INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Behavioral Health Services

Mental Health and Addiction Treatment

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3.0	Policies and procedures as of July 1, 2021 Published: Feb. 22, 2022	Scheduled update: • Revised content throughout the module to reflect policy and procedure changes since the previous version • Reorganized and edited text as needed for clarity • Renamed module *Behavioral Health Services* and made changes as needed throughout module • Merged applicable information regarding mental health and addition services from the *Medical Policy Manual*	FSSA and Gainwell

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Section 1: Introduction

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the* ***fee-for-service (FFS)*** *delivery system. For information about services provided through the* ***managed care*** *delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

The Indiana Health Coverage Programs (IHCP) provides coverage for inpatient and outpatient behavioral health services – including mental health and addiction treatment services – in accordance with the coverage, prior authorization (PA), billing and reimbursement guidelines presented in this document.

Subject to the limitations specified in the Indiana Medicaid State Plan and *Indiana Administrative Code 405 IAC 5-20-1*, IHCP reimbursement is available for behavioral health services performed by providers including but not limited to the following:

- Psychiatric hospitals
- General hospitals
- Psychiatric residential treatment facilities (PRTFs) for children under 21 years of age
- Outpatient mental health facilities
- Community mental health centers (CMHCs)
- Licensed physicians (including psychiatrists)
- Psychologists endorsed as health service providers in psychology (HSPPs)
- Other licensed professionals

Managed Care Considerations for Behavioral Health Services

Other than services that are specifically carved out of the managed care delivery system, behavioral health services rendered to Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise members should be billed to the managed care entity (MCE) with which the member is enrolled, or to the behavioral health organization (BHO) subcontracted by that MCE, if applicable.

When furnished to members enrolled in a managed care program, services (other than carved-out services) that require PA must be prior authorized by the member's MCE (or the subcontracted BHO) in accordance with the MCE guidelines. For more information, see the *Healthy Indiana Plan*, *Hoosier Care Connect* and *Hoosier Healthwise* pages at in.gov.

Carved-Out and Excluded Services

Most behavioral health services are carved in to HIP, Hoosier Care Connect and Hoosier Healthwise. However, the following behavioral health services are **carved out** of the managed care programs and are billed and paid according to the fee-for-service methodology:

- Medicaid Rehabilitation Option (MRO) services rendered to individuals, families or groups living in the community who need aid intermittently for emotional disturbances or mental illness
- 1915(i) State Plan Home and Community-Based Services (HCBS), including the following:
  - Adult Mental Health and Habilitation (AMHH) services
  - Behavioral and Primary Healthcare Coordination (BPHC) services
  - Child Mental Health Wraparound (CMHW) services

The following services are **excluded** from managed care programs, and members are disenrolled or suspended from managed care and moved to a fee-for-service program when they qualify for such services:

- PRTF services rendered by a provider enrolled in the IHCP with a specialty of 034
  - See *Section 6: Psychiatric Residential Treatment Facilities* for more information.
- Long-term care services in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disability (ICF/IID)
  - See the *Long-Term Care* module for information on short-term stays that are covered by MCEs.
- Services provided to members who are residents of a 590 Program facility (such as a state psychiatric hospital)
  - See the *590 Program* module for details about this program.
- Services provided through a 1915(c) HCBS waiver or Money Follows the Person (MFP) demonstration grant, including the following:
  - Aged and Disabled (A&D) Waiver services
  - Traumatic Brain Injury (TBI) Waiver services
  - Community Integration and Habilitation (CIH) Waiver services
  - Family Supports Waiver (FSW) services

Section 2: Outpatient Behavioral Health Services

Outpatient behavioral 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.

For information about outpatient mental health services provided in a comprehensive outpatient rehabilitation facility (CORF), see the *Therapy Services* module. For information about both surgical and nonsurgical treatments for temporomandibular joint (TMJ) syndrome, including psychiatric/ psychological therapy, see the *Surgical Services* module.

Outpatient Behavioral Health – Professional Services

For Indiana Health Coverage Programs (IHCP) reimbursement of professional behavioral health services delivered on an outpatient basis, providers must identify and itemize services rendered on the professional claim (*CMS-1500* claim form, Provider Healthcare Portal [Portal] professional claim or 837P electronic transaction). Providers should bill one unit per encounter/session/date of service. The medical record documentation must identify the services and the length of time of each therapy session. Providers must make this information available for audit purposes.

Behavioral Health Practitioner Qualifications

The IHCP reimburses for outpatient behavioral health services rendered by the practitioners listed in Table 1.

As indicated in the table, all but one of these practitioners are eligible to enroll in the IHCP (under the provider type and specialty noted in the table) and bill directly for services as the rendering provider on the claim. See the *Billing and Reimbursement for Behavioral Health Practitioners* section for more information.

The IHCP reimburses for outpatient behavioral health services only if a qualifying practitioner certifies the diagnosis and supervises the treatment plan. Table 1 indicates which practitioners are eligible to perform these functions. See the *Certification of Diagnosis and Supervision Requirements for Behavioral Health Practitioners* section for more information.

Table 1 – Practitioners That Can Perform Outpatient Behavioral Health Services

Practitioner Qualifications	Can Enroll in the IHCP and Bill Directly as the Rendering Provider	Can Certify Diagnoses and Supervise Treatment Plans
Licensed physician (including licensed psychiatrist)	Yes; provider type 31	Yes
Licensed health service provider in psychology (HSPP)	Yes; provider type 11, specialty 114	Yes
Licensed clinical social worker (LCSW)	Yes; provider type 11, specialty 618	Yes
Licensed mental health counselor (LMHC)	Yes; provider type 11, specialty 620	Yes
Licensed marriage and family therapist (LMFT)	Yes; provider type 11, specialty 619	Yes
Licensed clinical addiction counselor (LCAC)	Yes; provider type 11, specialty 621	Yes
Licensed advanced practice registered nurse (APRN) with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing	Yes; provider type 09, specialties 090–093 and 095	Yes
Licensed psychologist	Yes provider type 11, specialty 616	No
Licensed independent practice school psychologist	Yes; provider type 11, specialty 617	No
Licensed physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *IC 25-27.5-5*	Yes; provider type 10, specialty 100	No
Individual who has completed a master's or doctoral degree in any of the following disciplines: • Social work from a university accredited by the Council on Social Work Education • Mental health counseling from an accredited university • Marital and family therapy from an accredited university	No	No

> *Note: In certain cases, the IHCP reimburses for behavioral health services rendered by an individual with qualifications* ***other than*** *those described in Table 1. For examples, see the Applied Behavior Analysis Therapy, CMHC Interns and Community Health Workers sections of this module.*

IHCP reimbursement for provider specialties 616-621 is limited to designated services only. For a list of procedure codes allowed for these practitioners, see the *Covered Procedure Codes for Behavioral Health Provider Specialties 616–621* table in *Mental Health and Addiction Services Codes*, accessible from the Code Sets page at in.gov/medicaid/providers.

Certification of Diagnosis and Supervision Requirements for Behavioral Health Services

Reimbursement for all outpatient behavioral health services requires that a physician, HSPP, LCSW, LMFT, LMHC, LCAC or APRN certify the diagnosis and supervise the plan of treatment.

The supervising practitioner must be available for emergencies and must see the patient or review the information obtained by the rendering practitioner within seven days of the intake process. During the course of treatment, at intervals not to exceed 90 days, the supervising practitioner must see the patient again or review the documentation to certify the treatment plan and specific treatment modalities. All reviews must be documented in writing; a cosignature is not sufficient.

Billing and Reimbursement for Behavioral Health Practitioners

Behavioral health services rendered by practitioners who are not enrolled in the IHCP must be billed using the National Provider Identifier (NPI) of the supervising practitioner as the rendering provider and the NPI of the clinic, facility or other enrolled billing entity as the billing provider. The procedure code must be billed with modifier **HE** – *Services provided by any behavioral health practitioner (excluding physicians, HSPPs and physician assistants*).

> *Note: As of Nov. 16, 2021, the IHCP no longer encourages use of the following modifiers to signify the qualifications of the provider that rendered the behavioral health service:*
>
> - AH – *Services provided by a clinical psychologist*
> - AJ – *Services provided by a clinical social worker*
> - HF – *Substance abuse program services provided by an LCAC*
>
> *Instead, only the HE modifier is encouraged to signify behavioral health services rendered by* ***any*** *eligible practitioner and billed under a supervising practitioner's NPI.*

For behavioral health services provided by an APRN and billed under a supervising practitioner's NPI, modifier **HE** should be used in conjunction with modifier **SA**. Physicians, HSPPs and physician assistants are always required bill under their own NPI. See the *Medical Practitioner Reimbursement* module for additional billing and reimbursement guidance for APRNs and physician assistants.

Behavioral health practitioners that are enrolled in the IHCP may bill directly for services rendered, using their own NPI as the rendering provider on the claim. In some cases, IHCP-enrolled behavioral health practitioners (other than physicians, HSPPs and physician assistants) may *choose* to bill using a supervising practitioner's NPI and the appropriate modifier (HE or HE+SA). However, if the NPI of the IHCP-enrolled practitioner who rendered the service is used on the claim, then no modifier is needed.

> *Note: For billing purposes, if a behavioral health professional, such as an independent practice school psychologist, is employed by a school corporation that provides covered Individualized Education Program (IEP) services, claims must be billed using the enrolled school corporation's NPI as the rendering provider.*

Services rendered by the behavioral health practitioners in Table 1, other than physicians and HSPPs, are reimbursed at a reduced rate (**75%** of the allowed fee schedule amount), compared to the full amount paid when the service is rendered by a physician (such as a psychiatrist) or by an HSPP. (The Professional Fee Schedule is accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.) This reduction applies regardless of whether the service is billed using the rendering provider's own NPI, or under a supervising practitioner's NPI along with modifier HE or HE+SA.

The following sections describe two exceptions to the preceding billing and reimbursement guidance.

CMHC Interns

To address the shortage of mental health professionals in Indiana, effective Jan. 1, 2019, the IHCP allows reimbursement for services provided by interns in the community mental health center (CMHC) setting. The provider billing for these services must be enrolled with the IHCP as a CMHC (provider type 11, specialty 111). CMHCs that are owned by or affiliated with a hospital, however, are an exception to this allowance. CMHCs associated with hospitals may not bill separately for intern services because reimbursement for intern services is included in the hospital's medical education add-on to inpatient claims.

To qualify for reimbursement, the intern must be a graduate or postgraduate student currently enrolled in an accredited college or university program in one of the following fields of study:

- Medical (including physician assistant)
- Nursing
- Behavioral health (includes mental health and addiction treatment)

Further, the student must be approved by the college or university to work as an intern or practicum student at a CMHC.

For reimbursement, the intern must be supervised by an IHCP-enrolled practitioner that is employed by or under contract with the billing CMHC. The services rendered by the intern must be within the scope of practice of the supervising practitioner. The following billing guidance applies to services rendered by interns under the fee-for-service (FFS) delivery system:

- Services must be billed on a professional claim (*CMS-1500* claim form or electronic equivalent).
- The supervising practitioner should be listed as the rendering provider on the claim.
- The modifier **HL** (intern) should be used to indicate that the service was performed by an intern.
- FFS reimbursement for intern services is at **50%** of the-professional fee schedule amount published on the Professional Fee Schedule, accessible from the *Fee Schedules* page at in.gov/medicaid/providers.

Community Health Workers

For dates of service on or after July 1, 2018, the IHCP covers community health worker (CHW) services when the CHW meets certification requirements, is employed by an IHCP-enrolled billing provider and renders the service under the supervision of a qualifying IHCP-enrolled provider type, which includes physicians, HSPPs, APRNs and physician assistants. The supervising provider's NPI should be indicated as the rendering provider on the claim. The CHW's name must be included in the claim notes.

