speech Language Therapy
  o Productive Activity/Physical Therapy
  o Occupational Therapy
  o Rehabilitation Therapy
  o Vocational Therapy
  o Neuro-cognitive Therapy
  o Mental/Behavioral Health

• Still unable to access their home environment, independent living options, or transitional supported living due to the continual unwanted behaviors or the significant cognitive/physical challenges.

• Ready to engage in therapeutic interventions geared toward maintaining the durability of goals achieved as well as continued work on upgraded objectives

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level II</td>
<td>25</td>
<td>$477</td>
</tr>
<tr>
<td>Level II</td>
<td>23 – 24</td>
<td>$445</td>
</tr>
<tr>
<td>Level II</td>
<td>21 – 22</td>
<td>$413</td>
</tr>
</tbody>
</table>

Members at level II will have a total domain score between 21 and 25.

Level III: NeuroRehabilitation/NeuroBehavioral Step Down Program

Level III members’ have made progress in more intensive, active rehabilitation and require reduced formal clinical service delivery. Members who are appropriate for this level of program will transition into a residential and programmatic continuum designed to replicate the type of support the person will experience once they return to their home community. Members will continue to practice strategies to increase independence, safety, and behavioral self-management while pursuing discharge placement in the discharge community. During times of crisis, a member may require or be provided additional residential and programmatic support.
the crisis maintains, the member may need to move to Level I or II with the corresponding rate until stabilized.

Level III places strong emphasis on discharge planning as the member continues to practice skills attained and prepares for transfer to an alternative environment or to reside in the most independent environment possible.

Level III members’ exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral, or medical strategies to minimize health and safety risk.
- Continues to require specialized therapeutic intervention in the following areas although at a reduced frequency and duration:
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
  - Occupational Therapy
  - Rehabilitation Therapy
  - Vocational Therapy
  - Neuro-cognitive Therapy
  - Mental/Behavioral Health
Level III Per Diem Rates

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level III</td>
<td>20</td>
<td>$381</td>
</tr>
<tr>
<td>Level III</td>
<td>16 – 19</td>
<td>$349</td>
</tr>
</tbody>
</table>

Members at level III will have a total domain score between 16 and 20.

Level IV: NeuroRehabilitation/Neurobehavioral Step-Down Support Services

Level IV members' have made progress in more intensive, active rehabilitation and are appropriate for step down services to maintain goals achieved through supportive services. Members who are appropriate for this level of step down support services will attempt to replicate the type of interventions the individual will experience once they return to their home community. Members will continue to practice learned strategies to increase independence, safety, and behavioral self-management while pursuing discharge placement in the appropriate community. During times of crisis, members may require or be provided additional residential and programmatic support. If the crisis maintains, the member will be recommended to a move to Level I, II, or III with the corresponding rate until stabilized.

Level IV places a strong emphasis on discharge planning as the member continues to practice skills attained and maintain those skills designed to meet future placement needs in the home community.

Level IV members’ exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral, or medical strategies to maintain current health and overall functioning level.
- Continues to require specialized therapeutic intervention at a moderate level in the following areas although at a reduced frequency and duration:
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
  - Occupational Therapy
- Rehabilitation Therapy
- Vocational Therapy
- Neuro-cognitive Therapy
- Mental/Behavioral Health

**Level IV Per Diem Rates**

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level IV</td>
<td>15</td>
<td>$ 317</td>
</tr>
<tr>
<td>Level IV</td>
<td>10 – 14</td>
<td>$ 285</td>
</tr>
</tbody>
</table>

Members at this level will have a total domain score between 10 and 15.

**Per Diem Rates**

The total score of the domains determines the billing level and reimbursement rate. Rates are adjusted according to the level of intensity, on a scale of 1-3, as evidenced by medical necessity based upon the member’s individual needs. All reimbursement rates are directly communicated to the facility via the Notice of Action (Admission or Extension) letter. Each member’s reimbursement rate is reviewed at the time of the clinical reassessment and the extension request. Table 7 – TBI Per Diem Rates is utilized to determine the rate for reimbursement for the prospective period. Level assignment and rate determinations will be based upon the information supplied by the TBI facility from documentations submitted for review and dialogue from collaborative case rounds with the Prior Authorization Vendor.

The per diem rates include the following services:

- Room and board
- Staffed residence
- Therapeutic interventions

**TBI Per Diem Rates**

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>30</td>
<td>$ 567</td>
</tr>
<tr>
<td>Level I</td>
<td>28 – 29</td>
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<td>20</td>
<td>$ 381</td>
</tr>
</tbody>
</table>
Level III | 16 – 19 | $ 349
Level IV | 15 | $ 317
Level IV | 10 – 14 | $ 285

**Prior Authorization**

Prior Authorization is required for TBI services per 405 IAC 5-5. The IHCP does not reimburse providers for any services requiring prior authorization unless prior authorization is obtained first.