The following procedure codes are covered for billing CHW services:

- 98960 – *Self-management education & training, face-to-face, 1 patient*
- 98961 – *Self-management education & training, face-to-face, 2–4 patients*
- 98962 – *Self-management education & training, face-to-face, 5–8 patients*

The IHCP limits reimbursement for CHW services to four units (two hours) per day and 24 units (12 hours) per month per member.

Services provided by a CHW are reimbursed at the amount indicated on the IHCP Professional Fee Schedule, which is 50% of the base amount on the resource-based relative value scale (RBRVS).

Outpatient Behavioral Health – Facility Services

Facility claims associated with outpatient behavioral health services are reported using the appropriate clinic or treatment room revenue code on the institutional claim type (*UB-04* claim form, Portal institutional claim or 837I electronic transaction).

Providers must follow national coding guidelines for appropriate procedure codes to bill with revenue codes 513 –*Psychiatric Clinic* and *Behavioral Health Treatments/Services* revenue codes 900, 907, 914, 915, 916 and 918 to avoid the following outcomes:

- If one of these revenue codes is billed with a procedure code that is not linked to the revenue code according to national guidelines, the claim detail will be denied for explanation of benefits (EOB) 520 – *Invalid revenue code/procedure code combination*.
- If the claim detail is billed with one of these revenue codes and no corresponding procedure code is present on the claim, the detail will be denied for EOB 389 – *The revenue code submitted requires a corresponding HCPCS code*.

Revenue codes 900, 907, 914, 915, 916 or 918 are each restricted to one unit per member per billing provider per day. Payment is based on a treatment room methodology, with each revenue code paying at the flat rate indicated on the *Revenue Codes* tab of the Outpatient Fee Schedule, accessible from the *Fee Schedules* page at in.gov/medicaid/providers.

Providers cannot use revenue codes 500, 510 or 96X to bill FFS-covered outpatient behavioral health services.

> *Note: This restriction does not apply to claims for members who are dually eligible. Providers must continue to bill Medicare for dually eligible members following Medicare claim submission policy, which may include the use of revenue code 510. However, if using revenue code 513 when billing Medicare, providers must identify the service rendered to ensure that the claim detail will not be denied for one of the previously mentioned edits, and that the allowed amount is calculated appropriately.*

Providers must bill all *professional* services associated with outpatient behavioral health hospital services on the professional claim type (*CMS-1500* claim form or electronic equivalent).

Coverage and Requirements for Behavioral Health Services

The following sections provide information about coverage, prior authorization (PA) requirements and benefit limits for various behavioral health services, including substance use disorder (SUD) services, provided in an outpatient facility or office setting.

For information about **residential** SUD treatment services, see *Section 7: Residential Substance Use Disorder Treatment*.

> *Note: Specific criteria pertaining to PA for outpatient mental health services are found in 405 IAC 5-20-8. The PA requirements in this document should be used as a guideline for determining procedures requiring PA, but the IAC is the primary reference.*

Annual Depression Screening

The IHCP covers Healthcare Common Procedure Coding System (HCPCS) code G0444 – *Annual depression screening, 15 minutes*. This service is limited to one unit per member per provider per rolling 12-month period. PA is not required. Coverage is subject to limitations established for certain benefit plans.

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).

Applied Behavior Analysis Therapy

The IHCP provides coverage for applied behavior analysis (ABA) therapy when medically necessary for the treatment of autism spectrum disorder (ASD) for members 20 years of age and younger, within the parameters described in the following sections.

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.

ABA programs typically fall into either *focused* or *comprehensive* ABA treatment. The type of treatment may lend itself to different intensity of services. Total intensity of services includes both direct and indirect services (such as caregiver training and supervision). Hours may be increased or decreased based on the client’s response to treatment and current needs. Comprehensive services are typically rendered when individuals are early in their development. These services are not generally intended to be applied to older children or adolescents who are often more appropriate for focused intervention. Comprehensive services commonly target most areas of functioning and are intended to improve multiple skills. Focused intervention is intended to reduce dangerous or maladaptive behavior and strengthen more appropriate functional behavior.

Coverage Criteria for ABA Therapy

For IHCP coverage of ABA therapy services, the member must meet all the following criteria:

- The member has been diagnosed with ASD by a qualified healthcare provider, defined as one of the following:
  - Licensed physician (including licensed psychiatrists and pediatricians)
  - Licensed HSPP
  - Other behavioral health specialist with training and experience in the diagnosis and treatment of ASD
- A qualified healthcare provider (as defined under the previous bullet) has completed a comprehensive diagnostic evaluation of the member that meets both the following:
  - Uses the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) at the time of the evaluation
  - Includes a recommended treatment referral for ABA therapy services
- The member is no older than 20 years of age.

Practitioner Requirements for ABA Therapy

For IHCP reimbursement, ABA therapy services must be rendered by an appropriate practitioner. The following are appropriate practitioners for ABA therapy services:

- HSPP
- Licensed or board-certified behavior analyst, including the following:
  - Master's-level Board Certified Behavior Analyst (BCBA)
  - Doctoral-level Board Certified Behavior Analyst-Doctoral (BCBA-D)
  - Bachelor-level Board Certified Assistant Behavior Analyst (BCaBA)
- Credentialed Registered Behavior Technician (RBT)

ABA therapy services performed by a BCaBA or credentialed RBT must be under the direct supervision of a BCBA, BCBA-D or HSPP.

> *Note: When billed with the state-defined ABA codes that were effective for dates of service Feb. 6, 2016, through June 30, 2019, services performed by RBTs under the supervision of a BCBA, BCBA-D or HSPP reimbursed at 75% of the rate on file.*
>
> *Effective Jan. 1, 2019, the IHCP began covering the 2019 Category I ABA therapy procedure codes released in the 2019 annual HCPCS update as well as two previously released Category III ABA procedure codes (see the Billing Guidance for ABA Therapy section). The newly covered ABA therapy procedure codes are subject to all National Correct Coding Initiative (NCCI) guidelines and edits; allowances to bypass the medically unlikely edits are not in effect as was the case with the previous state-defined procedure codes. A "cutback" for services performed by RBTs is no longer applied.*

For dates of service on or after March 1, 2018, reimbursement of ABA therapy services will be made *only* to IHCP-enrolled providers with the following classifications:

- ABA therapists (provider type 11, provider specialty 615)
- School corporations (provider type 12, provider specialty 120)

To enroll with the IHCP under the ABA therapist provider specialty, the ABA therapist must have an NPI and hold a valid professional license as an HSPP or a valid board certification from the Behavior Analyst Certification Board as a BCBA or BCBA-D. ABA therapy services rendered by a BCaBA or RBT must be billed under the NPI of an IHCP-enrolled ABA therapist or school corporation.

For reimbursement of ABA therapy services, providers already enrolled as a licensed HSPP (provider type 11, specialty 114) must add the ABA specialty (615) to their enrollment profile, and qualifying group providers must have an enrolled ABA therapist linked to the service locations providing the ABA services. See the *Provider Enrollment* module for more information.

Enrolled school corporations continue to be reimbursed for ABA services as described in the *School Corporation Services* module.

Treatment Plan Requirements for ABA Therapy

The ABA therapy service provider (described in the *Practitioner Requirements for ABA Therapy* section) must develop an individualized treatment plan for each member receiving ABA therapy services. The treatment plan must be focused on addressing specific behavioral issues and community integration and must include a projected length of treatment. The treatment plan must be based on criteria such as the individual's needs, age, school attendance (including homeschooling) and other daily activities (excluding activities listed in the *Noncovered Services for ABA Therapy* section).

The treatment plan must include the following:

- Identification of the individual's behavioral, psychological, family and medical concerns
- Measurable short-term, intermediate and long-term goals that:
  - Are appropriate for the individual's age and impairment
  - Are based on standardized assessments relative to age-expected norms
  - Address the behaviors and impairments for which the intervention is to be applied
  - Include baseline measurements (and progress to date) in the following areas:
    - Social skills
    - Communication skills
    - Language skills
    - Adaptive functioning
    - Restricted, repetitive patterns of behavior, interests, or activities
    - Self-injurious, violent, destructive, or other maladaptive behavior
  - Anticipated timeline for achievement of the goal based on the initial assessment and subsequent interim assessments over the duration of the intervention
- The number of hours per week being requested, with justification and supporting documentation for the specific number of hours based on the individual's needs (giving consideration to the individual's age, school attendance requirements and other daily activities); see the *Service Limits for ABA Therapy* section for guidelines
- A clear schedule of services planned, and documentation that all identified interventions are consistent with ABA techniques
- Plans for parent/guardian training and school transition
- Documentation that ABA services will be delivered by an appropriate provider as described in the *Practitioner Requirements for ABA Therapy* section)

Prior Authorization Requirements for ABA Therapy

ABA therapy services require PA subject to the criteria outlined in *405 IAC 5-3*, with the exception that a BCBA may also submit a prior authorization request to the office for review and approval (according to *405 IAC 5-22-12(f)*).

The PA request for ABA therapy must include an individual-specific treatment plan, as described in the *Treatment Plan Requirements for ABA Therapy* section, as well as supporting documentation – including the comprehensive diagnostic evaluation as described in the *Coverage Criteria for ABA Therapy* section and documentation supporting the number of therapy hours being requested. Additional documentation may be requested to support medical necessity.

> *Note: Providers can use the IHCP Applied Behavior Analysis (ABA) Prior Authorization Checklist to prepare comprehensive PA requests for ABA therapy, which should reduce suspensions for requests for additional information. The checklist is relevant to PA information needed for both FFS and managed care ABA services. The checklist is available on the Forms page at in.gov/medicaid/providers.*

PA for the initial course of therapy may be approved for up to six months. To continue providing ABA therapy beyond the initial authorized time frame, providers must submit a new PA request and receive approval. PA requests for the **continuation** of ABA therapy may be approved when all of the following criteria are met:

- The member continues to meet criteria for ABA therapy. There should be documentation of symptoms that still meet criteria for autism and that would benefit from ABA.
- The individual-specific treatment plan is submitted with the following updates:
  - Measurable progress to date for each goal in the treatment plan
  - Revised anticipated timeline for achievement of each goal, based on both the initial assessment and subsequent interim assessments over the duration of the intervention
  - Clinically significant progress in the following areas:
    - Social skills
    - Communication skills
    - Language skills
    - Adaptive functioning
    - Behavior
  - Updates to any other section of the plan as applicable (hours per week, schedule of activities, plans for parent/guardian training and school transition)
- ABA services are delivered by an appropriate provider (see the *Practitioner Requirements for ABA Therapy* section)

Service Limits for ABA Therapy

Each PA request for ABA therapy services is limited to up to six months; PA requests for longer periods will not be approved.

The requested hours and treatment plan should be individualized to the child's needs. Up to 40 hours per week of ABA therapy services may be requested.

> *Note: Determinations for hours and duration of ABA therapy shall not be based on other therapies that do not address the specific behaviors being targeted or on any standardized formulas used to deduct hours based on daily living activities.*

Additional hours outside the authorized ABA therapy PA may be requested for a limited period if any of the following conditions occur:

- Sudden increase in self-injurious behaviors
- Sudden increase in aggression or aggressive behaviors
- Increase in elopement behaviors
- Regression in major self-care or language activities
- A shift in family or home dynamic
- Development of a health crisis or comorbidity that is not related to mental health

ABA therapy services extending beyond 40 hours per week of direct therapy must be medically necessary and require an additional prior authorization.

Noncovered Services for ABA Therapy

Reimbursement is **not available** when services do not meet medical necessity criteria or do not qualify as ABA therapy services. The following services are not covered under ABA therapy:

- Services that focus solely on recreational or educational outcomes
- Services that are duplicative of other covered services, such as services rendered under an individualized educational program (IEP) that address the same goals using the same techniques as the treatment plan

Billing Guidance for ABA Therapy

All ABA therapy services require PA and must be billed on a professional claim (*CMS-1500* form or its electronic equivalent) using the procedure codes listed in the *Procedure Codes for Applied Behavior Analysis Therapy* table in *Behavioral Health Services Codes* on the Code Sets page at in.gov/medicaid/providers.

> *Note: For PAs issued prior to Jan. 1, 2019, providers were required to bill ABA therapy services (for dates of service through June 30, 2019) with the appropriate modifier to indicate that services were for ABA therapy and to specify the educational level of the rendering provider:*
>
> - *U1 – ABA therapy service provided by BCBA, BCBA-D or HSPP*
> - *U2 – ABA therapy service provided by BCaBA*
> - *U3 – ABA therapy service provided by RBT*

As described in the *Practitioner Requirements for ABA Therapy* section, all ABA therapy claims for dates of service on or after March 1, 2018, must be billed under the NPI of a provider enrolled in the IHCP as specialty 615 – *ABA Therapist* or specialty 120 – *School Corporation.*

Crisis Intervention

Crisis intervention is a short-term emergency behavioral health service, available 24 hours a day, seven days a week. Crisis intervention includes, but is not limited to, the following:

- Crisis assessment, planning and counseling specific to the crisis
- Intervention at the site of the crisis (when clinically appropriate)
- Prehospital assessment

Crisis intervention may be provided to any eligible members who are at imminent risk of harm to self or others or who are experiencing a new symptom that places the member at risk.

The goal of crisis intervention is to resolve the crisis and transition the member to routine care through stabilization of the acute crisis and linkage to necessary services. Crisis intervention may be provided in an emergency room, crisis clinic setting or within the community. A face-to-face contact with the member is required to bill this service.

Crisis intervention services are billed using procedure code H2011 – *Crisis intervention service, per 15 minutes*.

Provider Reimbursement Restrictions

The following IHCP-enrolled providers may be reimbursed for this service when billing procedure code H2011 on the professional claim:

- Provider type 09 (Advanced Practice Registered Nurse), as defined in the *Behavioral Health Practitioner Qualifications* section
- Provider type 10 (Physician Assistant)
- Provider type 11 (Behavioral Health Provider)
  - Specialty 110 (Outpatient Mental Health Clinic)
  - Specialty 111 (Community Mental Health Center)
  - Specialty 114 (Health Service Provider in Psychology)
  - Specialty 616 (Licensed Psychologist)
  - Specialty 617 (Licensed Independent Practice School Psychologist)
  - Specialty 618 (Licensed Clinical Social Worker)
  - Specialty 619 (Licensed Marriage and Family Therapist)
  - Specialty 620 (Licensed Mental Health Counselor)
  - Specialty 621 (Licensed Clinical Addiction Counselor)
- Provider type 31 (Physician)

The following IHCP-enrolled facilities may be reimbursed for this service when billing procedure code H2011 with revenue code 900 or 914 on an institutional outpatient claim:

- Provider type 01 (Hospital)
  - Specialty 010 (Acute Care)
  - Specialty 011 (Psychiatric Facility)

Program Standards

The following program standards apply for crisis intervention:

- Crisis intervention does not require prior authorization.
- The supervising practitioner must be accessible 24 hours a day, seven days a week.
- Crisis intervention is a face-to-face service and may include contacts with the family and other nonprofessional caretakers to coordinate community service systems. These collateral contacts are not required to be face-to-face but must be in addition to face-to-face contact with the member.
- To bill crisis intervention, a face-to-face service must be delivered to the member.
- The provider must document action taken to facilitate the face-to-face visit occurring as follows:
  - For a member at imminent risk of harm to self or others – Within one hour of initial contact with the provider
  - For a member experiencing a new symptom that places the member at risk – Within four hours of initial contact with the provider
- Crisis intervention is, by nature, delivered in an emergency and nonroutine fashion.
- Crisis intervention should be limited to occasions when a member suffers an acute episode, despite the provision of other community behavioral health services.
- The intervention should be member-centered and delivered on an individual basis.

Limitations

The following limitations apply to crisis intervention services:

- Interventions targeted to groups are not billable as crisis intervention.
- Time spent in an inpatient setting is not billable as crisis intervention.
- Routine intakes provided without an appointment or after traditional hours do not constitute crisis intervention.
- Non-face-to-face services are not billable as crisis intervention

Intensive Outpatient Treatment

Intensive outpatient treatment (IOT) is covered for eligible members when the service is delivered as treatment for a behavioral health diagnosis and is rendered and billed as described in this section. Prior authorization is required.

IOT is a treatment program that operates at least three hours per day, at least three days per week. IOT is planned and organized with mental and behavioral health professionals and clinicians providing multiple treatment service components for rehabilitation of alcohol and other drug abuse or dependence in a group setting. IOT includes the following components:

- Individual and family therapy
- Group therapy
- Skills training
- Medication training and support
- Peer recovery services
- Care coordination
- Counseling

The IHCP requires the provision of at least 120 minutes of therapeutic interventions (for example, individual/family or group therapy) per three-hour session.

The following billing codes are applicable for IOT:

- Procedure code H0015 – *Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education*
- Procedure code S9480 – *Intensive outpatient psychiatric services, per diem*
- Revenue code 905 – *Behavioral health treatments/services – intensive outpatient services-psychiatric*
- Revenue code 906 – *Behavioral health treatments/services – intensive outpatient services-chemical dependency*

CMHCs may have interns perform these services, as described in the *CMHC Interns* section of this module.

Program Standards

The following program standards apply for IOT:

- IOT services require prior authorization.
- Regularly scheduled sessions, within a structured program, must be at least **three consecutive hours** per day and at least **three days** per week.
- IOT includes the following components: individual/family therapy, group therapy, skills training, medication training and support, peer recovery services, and care coordination.
- IOT must be offered as a distinct service.
- A psychologist or supervising practitioner (as defined in the *Behavioral Health Practitioner Qualifications* section) is responsible for the overall management of the clinical program.
- IOT must be provided in an age-appropriate setting for members younger than 21 years of age.
- IOT must be individualized.
- Access to additional support services (for example, peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated treatment, referral to other community supports) must be provided as needed.
- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when the service is in a group setting.
- Up to 20 minutes of break time is allowed during each session of three consecutive hours.
- IOT is available to members of all ages. A separate reimbursement rate applies for IOT services rendered to members who are younger than 21 years of age.

Limitations

The following limitations apply to IOT:

- One unit of the appropriate IOT code is equal to three or more hours, and only one unit is reimbursable per date of service.
- Members are not allowed to receive procedure code H0015 or revenue code 906 on the same date of service as H0020 – *Alcohol and/or drug services; methadone administration and/or services (provision of the drug by a licensed program)* regardless of the servicing provider.
- Members are not allowed to receive any combination of procedure code H0015, procedure code S9480, revenue code 905 or revenue code 906 on the same date of service regardless of the servicing provider.
- Members are limited to procedure codes H0015 and S9480 in a professional setting.
- Procedure codes are not allowed when billing revenue codes 905 or 906. Services will be considered stand alone and will be reimbursed a flat rate per day.
- Peer recovery services may not be billed by the same provider when performed on the same date of service as IOT.

> *Note: Any service that is less than three hours may not be billed as IOT, but may be billed as psychotherapy (if provider qualifications and program standards are met).*

Medication-Assisted Treatment Services for Opioid Use Disorder

Medication-assisted treatment (MAT) programs are covered by the IHCP. MAT services should be provided as part of a comprehensive treatment plan that is intended to help members who are suffering from an opioid use disorder (OUD).

IHCP members who are receiving MAT services are expected to discontinue the use of all illicit and nonprescribed drugs and alcohol. Drug testing should be conducted at random intervals to verify this discontinuance. Per Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines, testing will be done at least eight times per year.

Providers must conduct a full evaluation and medical exam. This exam should verify that the member suffers from an OUD, and MAT services are the most appropriate treatment options.

The IHCP covers the three medications that have been approved by the Food and Drug Administration (FDA) to be used to treat opioid dependence:

- Methadone
- Buprenorphine
- Naltrexone

For more information about these approved medications, see the *MAT Medications, Counseling, and Related Conditions* page of the SAMHSA website at samhsa.gov and the *Information about Medication-Assisted Treatment (MAT)* page of the FDA website at fda.gov. Each medication must be administered according to federal and state regulations in the appropriate clinical setting. See the *Buprenorphine Billing and Reimbursement* section for provider requirements specific to buprenorphine.

> *Note: The American College of Obstetricians and Gynecologists supports the use of either methadone or buprenorphine (with or without naloxone) in women who are pregnant or breastfeeding.*

Opioid Treatment Program Requirements

The IHCP provides coverage for services provided within an OTP when all requirements are met. OTP facilities must meet all state and federal licensure, staffing and procedural requirements. In addition, the facilities must be licensed by DMHA and be an IHCP-enrolled OTP provider. See *Title 440, Article 10 – DMHA Minimum Standards for the Provision of Services by Opioid Treatment Facilities and Programs* for additional OTP requirements.

For a member to qualify to receive methadone and related OTP services, the member must go through an initial screening and meet any and all medical necessity criteria used for opioid treatment program (OTP) services. Medications are required to be rendered in combination with counseling and behavioral therapy services.

Prior authorization 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.

Medical Necessity Criteria for OTP Services

OTP services are available to eligible IHCP members **age 18 and older** who meet the following medical necessity criteria:

- Must be addicted to an opioid drug
- Must have been addicted for at least one year before admission to the OTP
  - The following individuals are exempt from the one-year addiction requirement:
    - Members released from a penal institution – if the individual seeks OTP services within 6 months of release
    - Pregnant women
    - Previously treated individuals – if the individual seeks OTP services within two years after treatment discharge
- 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 OTS level of care, according to all six dimensions of the ASAM Patient Placement Criteria

Provider Requirements for OTP Services

Opioid treatment programs certified by the Indiana FSSA DMHA are required to enroll as IHCP providers. OTPs wanting to bill for the administration of methadone and other related services exclusive to OTPs must be enrolled under provider type 11 – *Behavioral Health Provider*, specialty 835 – *Opioid Treatment Program*. See the *Provider Enrollment* module for details.

The IHCP recognizes the following credentials for individuals rendering individual, group or family counseling services in an OTP setting:

- Physician (such as psychiatrist)
- HSPP
- Licensed psychologist
- LCSW
- LMFT
- LMHC
- LCAC
- Physician assistant
- APRN, as defined in *405 IAC 5-20-8-2*
- Individual credentialed in addiction counseling by a nationally recognized credentialing body approved by the Division of Mental Health and Addiction (DMHA)

Billing and Reimbursement for OTP Services

OTP providers (provider type 11, specialty 835) are reimbursed at a daily bundled rate that includes payment for required opioid treatment services. Providers should bill one unit of HCPCS code H0020 – *Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)* for each day a member presents for treatment.

Providers that allow members take-home doses of methadone must bill code H0020 with modifier UA – *Take home Methadone Dose (Medicaid Specific)* (H0020 UA) for each date of service for which a take-home dose of methadone is dispensed. Methadone dispensed for unsupervised, take-home use should be dispensed in alignment with federal opioid treatment standards, as stated in *42 CFR 8.12*.

The daily bundled rate for H0020 includes reimbursement for the following services:

- 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

In addition to services covered under the daily bundled rate, OTP providers may render and bill separately for the following services:

- A psychiatric diagnostic evaluation with medical services (Current Procedural Terminology [CPT®[1]] code 90792), subject to the limitations described in the *Psychiatric Diagnostic Evaluations* section
- Psychotherapy services (CPT codes 90832–90834 and 90836–90838) over and above the therapy covered under the bundled rate, available to individuals in the event of a relapse and subject to the limitations described in the *Psychiatric Services* section
  - Any psychotherapy services billed outside the bundled rate must be billed with modifier SC – *Medically necessary service or supply*.

All services billed outside the bundled rate are subject to postpayment review and must comply with all medical necessity requirements.

> *Note: Providers enrolled as OTP providers cannot be reimbursed for buprenorphine or naltrexone. To be reimbursed for these services, an OTP must be enrolled and must bill under another IHCP provider type and specialty appropriate for delivering these services.*

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Individuals who are presumptively eligible for the IHCP due to pregnancy are eligible for OTP services only if services are billed with specific pregnancy-related diagnoses. Providers are encouraged to use diagnosis codes O99.320, O099.321, O99.322 or O99.323, as appropriate. A comprehensive list of diagnosis codes for this benefit plan is available in *Presumptive Eligibility for Pregnant Women Codes* on the [Code Sets] page at in.gov/medicaid/providers.