**Admission Requests**

Placement within a TBI facility is available to members who have been determined to meet eligibility. Qualifications for enrollment in the TBI-program include (but are not limited to) the following:

- Diagnosis of Traumatic Brain Injury
  - The injury resulted from an acute anoxic event or brain injury caused by external trauma
- Medical need for long term neuro-cognitive rehabilitation
- Therapeutic benefit from rehabilitation services proposed is reasonable
- Acute services for brain injury and other services within Indiana must have been considered and utilized when available
- Formal clinical assessment for need of long term rehabilitation has been conducted by brain injury specialists within Indiana
- Member must be 18 years of age or older.
  - Requests for admission for members under age 18 will be reviewed on a case-by-case basis

Consideration of admission includes submission of documentation to support the following criteria:

- Diagnosis of Traumatic Brain Injury
- Rancho Los Amigos Levels of Cognitive Functioning level of V or greater and/or
- Mayo-Portland Adaptability Inventory (MPAI-4)
- The member’s current residence/living situation
- Summary of the member’s complete medical history, including
  - past hospitalizations
  - rehabilitation services
"Medical Policy Manual
Office of Medicaid Policy & Planning

- initial date of any head injury
- history of previous head injury or cerebral harm
- history of pre-injury behavior and social condition (including history of drug abuse, abuse, or police arrests)

- Evidence of behavioral problems including
  - aggressiveness
  - sexual inappropriateness
  - danger to self or others

- Neuropsychiatric evaluation (if completed)
- Psychiatric history (including depression, suicide, etc)
- Ability to participate in a minimum of 3 hours of therapy per day
- Free of mental illness or illicit drug use
- Medically stable
- A reasonable expectation for improvement with therapy
- A reasonable expectation that the member would be eligible to return to his/her community for ongoing services upon completion of program
- Head injury that is no more than 4 years old; exceptions include
  - Member has had no previous treatment for their TBI
- Cannot be placed and adequately cared for in any in-state facility
- The member must meet one of the four (4) levels of need

All TBI admission requests are reviewed by the Prior Authorization (PA) Vendor on a case-by-case basis. The PA vendor determines the medical necessity for placement and if appropriate services are available to address the member’s needs within Indiana. When members qualify for placement, the level of services provided is reviewed as submitted by the requesting facility.

Extension Requests

Providers must submit a re-assessment of the member’s functional status along with the extension request. The re-assessment is utilized to review each case based upon the ten domains of service, the intensity of service within each discipline, as well as services provided to the member during the review process, and initial or ongoing discharge planning efforts.

Each domain will be evaluated by the Prior Authorization Vendor as documented in the extension request and a determination will be made based upon the member’s level of need in each of the ten (10) domains.

Hearing & Appeals Procedures
Requests for the Administrative Review, Appeals, & Hearing process are consistent with the procedures as outlined in the Prior Authorization provider reference module.

**Billing and Coding**

Once a member’s stay has been authorized for admission or an extension, the authorization will be approved with one of the 10 HCPCS procedure codes listed below. Providers must bill on the UB-04 claim form utilizing the authorized HCPCS procedure code along with the usual and customary charges. Billing, payment, and enrollment is contingent upon member’s Medicaid eligibility.

**TBI HCPCS Codes and Rates**

<table>
<thead>
<tr>
<th>HCPC Code</th>
<th>Rate</th>
<th>Billing Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2013 UB</td>
<td>$567</td>
<td>Level I</td>
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<tr>
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<td>H2013 U1</td>
<td>$285</td>
<td>Level IV</td>
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</tbody>
</table>

The following services are included in the per diem rate:

- Room and board
- Staffed residence
- Therapeutic interventions

**Member Leave Days**

The IHCP no longer covers “bed hold” days in a TBI facility as a member benefit. This change impacts all IHCP members receiving long term neuro-cognitive rehabilitation in the TBI facilities. Facilities must make members aware of their policies and that members cannot be charged for services that they do not request or that are not provided.

**Rules and Citations**

405 IAC 5
- 405 IAC 5-5-1 Services; General
• 405 IAC 5-3 Prior Authorization

IHCP Provider Bulletins

• BT201127 The IHCP eliminates reimbursement for targeted case management

IHCP Provider Banners

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
Vision Services

This information has been incorporated into the Vision Services provider reference module.