Buprenorphine Billing and Reimbursement

Buprenorphine can only be prescribed when the provider has DATA 2000 waiver training provided by SAMHSA.

The following IHCP-enrolled providers may be reimbursed for buprenorphine (either oral or injected) when the drug is billed on a professional claim:

- Provider type 11 (Behavioral Health Provider)
  - Specialty 110 (Outpatient Mental Health Clinic)
  - Specialty 111 (Community Mental Health Center)
  - Specialty 114 (Health Service Provider in Psychology)
- Provider type 09 (Advanced Practice Registered Nurse)
  - Specialty 090 (Pediatric Nurse Practitioner)
  - Specialty 091 (Obstetric Nurse Practitioner)
  - Specialty 092 (Family Nurse Practitioner)
  - Specialty 093 (Nurse Practitioner [Other, for Example, Clinical Nurse Specialist])
  - Specialty 095 (Certified Nurse Midwife)
- Provider type 10 (Physician Assistant)
- Provider type 31 (Physician)

The following IHCP-enrolled facilities may be reimbursed for oral buprenorphine when the drug is billed with revenue code 636 – *Drugs requiring detailed coding* on an institutional outpatient claim:

- Provider type 01 (Hospital)
  - Provider specialty 010 (Acute Care)
  - Provider specialty 011 (Psychiatric Facility)

The buprenorphine injection (procedure code J0592) is also separately reimbursable to facilities for outpatient claims, but is not billed with revenue code 636.

For more information about billing buprenorphine, including prior authorization requirements for buprenorphine extended-release (Sublocade), see the *Injections, Vaccines and Other Physician-Administered Drugs* module.

NARCAN

Effective Jan. 10, 2020, the IHCP reimburses naloxone nasal spray, also known as NARCAN, when billed on a professional claim (*CMS-1500* form or electronic equivalent) or institutional outpatient claim (*UB-04* form or electronic equivalent). Providers should bill for this physician-administered drug using HCPCS code J3490 – *Unclassified drugs*.

Providers will be reimbursed 105% of the wholesale acquisition cost (WAC) of the National Drug Code (NDC) billed by the provider. Separate reimbursement is allowed under revenue code 636 – *Drugs Requiring Detailed Coding*. For reimbursement consideration, providers may bill the procedure code and revenue code together, as appropriate.

Observation Level of Care

IHCP-enrolled providers may be reimbursed for professional services rendered during a hospital stay for observation care when billing procedure codes 99217–99220 and 99224–99226 on a professional claim. Additionally, facilities enrolled with the IHCP as acute care or psychiatric hospitals may be reimbursed for observation level-of-care services when billing procedure codes 99217–99220 with revenue code 762 – *Specialty Services – Observation Hours* and procedure codes 99224–99226 with revenue code 761 – *Specialty Services –Treatment Room* on the institutional claim.

> *Note: For dates of service July 1, 2020, through March 31, 2021, procedure codes 99224–99226 could be billed with revenue code 762. For dates of service on or after April 1, 2021, these services can be billed with revenue code 761.*

Hospitals can retain members for up to three days (or 72 hours) when the member has not met criteria for inpatient admission but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. The hospital bills this observation period as an outpatient claim unless the member is subsequently admitted as an inpatient within 72 hours of the observation service, in which case, the observation period must be billed as part of the inpatient claim. For more information about inpatient hospital observation and care for evaluation and management, see the *Evaluation and Management Services* module.

Peer Recovery Services

Peer recovery services are covered for eligible members when delivered and billed as described in this section. Peer recovery services can also be referred to as *peer support* or *peer counseling* services. Peer recovery services are individual, face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills. Peer recovery services are billed using procedure code H0038 – *Self-help/peer service, per 15 minutes*.

Practitioner Qualifications

Peer recovery services must be delivered by individuals certified in peer recovery services per the Division of Mental Health and Addiction (DMHA) training and competency standards for a certified recovery specialist (CRS). Individuals providing peer recovery services must be under the supervision of one of the following practitioners:

- Physician (such as a psychiatrist)
- HSPP
- Licensed psychologist
- Independent practice school psychologist
- LCSW
- LMFT
- LMHC
- LCAC
- Physician assistant
- APRN, as defined in *405 IAC 5-20-8-2*
- Individual with a master's or doctoral degree in any of the following disciplines:
  - Social work from a university accredited by the Council on Social Work Education
  - Mental health counseling from an accredited university
  - Marital and family therapy from an accredited university

Program Standards

The following program standards apply for peer recovery services:

- Peer recovery services are available without prior authorization up to 365 hours (1,460 units) per rolling 12-month period.
- Additional units may be authorized via the PA process.

Psychiatric Services

Psychiatric services are billed using covered codes within the CPT code range 90785–90899.

Certain psychiatric codes *in combination* are subject to 20 units per member per provider per rolling 12-month period without prior authorization. For applicable codes, see the *Psychiatric Service Procedure Codes with 20-Unit Limit* table on *Mental Health and Addiction Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

For additional units beyond this limit, providers must attach a current treatment plan and progress notes explaining the necessity and effectiveness of therapy to the PA form. This information must be retained for audit purposes.

Psychiatric Diagnostic Evaluations

In accordance with *405 IAC 5-20-8 (14)*, IHCP reimbursement is available without prior authorization for **one unit** of psychiatric diagnostic evaluation interview examinations per member, per provider , per rolling 12-month period, billed using one of the following CPT codes:

- 90791 – *Psychiatric diagnostic evaluation*
- 90792 – *Psychiatric diagnostic evaluation with medical services*

All additional units of psychiatric diagnostic evaluations require prior authorization; with the exception that two units are allowed per rendering NPI per rolling 12-month period without PA when the member is separately evaluated by **both** of the following (one unit must be provided by each):

- A physician or HSPP
- Another behavioral health practitioner identified in the *Behavioral Health Practitioners Qualifications* section of this module.

CPT codes 90791 and 90792 are used for diagnostic assessments or reassessments, if required. These codes may not be billed on the same day as an E/M service performed by the same individual for the same patient. CPT codes 90791 and 90792 do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be billed on the same day as CPT codes 90791 or 90792.

Procedure code 90792 can be rendered only by a physician, HSPP, APRN or physician assistant.

Facilities enrolled with the IHCP as acute care or psychiatric hospitals may be reimbursed for 90791 or 90792 when billing the service on an outpatient claim along with revenue code 900 – *Behavioral Health Treatments/Services*.

Psychotherapy With Evaluation and Management on the Same Day

Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified healthcare professional. These services are reported using codes specific for psychotherapy performed with E/M services (90833, 90836 or 90838) as add-on codes to the E/M service. For a single provider to report both services individually, for separate reimbursement, the two services must be significant and separately identifiable to override the applicable National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits, as required by the Centers for Medicare & Medicaid Services (CMS).

Because CPT codes 90833, 90836 and 90838 are *medical* services, the IHCP does not reimburse for these codes if the service is rendered by a *nonmedical* provider such as a licensed behavioral health provider (other than an HSPP) or a nonlicensed individual.

If a practitioner who is billing under a supervising practitioner's NPI provides psychotherapy services to a member on the same date as their supervising practitioner provides the E/M service , both services can be billed under the supervising practitioner's NPI if the midlevel modifier **HE** is used for the stand-alone psychotherapy service. The **HE** modifier will override the applicable NCCI PTP edit.

Psychiatric Services With Health and Behavior Assessment or Intervention on the Same Day

For patients that require psychiatric services as well as health and behavior assessment or intervention, providers report only the predominant service preformed.

Psychological and Neuropsychological Testing

The IHCP requires PA for psychological and neuropsychological testing.

Psychological and neuropsychological testing corresponding to the following CPT codes must be provided by a physician, HSPP, APRN or physician assistant:

- 96132 – *Neuropsychological testing evaluation by qualified health care professional, first 60 minutes*
- 96133 – *Neuropsychological testing evaluation by qualified health care professional, additional 60 minutes*
- 96136 – *Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes*
- 96137 – *Psychological or neuropsychological test administration and scoring by qualified health care professional, additional 30 minutes*

With prior authorization, the IHCP provides reimbursement for the following psychological and neuropsychological testing CPT codes when rendered by any practitioner meeting the criteria (including supervision requirements, where applicable) in the *Behavioral Health Practitioner Qualifications* section of this module:

- 96138 – *Psychological or neuropsychological test administration and scoring by technician, first 30 minutes*
- 96139 – *Psychological or neuropsychological test administration and scoring by technician, additional 30 minutes*
- 96146 – *Psychological or neuropsychological test administration and scoring by single standardized instrument via electronic platform with automated result*

To ensure no duplication of services, providers are responsible for following national guidance when billing psychological and neuropsychological testing. When requesting PA, the provider must have a list of the tests or services to differentiate these psychological and neuropsychological testing codes.

Screening and Brief Intervention Services

The IHCP reimburses providers for screening and brief intervention (SBI) services. SBI identifies and intervenes with individuals 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.

The IHCP reimburses providers when they bill for SBI using either of the following procedure codes:

- 99408 – *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes*
- 99409 – *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes*

These CPT codes were developed by the American Medical Association (AMA) to make it possible for the healthcare system to "efficiently report screening services for drug and alcohol abuse." Providers can bill procedure code 99408 or 99409 only after an individual has been screened for alcohol or drug abuse by a healthcare professional.

SBI services currently do not require prior authorization.

Procedure codes 99408 and 99409 are limited to one structured screening and brief intervention per individual, every three years, when billed by the same provider. This screening and intervention visit does not count toward the number of annual office visits allowed per year for an individual.

SBI services are available for reimbursement only one time per year per member per provider.

Reimbursement for SBI services is restricted to the following place-of-service codes:

- 04 – *Homeless shelter*
- 11 – *Office*
- 20 – *Urgent care facility*
- 23 – *Emergency room*
- 50 – *Federally qualified health center (FQHC)*
- 72 – *Rural health clinic (RHC)*

Services performed at an FQHC or RHC are not subject to additional reimbursement beyond the traditional encounter rate set forth by the prospective payment system (PPS).

Tobacco Dependence Treatment

The IHCP reimburses for tobacco dependence treatment in accordance with *Indiana Administrative Code 405 IAC 5-37*, subject to limitations established for certain benefit packages. Treatment may include prescription of any combination of tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers *must* include counseling in any combination of treatment.

Providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself.

The IHCP does not require prior authorization for reimbursement for tobacco dependence treatment products or counseling.

Tobacco Dependence Drug Treatment

The IHCP covers tobacco dependence drug treatment (pharmacotherapy) for up to 180 days per member per calendar year. Treatment beyond 180 days within a calendar year will require the prescriber to document the medical necessity of continued treatment.

The IHCP reimburses pharmacy providers for tobacco dependence treatment products, including over-the counter products, only when a licensed practitioner prescribes them for a member. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may request that the patient sign a commitment to establish a "quit date" and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment.

> *Note: For more information about reimbursement of tobacco dependence pharmacotherapy products, see the Pharmacy Services module.*

Tobacco Dependence Counseling

Tobacco dependence counseling services must be prescribed by a licensed practitioner within the scope of license under Indiana law. The IHCP reimburses for tobacco dependence counseling rendered by the following licensed practitioners participating in the IHCP:

- Certified nurse midwife
- Clinical nurse specialist
- Dentist
- HSPP
- Licensed psychologist
- Licensed independent practice school psychologist
- LCAC
- LCSW
- LMFT
- LMHC
- Nurse practitioner
- Optometrist
- Pharmacist
- Physician
- Physician assistant
- Registered nurse*

A service performed by one of the preceding practitioners who is not enrolled in the IHCP is eligible for reimbursement if the claim is billed under the supervising practitioner's NPI.

Eligible practitioners that are not individually enrolled in the IHCP can bill for treatment services rendered through the IHCP-enrolled entity where services are provided. For example, pharmacists that are not individually enrolled can bill for treatment services through the IHCP-enrolled pharmacy for which they work.

Dentists may bill this service using Current Dental Terminology (CDT©[2]) procedure code D1320 – *Tobacco counseling for the control and prevention of oral disease*. All other eligible providers bill this service using the appropriate CPT procedure code based on the length of the session:

- 99406 – *Smoking and tobacco use intermediate counseling, greater than 3 minutes up to 10 minutes*
- 99407 – *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*

> *Note: For dates of service before July 1, 2021, tobacco dependence counseling had to be billed cumulatively, using one unit of procedure code 99407 along with modifier U6 for each 15 minutes of counseling delivered. The service was limited to a maximum of 150 hours (10 units) per member per calendar year, and a primary diagnosis code of F17.200–F17.299 was required.*
>
> *For dates of service on or after July 1, 2021, the service may be billed using 99406 for sessions of three to 10 minutes and 99407 for sessions greater than 10 minutes; modifier U6 should not be used. Additionally, dentists may bill the service using D1320. The IHCP also removed unit limits for the amount of tobacco dependence counseling that could be reimbursed, and no longer limits reimbursement to designated diagnosis codes.*

Providers must bill the usual and customary charge for the units of service rendered, and the IHCP calculates the final reimbursement amount. When providers furnish a service to the general public at no charge, including tobacco dependence counseling services, they cannot receive IHCP reimbursement for that service. The FSSA Program Integrity staff closely monitors adherence to this program limitation.

Transcranial Magnetic Stimulation

Effective for dates of service on or after March 21, 2019, the IHCP covers transcranial magnetic stimulation (TMS) for the treatment of depression for adults 18 years of age and older.

Prior Authorization for TMS Treatment

Coverage for TMS treatment requires prior authorization of medical necessity. Left prefrontal TMS of the brain is considered medically necessary for use with adults who meet the following criteria:

- Have a confirmed diagnosis of severe major depressive disorder (MDD) (single or recurrent episode)
- Have one or more of the following:
  - The patient has demonstrated resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to four trials of such agents, in the current depressive episode, from at least two different agent classes. (At least one of the treatment trials must have been administered as an adequate course of mono- or poly-drug therapy; antidepressants involving standard therapeutic doses of at least 4 weeks duration)
  - Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents with distinct side effects
  - History of response to TMS in a previous depressive episode (evidenced by a greater than 50% improvement in a standard rating scale for depression symptoms)
  - Is currently receiving or is a candidate for and has declined electroconvulsive therapy (ECT), and TMS is considered a less invasive treatment option
- Have undergone a trial of an evidence-based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms

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Provider Requirements for TMS Treatment

TMS services must be performed or supervised by a qualified provider. The following requirements must be met:

- The qualified provider must be a psychiatrist or neurologist who has completed and demonstrated proficiency in TMS treatment at a university-based training course or a company-sponsored training course.
- The qualified provider must personally supervise the initial individual motor threshold determinations, treatment parameter definition and course of TMS treatment planning.
- Subsequent delivery and management of TMS sessions may be performed by the qualified provider or an appropriately trained technician under the direct supervision of the qualified provider ensuring the patient has someone in attendance at all times during the TMS session.
- During subsequent delivery and management of TMS sessions, the qualified provider must meet face to face with the patient when there is a change in the patient's mental status or other significant change in clinical status.

Billing and Reimbursement for TMS Treatment

The following procedure codes are covered for the reimbursement of TMS services:

- 90867 – *Transcranial magnetic stimulation treatment (stimulates nerve cells in brain to improve symptoms of depression) [initial, including cortical mapping, motor threshold determination, delivery and management]*
- 90868 – *Transcranial magnetic stimulation treatment (stimulates nerve cells in brain to improve symptoms of depression), per session [subsequent delivery and management per session]*
- 90869 – *Transcranial magnetic stimulation treatment (stimulates nerve cells in brain to improve symptoms of depression) [subsequent motor threshold redetermination with delivery and management]*

For outpatient facility claims, these procedure codes must be billed with the appropriate revenue code. See *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers. For reimbursement information related to these codes, see the *Professional Fee Schedule* and the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Urine Drug Testing

The IHCP covers presumptive urine drug testing (UDT) and definitive UDT when medically necessary. For individuals being treated for SUD or opiates for chronic pain, providers should use UDT to assess for prescribed opioids, as well as other controlled substances and illicit drugs that increase risk for overdose when combined with opioids, such as nonprescribed opioids, benzodiazepines and heroin. See the *Laboratory Services* module for more information.

Medicaid Rehabilitation Option

Providers must use the HW modifier to denote MRO services, in addition to modifiers that identify the qualifications of the midlevel practitioner rendering the service and any other modifiers needed to indicate the service rendered. For information regarding MRO services, see the *Medicaid Rehabilitation Option Services* module.

1915(i) Home and Community-Based Services

When billing for home and community-based services provided through the Adult Mental Health and Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC) or Child Mental Health Wraparound (CMHW) programs, providers must bill with UB, UC and HA modifiers, respectively.

For more information about these programs, see the following modules:

- *Division of Mental Health and Addiction Adult Mental Health Habilitation Services*
- *Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services*
- *Division of Mental Health and Addiction Child Mental Health Wraparound Services*

Behavioral Health Services Rendered During the Same Visit as Primary Care Services

Primary care services and behavioral health services may be reimbursed for the same date of service when the services are rendered by the appropriate provider and the visits are for distinct purposes. The IHCP applies NCCI PTP edits, as required by the CMS. PTP edits are applied to pairs of services delivered by the same provider to the same member on the same date of service, regardless of whether the services are billed on the same or separate claims.

> *Note: The IHCP allows CMHCs to provide primary care services to IHCP members in accordance with IC 12-15-11-8. These services must be provided by IHCP-enrolled providers authorized to provide primary healthcare within their scope of practice and must be billed in accordance with IHCP guidelines.*

Noncovered Services

The IHCP does not cover the following behavioral health services:

- Biofeedback
- Broken or missed appointments
- Day care or partial day care
- Hypnosis
- Hypnotherapy
- Experimental drugs, treatments and procedures, including all related services
- Acupuncture
- Hyperthermia
- Cognitive rehabilitation, except for treatment of traumatic brain injury (TBI) (See the *Therapy Services* module for more information.)

Section 3: Inpatient Behavioral Health Services

Indiana Health Coverage Programs (IHCP) members must meet medical necessity to be eligible for acute psychiatric or substance use inpatient services. Reimbursement is available for inpatient care provided in a freestanding psychiatric hospital or in the psychiatric unit of an acute care hospital only when the need for admission has been certified. Short-term residential treatment for substance use disorder treatment is reimbursed on a per diem basis (see *Section 7: Residential Substance Use Disorder Treatment* for more information).

Inpatient behavioral health services provided to managed care members in acute care facilities are the responsibility of the managed care entity (MCE) in which the member is enrolled. The State requires MCEs to manage behavioral healthcare to promote comprehensive and coordinated medical and behavioral services for Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise members. This policy excludes psychiatric residential treatment facility (PRTF) services and Medicaid Rehabilitation Option (MRO) services, which continue to be carved out or excluded from managed care and paid on a fee-for-service basis, as well as long-term inpatient services in state-operated facilities.

Psychiatric Hospital Requirements

According to *Indiana Administrative Code 405 IAC 5-20-3*, a psychiatric hospital must meet the following conditions to receive IHCP reimbursement for inpatient services:

- The facility must be enrolled in the IHCP.
- The facility must maintain special medical records for psychiatric hospitals as required by *Code of Federal Regulations 42 CFR 482.61*.
- The facility must provide services under the direction of a licensed physician.
- The facility must meet federal certification standards for psychiatric hospitals.
- The facility must meet utilization review requirements.

The IHCP reimburses providers for inpatient services provided to eligible members in a certified psychiatric hospital (provider type 01, provider specialty 011) or a psychiatric unit of an acute care hospital (provider type 01, specialty 101). Certain restrictions apply for inpatient stays in a psychiatric hospital with more than 16 beds, as described in the following section.

Institutions for Mental Disease

As defined under *42 CFR 435.1010*, an institution for mental diseases (IMD) means a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

The IHCP provides coverage for inpatient stays in psychiatric hospitals that qualify as an IMD to members of all ages, when the stay is for substance use disorder (SUD) treatment, including treatment for opioid use disorder (OUD), or for serious mental illness (SMI). The following restrictions apply for members ages 21 through 64:

- Inpatient stays **for SUD treatment** in an IMD may be authorized for up to 15 days in a calendar month.

  If the member is enrolled in a managed care program and is awaiting placement in a state-operated facility, and the member's inpatient stay in the IMD exceeds 15 days in a calendar month, the member will be disenrolled from the managed care entity (MCE) and enrolled in Traditional

Medicaid. The MCE is responsible for ensuring that the member is properly transitioned with no gap in coverage. The *590 Program* module provides additional information regarding this process.

- Effective Jan. 1, 2020, the length of stay **for SMI** in an IMD will be authorized based on medical necessity. (Prior to Jan. 1, 2020, IMD stays for anything other than SUD treatment were noncovered for members ages 21–64.) In accordance with federal requirements, the IHCP will be required to achieve a statewide average length of stay of no greater than 30 days, and reimbursement will not be available for inpatient stays longer than 60 days. Claims submitted for inpatient stays more than 60 days will be denied.

For information about *residential* stays for SUD in facilities that qualify as an IMD, see *Section 7: Residential Substance Use Disorder Treatment*. Reimbursement is not extended to IMDs for residential stays for SMI.

Prior authorization (PA) is required for all inpatient stays. Providers are required to submit all appropriate documentation demonstrating medical necessity, as described in the *Prior Authorization for Inpatient Behavioral Health Services* section. The stay is reimbursed using the diagnosis-related group (DRG) payment methodology.

Reimbursement Methodology for Inpatient Behavioral Health Services

The IHCP reimburses for hospital inpatient claims on a hybrid system that consists of the following two distinct reimbursement methodologies:

- A diagnosis-related group (DRG) system that reimburses a per-case rate according to diagnoses, procedures, age, gender and discharge status
- A level-of-care (LOC) system that reimburses psychiatric, burn and rehabilitation cases on a per diem basis

The IHCP reimburses most inpatient psychiatric stays provided by freestanding psychiatric hospitals or psychiatric units of acute care hospitals at an all-inclusive, statewide LOC per diem rate. For a list of psychiatric DRGs excluded from the DRG system and reimbursed under the LOC system, see the *Inpatient Hospital Services* module.

The LOC per diem rate includes routine, ancillary and capital costs, with the following exceptions:

- Direct care services of physicians, including psychiatric evaluations, are excluded from the per diem rate and are billable separately by the rendering provider on the professional claim (*CMS-1500* claim form or electronic equivalent).
- Evaluation and management (E/M) rounding performed by a nurse practitioner (NP) or clinical nurse specialist (CNS) in the inpatient mental health setting is also reimbursed separately from the per diem rate paid to the facility. (CRNAs are excluded from this reimbursement policy.) E/M rounding includes initial, subsequent and discharge-day management. Rounding services provided by an NP or CNS in the inpatient mental health setting should be billed separately on the professional claim. These services can be billed under the National Provider Identifier (NPI) of the NP or CNS (if available), or under the physician's NPI with the addition of the SA modifier.

The per diem rate includes all other supplies and services provided to patients in inpatient psychiatric facilities, including psychiatric services, such as group and individual therapy, performed by an NP or a CNS, as well as services performed by HSPPs, clinical psychologists and clinical social workers, regardless of whether they are salaried, contracted or independent providers. Providers cannot bill these supplies and services separately.

See the *Inpatient Hospital Services* module for general information about inpatient stays, including billing and reimbursement for readmissions, outpatient services within three days of an inpatient stay, and inpatient stays that last fewer than 24 hours.

Observation Stays

Behavioral health observation stays in acute care hospitals and freestanding psychiatric hospitals are reimbursable as described in the *Evaluation and Management Services* module. 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.

Observation stays are reimbursed as an outpatient service unless the member is admitted for an inpatient stay within 72 hours of the service.

Reserving Beds

The IHCP reimburses providers for reserving beds in a psychiatric hospital (but not in a general acute care hospital) for hospitalization of fee-for-service members, as well as for a therapeutic leave of absence. In both instances, the IHCP reimburses the facility at one-half the regular per diem rate. Per *405 IAC 5-20-2,* the following criteria apply:

- Hospitalizations must be ordered by a physician for the treatment of an acute condition that cannot be treated in a psychiatric 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.
- Leaves of absence must be for therapeutic reasons and ordered by a physician, as indicated in the member's plan of care. The total length of time reimbursable for therapeutic leaves of absence is 60 days per calendar year per member.

In both cases, physician orders must be maintained in the member's file at the facility.

Prior Authorization for Inpatient Behavioral Health Services

The IHCP requires prior authorization (PA) for all psychiatric, rehabilitation and SUD inpatient stays. All requests for PA are reviewed on a case-by-case basis. If a PA request is denied, providers may appeal the denial as outlined in the *Prior Authorization Administrative Review and Appeal Procedures* section of the *Prior Authorization* module.

Providers must submit inpatient claims using the revenue code that has been authorized for the admission. The IHCP does not reimburse providers for days that are not approved for PA.

The facility is responsible for initiating the PA review process. Table 2 provides an overview of the PA process for inpatient admissions to freestanding psychiatric hospitals or psychiatric units of acute care hospitals. For detailed information, see the subsections following the table.

Table 2 – Inpatient Admission PA Policy Parameters for Freestanding Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals

Category	Requirements
Telephone Precertification and Written Certification of Need (*1261A* Form)	Emergency and nonemergency admissions to private, freestanding psychiatric hospitals or psychiatric units of acute care hospitals require telephone precertification review. For each admission, the facility is responsible for initiating this review with the appropriate PA contractor based on the program assignment of the member. The precertification review must be followed by a written certification of need submitted as an attachment via the Portal or by mail or fax. *State Form 44697 (R4/5-15)/OMPP 1261A*, *Certification of the Need for Inpatient Psychiatric Hospital Services* (*1261A* form) fulfills the requirement for a written certification of need submitted via the Portal or by mail or fax. The form is available for download from the *Forms* page at in.gov/medicaid/providers. *Note: Private freestanding psychiatric hospitals are required to submit the 1261A form to the appropriate PA contractor based on the program assignment of the member. State-operated facilities submit the 1261A form to the IHCP office.*
Certification of Need Requirements	Reimbursement is available for inpatient care provided in a freestanding psychiatric hospital or the psychiatric units of acute care hospitals only when the need for admission has been certified. The certification of need must be completed by the attending physician or staff physician for members 22 years old and older (or, for members 21 years old or younger, by the physician and an interdisciplinary team as described in *42 CFR 441.152(a)* and *42 CFR 441.153*). The certification of need must be completed as follows: • **For nonemergency admissions** – By telephone precertification review before admission, to be followed by a written certification of need submitted via the Portal or by mail or fax within 10 business days of admission • **For emergency admissions** – By telephone precertification review within 48 hours of admission (not including Saturdays, Sundays and legal holidays), to be followed by a written certification of need submitted via the Portal or by mail or fax within 14 working days of admission *Note: If the provider fails to call within 48 hours of emergency admission (not including Saturdays, Sundays and legal holidays), reimbursement is denied for the period from admission to the actual date of notification. Denial of the certification of need may be appealed as outlined in the Prior Authorization module.* • **For individuals applying for the IHCP while in the facility** –In writing, submitted via the Portal or by mail or fax within 10 business days of receiving notification of an eligibility determination and covering the entire period for which reimbursement is being sought • **For recertification** – In writing, submitted via the Portal or by mail or fax at least every 60 days after admission, or as requested by the Family and Social Services Administration (FSSA) or the appropriate PA contractor to recertify that the patient continues to require inpatient psychiatric hospital services

Category	Requirements
Plan of Care Requirements	In addition to the certification of need, an individually developed plan of care is also required for each member admitted: • For members 22 years old or older, the attending or staff physician must develop and submit a plan of care within 14 days of the admission date and must update the plan at least every 90 days. • For members 21 years old and younger, a physician and interdisciplinary team must develop and submit a plan of care within 14 days of the admission date and review the plan at least every 30 days. For specific plan of care requirements, see the *Plan of Care* section.
Basis for Reimbursement	Telephone precertification of medical necessity provides a basis for reimbursement only if adequately supported by the written certification of need submitted in accordance with the previously listed requirements. If the required written documentation is not submitted via the Portal or by mail or fax within the specified time frame, reimbursement is denied. The PA contractor (or, for State-operated facilities, the IHCP agency) reviews the written certification of need for each member and determines whether inpatient psychiatric care is warranted and what length of stay is justified given the member's medical needs. Reimbursement is denied for any days during the inpatient psychiatric hospitalization that are found to be not medically necessary.

Telephone Precertification

For IHCP reimbursement, all admissions to psychiatric units of acute care hospitals and to private, freestanding psychiatric hospitals require telephone precertification of medical necessity. If the provider fails to complete a telephone PA precertification, reimbursement will be denied from the admission to the actual date of notification.

Telephone precertification provides a basis for reimbursement only if adequately supported by a written certification of need, as described in the *Written Certification of Need* section.

PA Request Submission

As described in the *Prior Authorization* module, providers can submit PA requests for psychiatric or substance use disorder (SUD) inpatient admission electronically via the Provider Healthcare Portal (Portal) or by fax or mail using the appropriate form, as follows:

- For inpatient **psychiatric** services – *IHCP Prior Authorization Request Form* (universal PA form)
- For inpatient **SUD** treatment services – *Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form*

Both forms are available on the *Forms* page at in.gov/medicaid/providers.

PA requests for fee-for-service (FFS) members should be directed to Gainwell Technologies. PA requests for managed care members should be directed to the managed care entity (MCE) with which the member is enrolled.

All PA requests for psychiatric or SUD inpatient admission must include the required documentation, as described in the following sections.

Assessment Forms for Substance Use Disorder Inpatient Services

The IHCP requires providers to include specific documentation of the assessment or reassessment when requesting PA for residential SUD treatment. The documentation may be submitted as follows:

- On the Portal – Providers can complete the assessment and reassessment forms online when submitting the inpatient SUD treatment PA request through the Portal, as follows:
  - For the initial request – At the *Create Authorization* page, select **Substance Abuse** in the Service Type field and check the SUD Authorization checkbox to access the interactive *SUD Initial Assessment Form* panel and complete the form fields as indicated.
  - For extensions to an existing request – Select **System Update** on the *View Authorization Response* page for a previously approved SUD PA request to access the *SUD Reassessment Form* panel and complete the form fields as indicated.
- By fax or mail, using the following forms, available on the *Forms* page at in.gov/medicaid/providers:
  - *Initial Assessment Form for Substance Use Disorder Treatment Admission* – This assessment form must be completed and submitted as an attachment to the residential/inpatient SUD treatment PA request form for initial admissions.
  - *Reassessment Form for Continued Substance Use Disorder Treatment* – This assessment form must be completed and submitted with the *IHCP Prior Authorization System Update Request Form* to request an extension to an existing authorization for inpatient SUD treatment.

Written Certification of Need

All psychiatric and SUD treatment inpatient admissions, regardless of the setting, require a written certification of need. The *Certification of the Need for Inpatient Psychiatric Hospital Services* (*State Form 44697 [R4/5-15]/OMPP 1261A)*, referred to as the *1261A* form, satisfies the requirements for the written certification of need. The *1261A* form is available for download from the *Forms* page at in.gov/medicaid/providers. The *1261A* form must include detailed information to document the admission.

The PA contractor reviews each *1261A form* to determine whether the requested services meet medical necessity. For specific PA criteria, see the *Admission Criteria for Acute Inpatient Psychiatric and Substance Use Disorder Services* section. Authorization is denied for any days the facility cannot justify a need for inpatient care. Denial of a PA request may be appealed as outlined in the *Prior Authorization Administrative Review and Appeal Procedures* section of the *Prior Authorization* module.

> *Note: Managed care members may have different requirements that deviate from the 1261A requirements. Contact the member's MCE for details.*

Plan of Care

Along with the written certification of need, a written plan of care (POC) must also be submitted, with the PA request. A copy of the plan of care must be kept as part of the member's record.

Each Medicaid-eligible patient admitted to an acute psychiatric facility or unit must have an individually developed plan of care.

POC Development

All POCs must be developed within 14 days of the admission date. 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 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 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

For members 22 years old or older, the POC must be developed by the attending or staff physician. For members 21 years old or younger, the POC must be developed an interdisciplinary team that includes the following:

- At least one of the following professionals or combinations of professionals:
  - A board certified or eligible psychiatrist
  - A physician licensed to practice medicine or osteopathy, **and** a psychologist endorsed as a health service provider in psychology (HSPP)
  - A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, **and** an HSPP or licensed psychologist
- At least one of the following **additional** professionals qualified to make determinations regarding behavioral health conditions and treatments:
  - 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 registered nurse or RN who has specialized training or one year of experience treating people with mental illnesses
  - An occupational therapist who is registered with the National Association of Occupational Therapists and who has specialized training or one year of experience treating people with mental illnesses
  - A psychologist endorsed as a HSPP or a licensed psychologist
- The member and the member's parents, legal guardians or others to whose care or custody the member will be released following discharge

POC Periodic Review

For members 22 years old or older, the attending or staff physician must review and update the POC at least every 90 days. For members 21 years old and younger, the interdisciplinary team is responsible reviewing POCs at least every 30 days.

The POC will be reviewed to ensure that appropriate services are being provided and that they continue to be medically necessary. The reviewing physician (or interdisciplinary team) will also recommend necessary adjustments in the plan, as indicated by the member's overall adjustment as an inpatient. The periodic review and update of the POC must be in writing and must be part of the member's record.

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

Admission Criteria for Acute Inpatient Psychiatric and Substance Use Disorder Services

Members must meet medical necessity criteria at the time of admission to be eligible for acute inpatient psychiatric or substance use disorder (SUD) services. Providers are required to include all appropriate documentation demonstrating medical necessity for inpatient treatment with the PA request.

Criteria for Psychiatric Inpatient Admissions

Members with any of the following presenting factors may meet medical necessity for psychiatric inpatient services:

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

Emergency 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

Criteria for SUD Inpatient Admissions

Inpatient admissions for SUD must be to a psychiatric facility or unit. Admission to a general hospital floor is not indicated unless the medical services are required for life support and cannot be rendered in an SUD treatment unit or facility. For psychiatric hospitals with more than 16 beds, FFS members ages 21–64 are limited to short-term stays as described in the *Institutions for Mental Disease* section.

Admission criteria for inpatient stays for SUD treatment in all settings, including IMDs, will be based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, Level 4 (Medically Managed Intensive Inpatient Services). Providers are required to include all appropriate documentation demonstrating medical necessity for inpatient treatment with the PA request.

PA for inpatient detoxification, rehabilitation and aftercare for chemical dependency is reviewed on a case-by-case basis by the appropriate PA contractor based on the member's program assignment. The review must include consideration of the following:

- Treatment, evaluation and detoxification are based on the stated medical condition and/or primary diagnosis for inpatient admission.
- Need for safe withdrawal from alcohol or other drugs is indicated.
- There is a history of recent convulsions or poorly controlled convulsive disorder.
- Reasonable evidence exists that detoxification and aftercare cannot be accomplished in an outpatient setting.

Inpatient Admission Criteria for Detoxification Stays

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
- ASAM Patient Placement Criteria
- Anthem Clinical Utilization Management (UM) Guidelines

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 coexisting medical and/or psychiatric condition that requires medical and psychiatric services
- Recent history of alcohol or other drug abuse and current inability 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, such as vocational, familial or social

Section 4: Bridge Appointments

Bridge appointments 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.

Reimbursement Requirements for Bridge Appointments

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

- Appointments must be conducted face-to-face in an outpatient setting on the day of discharge from an inpatient setting.
- Appointments must be a minimum of 15 minutes long.
- The member must have one or more identified barriers to continuing care, such as:
  - Special needs
  - Divorce or custody issues
  - Work conflicts
  - Childcare problems
  - Inability to schedule within seven days
  - History of noncompliance
  - Complex discharge plans
- The member must have an appropriate diagnosis to justify the medical necessity of a bridge appointment, such as one of the International Classification of Diseases (ICD) diagnosis codes listed on the *Diagnosis Codes for Bridge Appointments* table in *Mental Health and Addiction Services Codes* on the *Code Sets* page at in.gov/medicaid/providers. 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 bridge 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 marriage 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 registered nurse (APRN) 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

The Indiana Health Coverage Programs (IHCP) limits reimbursement of bridge appointments to one unit per member, per hospitalization. As previously noted, bridge appointments must be conducted face to face for a minimum of 15 minutes.

Bridge Appointment Billing

Providers must bill bridge appointments on a professional claim (*CMS-1500* claim form or electronic equivalent) using Current Procedural Terminology (CPT) code 99401 – *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual*, along with the HK modifier, to indicate bridge appointment service.

> *Note: Fractional or multiple units may not be billed. Only one unit may be billed per hospitalization.*

Section 5: Acute Partial Hospitalization

Partial hospitalization programs are highly intensive, time-limited medical services intended to provide a transition from inpatient behavioral health hospitalization to community-based care or, in some cases, substitute for an inpatient admission. The Indiana Health Coverage Programs (IHCP) reimburses for partial hospitalization only when the program is highly individualized, with treatment goals that are measurable, functional, time framed, medically necessary and directly related to the reason for admission.

Admission criteria for a partial hospitalization program are essentially the same as for the inpatient level of care, except that the patient does not require 24-hour nursing supervision. Patients must have the ability to reliably maintain safety when outside the facility. Patients with clear intent to seriously harm themselves or others are not candidates for partial hospitalization.

Services for partial hospitalization must be billed using H0035 – *Mental health, partial hospitalization, treatment, less than 24 hours.*

Target Population for Partial Hospitalization

The target population for partial hospitalization is members with psychiatric disturbances that meet the criteria for acute inpatient admission, but who can maintain safety in a reliable, independent housing situation.

To qualify for partial hospitalization services, IHCP members must have a diagnosed or suspected behavioral health condition (mental health or substance use disorder) and one of the following:

- A short-term deficit in daily functioning
- An assessment indicating a high probability of serious deterioration of the patient’s general medical or behavioral health

Partial hospitalization is not covered for persons currently residing in group homes or other residential care settings.

Any Child and Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA) level of need can qualify for partial hospitalization services.

Partial Hospitalization Program Standards

Partial hospitalization has the following program standards:

- Services must be ordered and authorized by a psychiatrist.
- Services require prior authorization, pursuant to *Indiana Administrative Code 405 IAC 5-3-13(a).*
- A face-to-face evaluation and assignment of behavioral health diagnosis must take place within 24 hours following admission to the program.
- A psychiatrist must actively participate in the case review and monitoring of care.
- The patient’s clinical record must include documentation of active oversight and monitoring of progress by one of the following:
  - Licensed physician (including licensed psychiatrist)
  - Licensed health service provider in psychology (HSPP)
  - Licensed clinical social worker (LCSW)
  - Licensed mental health counselor (LMHC)

  - Licensed marriage and family therapist (LMFT)
  - Licensed clinical addiction counselor (LCAC)
  - Licensed advanced practice registered nurse (APRN) with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing
- At least one individual psychotherapy service or group psychotherapy service must be delivered daily.
- For members under 18 years old, documentation of active psychotherapy must appear in the patient's clinical record, including a minimum of one family encounter per five business days of episode of care.
- Partial hospitalization programs must include *four to six hours* of active treatment per day and must be provided at least *four days a week.*
  - If less than four to six hours (or four days per week) of active treatment is to be provided, the individual services provided (for example, therapy) must be billed instead of partial hospitalization.
- The program must not mix members receiving partial hospitalization with members receiving outpatient behavioral health services.

Treatment Plan

The individual treatment plan must identify the following:

- The coordinated services to be provided around the individual needs of the patient
- The behaviors or symptoms that resulted in admission, and treatments for those behaviors or symptoms
- The functional changes necessary for transition to a lower intensity of service, and the means through which progress will be evaluated
- The criteria for discharge and the planned transition to community services

The treatment plan must receive regular review by the supervising practitioner, as described in the *Certification of Diagnosis and Supervision Requirements for Behavioral Health Services* section.

Exclusions

The following are excluded from partial hospitalization service:

- Persons at imminent risk of harming themselves or others
- Persons who concurrently reside in a group home or other residential care setting
- Persons who cannot actively engage in psychotherapy
- Persons with withdrawal risk or symptoms of substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services
- Persons who, by virtue of age or medical condition, cannot actively participate in group therapies

Authorization for Partial Hospitalization

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

Providers must contact the PA contractor at the time of partial hospitalization admission to request authorization for services.

Services are authorized for up to five days, depending on the patient's condition. For continued stays that exceed five days, at least one of the following reauthorization criteria must be met:

- Clinical evidence indicates the persistence of problems that caused the admission, to the degree that would necessitate continued treatment in the partial hospitalization program.
- Current treatment plan must include documentation of diagnosis, discharge planning, individualized goals of the treatment and treatment modalities needed and provided.
- Patient's progress confirms that the presenting or newly defined problems will respond to the current treatment plan.
- Daily progress notes, written and signed by the provider, document the treatment received and the patient's response.
- Severe reaction to the medication or need for further monitoring and adjustment of dosage in a controlled setting. This should be documented daily in the progress notes by a physician.
- Clinical evidence that disposition planning, progressive decreases in time spent in the partial hospitalization program and attempts to discontinue the partial hospitalization program have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate inpatient hospitalization.

Limits and Restrictions

IHCP partial hospitalization coverage carries the following limits and restrictions:

- Prior authorization is required.
- Providers are subject to postpayment review to ensure that the minimum requirement of four to six hours of active therapy is provided.
- One unit (H0035) is allowed per date of service.
- Inpatient services are not reimbursable on the same date as H0035.
- Physician services and prescription drugs are reimbursed separately from H0035.
- Service must be provided at least four days per week.

Acute Partial Hospitalization and Third-Party Liability

The IHCP requires third-party insurance, including commercial carriers and Medicare, be billed before submitting the claim to Medicaid. For more information about the process for billing claims when a member has coverage through another insurer or policy, see the *Third-Party Liability* module.

Section 6: Psychiatric Residential Treatment Facilities

The Indiana Health Coverage Programs (IHCP) reimburses for medically necessary services provided to children younger than 21 years old in a psychiatric residential treatment facility (PRTF). The IHCP also reimburses for children younger than 22 years old who began receiving PRTF services immediately before their 21st birthday. **All PRTF services require prior authorization.**

> *Note: The PRTF Model Attestation Letter Addendum has been updated to include State Survey Provider ID so that the Indiana State Department of Health (ISDH) and the Family and Social Services Administration (FSSA) can track facilities. The ISDH issues a State Survey Provider ID after reviewing the PRTF Attestation Form. Because the State Survey Provider ID is used for internal purposes, the provider should disregard this field. Additional information can be found in the Provider Enrollment module.*

Prior Authorization for PRTF Admission

The IHCP requires prior authorization (PA) for admission to a PRTF. Each PA request is reviewed for medical necessity on a case-by-case basis. Before approval can be given for an admission to a PRTF, documentation to support the admission must be provided. Gainwell processes PRTF requests for fee-for-service and managed care members.

On receipt of the PA request, a decision is issued within seven calendar days, excluding holidays.

Required Documentation for PRTF Authorization

The required documentation for a PA request for PRTF services includes the following:

- PRTF Admission Assessment or PRTF Extension Request Tool, as appropriate
- Intake assessment
- *Indiana Health Coverage Programs Prior Authorization Request Form*
- *Certification of the Need for Inpatient Psychiatric Hospital Services (State Form 44697 [R4/5-15]/OMPP 1261A)*
- Child and Adolescent Needs and Strengths (CANS) assessment
- Physician history and physical
- Initial Master Multidisciplinary Treatment Plan
- Documentation indicating the severity of the member's mental disorder
- Nursing notes from the inpatient treatment
- Documentation indicating that intermediate or long-term care in a secure facility is needed for the member
- Freedom of Choice Form

If the member is hospitalized, documentation should include a current inpatient treatment plan and the nursing notes related to the inpatient treatment.

Emergency PA for PRTF Services

If a PA request for PRTF services warrants the need for urgent review, the provider can call the appropriate PA contractor based on the program assignment of the member to ask for an emergency PA number. The PA request is then placed in a pending status awaiting all required documentation as stated previously. This documentation can be mailed, faxed or uploaded to the Portal as a system update to the pending request. All documentation must be submitted within 14 business days of the date of the initial request for emergency review. When the documentation is received, a decision is issued. If the admission is approved, the approval is back-dated to the date of the admission or to the date of the initial telephone or fax request. However, if the request for admission is denied, the provider is not reimbursed by the IHCP for any days of the PRTF stay.

Emergency admissions to a PRTF are not permitted. Members with emergency situations should be placed in an acute psychiatric facility and follow any criteria deemed necessary for that placement.

Telephone Requests for PRTF Prior Authorization

Clinical providers have the option to request PA for a member's admission to a PRTF via telephone. The clinician or provider must maintain the same documentation in the chart that would be required if submitting the request via mail, fax or the Portal. The PA request will remain in a "pending" status until the required documentation has been submitted via mail or fax or uploaded to the Portal as a system update to the pending request. Submission is required within 14 business days of admission. See the *Prior Authorization* module for complete information on required forms and documentation.

PRTF Admission Criteria

All the following criteria must be present for psychiatric residential care:

- The member's mental disorder (as classified in the current edition of the *Diagnostic and Statistical Manual* is rated severe, or the presence of two or more diagnoses on Axes I and II indicates that the member's disturbance is severe or complex.
- The member's behavior has disrupted his or her placement in the family or in a group residence two or more times in the past year, or the member has a persistent pattern of behavior that has severely disrupted life at home and school over the nine months preceding inpatient care. For children younger than 12 years old, these time frames are six months for a family or group residence, and six months for home and school.
- Family functioning or social relatedness is seriously impaired as evidenced by one or more of the following circumstances:
  – History of severe physical, sexual or emotional maltreatment
  – History of a disrupted adoption or multiple, two or more, foster family placements
  – A physical assault against a parent or adult caregiver
  – A history of sexual assault by the member
  – A history of fire setting resulting in damage to a residence
  – Runaways from two or more community placements by a child younger than 14 years old
  – Other impairment of family functioning or social relatedness of similar severity
- The illness must be of a subacute or chronic nature where there has been failure of acute or emergency treatment to sufficiently ameliorate the condition to allow the member to function in a lower level of care. The following are examples of lower levels of care:
  – Family or relative placement with outpatient therapy
  – Day or after-school treatment
  – Foster care with outpatient therapy

  - Therapeutic foster care
  - Group childcare supported by outpatient therapy
  - Therapeutic group childcare
  - Partial hospitalization
  - Other

- The following symptom complexes must show a need for extended treatment in a residential setting due to a threat to self or others:
  - Self-care deficit, not age-related. Basic impairment of needs for nutrition, sleep, hygiene, rest or stimulation included in the following:
    - Self-care deficit severe and long-standing enough to prohibit participation in an alternative setting in the community, including refusal to comply with treatment (for example, refusing medications)
    - Self-care deficit places child in life-threatening physiological imbalance without skilled intervention and supervision – for example, dehydration, starvation states or exhaustion due to extreme hyperactivity
    - Sleep deprivation or significant weight loss

- Impaired safety such as threat to harm others. Verbalization or gestures of intent to harm others caused by the member's mental disorder, such as the following indicators:
  - Threats accompanied by one of the following behaviors:
    - Depressed mood (irritable mood in children, weight gain, weight loss)
    - Recent loss
    - Recent suicide attempt or gesture, or past history of multiple attempts or gestures
    - Concomitant substance abuse
    - Recent suicide or history of multiple suicides in family or peer group
    - Aggression toward others
  - Verbalization escalating in intensity, or verbalization of intent accompanied by gesture or plan
  - Impaired thought processes (reality testing). Inability to perceive and validate reality to the extent that the child cannot negotiate his or her basic environment, nor participate in family or school (paranoia, hallucinations, delusions). The following indicators are examples of this behavior:
    - Disruption of safety of self, family or peer or community group
    - Impaired reality testing sufficient to prohibit participation in any community educational alternative
  - Nonresponsive to outpatient trial of medication or supportive care
  - Severely dysfunctional patterns of behavior that prohibit any participation in a lower level of care – for example, habitual runaway, prostitution or repeated substance abuse

- Member must show need for long-term treatment modalities. Modalities can include behavior modification treatment with some form of aversive therapy and operant conditioning procedures. Special, strictly educational programs do not qualify as behavior therapy. Modalities include multiple therapies such as group counseling, individual counseling, recreational therapy, expressive therapies and so forth.

Managed Care Considerations for PRTF Services

Hoosier Care Connect and Hoosier Healthwise members must be disenrolled or suspended from managed care, respectively, and their coverage converted to a fee-for-service (FFS) benefit during their PRTF stay. PRTF providers should verify the member's eligibility at initial admission and on the 1st and 15th of every month to determine whether the member's current coverage is managed care or FFS.

To facilitate appropriate claim payment, a level of care is established for members receiving PRTF services. When a managed care member is going to be admitted, PRTF providers need to contact Gainwell Prior Authorization at 800-457-4584, option 7, so that Gainwell can assign a level of care. After the level of care is assigned, the member will be disenrolled or suspended from the managed care program.

When IHCP members are discharged from the PRTF, they are reenrolled immediately into the most applicable IHCP program.

Leave Days for PRTFs

The days of care that providers can bill to the IHCP for a member admitted to a PRTF must be expressed in units of full days. A day consists of 24 hours, beginning at midnight and ending 24 hours later at midnight. For IHCP billing purposes, **PRTFs are expected to follow the midnight-to-midnight method when reporting days of care for members**, even if the health facility uses a different definition of a day for statistical or other purposes.

Although it is not mandatory for facilities to reserve beds, Medicaid reimburses for reserving beds for members at one-half the regular, customary per diem rate, provided that criteria set forth for medical and therapeutic leave is met. These services are available to Medicaid members younger than 21 years old. **In no instance will the IHCP reimburse a PRTF for reserving beds for Medicaid members when the facility has an occupancy rate of less than 90%**. The occupancy rate must be determined by dividing the total number of residents in licensed beds (excluding residential beds) in the psychiatric treatment facility taken from the midnight census as of the day that a Medicaid member takes a leave of absence, by the total number of licensed PRTF beds (excluding residential beds) in the PRTF.

Medical Leave Days

For members younger than 21 years old, the IHCP reimburses for medical leave days in a PRTF at one-half the regular customary per diem rate when the provider meets all the following conditions:

- The physician orders hospitalization for treatment of an acute condition that cannot be treated in the PRTF.
- The total length of time allowed for payment of a reserved bed in a PRTF for a single hospital stay is four consecutive days. If the member requires hospitalization longer than four consecutive days, the PRTF must discharge the member.
- The PRTF must maintain a physician's order for the hospitalization in the member's file.
- The facility has an occupancy rate of at least 90%. In no instance does the IHCP reimburse a PRTF for reserving beds for Medicaid members when the facility has an occupancy rate of less than 90%. Documentation is subject to retrospective review.

Therapeutic Leave Days

For members younger than 21 years old, the IHCP reimburses for therapeutic leave days in a PRTF at one-half the regular customary per diem rate when the provider meets all the following conditions:

- A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the member's plan of care.
- In a PRTF, the total length of time allotted for therapeutic leaves in any calendar year is 14 days per member. If the member is absent from the PRTF for more than 14 days per year, the IHCP makes no further reimbursement in that year for reserving a bed for therapeutic leave for that member. Therapeutic leave days do not have to be consecutive.
- The facility must maintain a physician's order for therapeutic leave in the member's file.
- The facility must have an occupancy rate of at least 90%. In no instance does the IHCP reimburse a PRTF for reserving beds for Medicaid members when the facility has an occupancy rate of less than 90%. Documentation is subject to retrospective review.

Billing for PRTF Services

Providers must submit claims for PRTF services on the professional claim (*CMS-1500* claim form or electronic equivalent). PRTF services are reimbursed on a per diem basis. PRTF providers may bill a single date of service per detail with consecutive dates of service, per individual claim.

The PRTF per diem does not include pharmaceutical supplies or physician services. The IHCP reimburses for these services separately from the PRTF per diem rate. Pharmaceutical supplies and physician services are subject to provisions set forth in *Indiana Administrative Code 405 IAC 5-24* and *405 IAC 5-25*, respectively. The PRTF per diem rate includes the cost of all other IHCP-covered psychiatric services provided to members residing in a PRTF, as well as the cost for IHCP-covered services not related to the member's psychiatric condition, if such services are performed at the PRTF. The IHCP makes separate reimbursement available only in instances where IHCP-covered services, not related to the member's psychiatric condition, are unavailable at the PRTF and are performed at a location other than the PRTF.

Providers should use the following codes when billing for services included in the PRTF per diem:

- T2048 – Use for billing *per diem services* (behavioral health, long-term care residential or nonacute care in a residential treatment facility where the stay is typically longer than 30 days).
- T2048 U1 – Use for billing *medical leave days* (behavioral health, long-term care residential, nonacute care in a residential treatment facility where the stay is typically longer than 30 days). Medical leave days are limited to four.
- T2048 U2 – Use for billing *therapeutic leave days* (behavioral health, long-term care residential, nonacute care in a residential treatment facility where the stay is typically longer than 30 days). Therapeutic leave days are limited to 14.

Billing PRTF Services Provided to DCS-Placed Children

Effective for dates of service on or after Sept. 1, 2018, the IHCP allows PRTF providers serving Medicaid-eligible, Department of Child Services (DCS)-placed children to be reimbursed the provider-specific Medicaid base rate for the PRTF stay, as well as a provider-specific wraparound payment intended to reimburse providers for non-Medicaid covered services that are usually included within the DCS PRTF rate.

When providing services to DCS-placed children with Medicaid coverage, PRTF providers should use the following procedure code and modifier combinations to bill for services included in the per diem for PRTF stays:

- T2048 U3 – Use for billing *per diem services* (behavioral health, long-term care residential or nonacute care in a residential treatment facility where the stay is typically longer than 30 days).
- T2048 U1 U3 – Use for billing *medical leave days* (behavioral health, long-term care residential, nonacute care in a residential treatment facility where the stay is typically longer than 30 days). Providers should follow DCS guidelines regarding leave-day restrictions.
- T2048 U2 U3 – Use for billing *therapeutic leave days* (behavioral health, long-term care residential, nonacute care in a residential treatment facility where the stay is typically longer than 30 days). Providers should follow DCS guidelines regarding leave-day restrictions.

In each scenario, the U3 modifier triggers the payment of the additional DCS wraparound payment. Reimbursement for the code/modifier combinations is equal to the full Medicaid rate plus the full DCS wraparound payment.

Section 7: Residential Substance Use Disorder Treatment

The Indiana Health Coverage Programs (IHCP) provides coverage for short-term low-intensity and high-intensity residential treatment for opioid use disorder (OUD) and other substance use disorders (SUDs) in settings of all sizes, including facilities that qualify as institutes of mental disease (IMDs), when the facility is enrolled with the IHCP as an SUD residential addiction treatment facility and the service is delivered and billed as described in this section.

Admission Criteria for Residential SUD Stays

Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria:

- ASAM Level 3.1 – *Clinically Managed Low-Intensity Residential Services*
- ASAM Level 3.5 – *Clinically Managed High-Intensity Residential Services*

> *Note: If a provider has been designated as offering ASAM Level 3.5 services only, the provider can seek PA and reimbursement only for stays at ASAM Level 3.5. Conversely, providers designated as offering ASAM Level 3.1 services only can seek PA and reimbursement only for stays at ASAM Level 3.1.*
>
> *If a provider has **separate units** within the facility, distinctly designated for ASAM Level 3.1 services and ASAM Level 3.5 services, the provider may seek PA and reimbursement for both levels, as appropriate. Residential stays for either level will only be approved with evidence of medical necessity.*

Providers can submit PA requests for residential SUD treatment electronically via the Provider Healthcare Portal (Portal) or by fax or mail using the *Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form*, as described in the *Prior Authorization* module.

The IHCP requires providers to include specific documentation regarding the assessment or reassessment when requesting PA for residential SUD treatment. The documentation may be submitted as follows:

- On the Portal – Providers can complete the assessment and reassessment forms online when submitting the residential SUD treatment PA request through the Portal, as follows:
  - For the initial request – At the *Create Authorization* page, select **Substance Abuse** in the Service Type field and check the SUD Authorization checkbox to access the interactive *SUD Initial Assessment Form* panel and complete the form fields as indicated.
  - For extensions to an existing request – Select **System Update** on the *View Authorization Response* page for a previously approved SUD PA request to access the *SUD Reassessment Form* panel and complete the form fields as indicated.
- By fax or mail, using the following forms (accessible from the *Forms* page at in.gov/medicaid/providers):
  - *Initial Assessment Form for Substance Use Disorder Treatment Admission* – This assessment form must be completed and submitted as an attachment to the SUD residential and inpatient treatment PA request form for initial admissions.
  - *Reassessment Form for Continued Substance Use Disorder Treatment* – This assessment form must be completed and submitted with the *IHCP Prior Authorization System Update Request Form* to request an extension to an existing authorization for residential SUD treatment.

> *Note: Prior to March 15, 2019, PA requests for residential SUD treatment followed the standard "universal PA" process. From March 15, 2019, through July 31, 2019, providers were required to submit all PA requests for residential SUD services by mail or fax using the printed forms described in this section. Beginning July 31, 2019, enhancements to the Portal enabled providers to resume submitting these requests via the Portal, as described in this section.*

PA requests for FFS members should be directed to Gainwell. PA requests for managed care members should be directed to the managed care entity (MCE) with which the member is enrolled.

Residential stays are allowed to be authorized with a statewide average length of 30 calendar days, based on medical necessity. If a facility determines that a member requires more time than was initially authorized, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

Practitioner Interaction Requirements for Residential SUD Treatment

Initial evaluations must be completed in person. Follow-up face-to-face evaluations during the member's stay may be conducted through telemedicine if necessary.

A physician (such as a psychiatrist), physician assistant or advanced practice registered nurse (APRN) must see the member face-to-face at least every seven days during the residential SUD treatment stay.

Billing and Reimbursement for Residential SUD Treatment

IHCP reimbursement for SUD residential treatment will be made **only** to facilities that are enrolled under provider type 11 – *Behavioral Health Provider*, specialty 836 – *SUD Residential Addiction Treatment Facility*. Providers that are enrolled under a different provider type and specialty (such as psychiatric hospitals enrolled under provider type 01, specialty 011), must separately enroll as type 11, specialty 836, to receive reimbursement for residential addiction treatment services. See the *Provider Enrollment* module for more information about enrollment requirements.

Providers should bill for residential SUD treatment using a professional claim. Reimbursement for residential stays for SUD treatment is made on a per diem basis. A provider enrolled as an SUD residential addiction treatment facility (provider type 11, specialty 836) is limited to billing only the following procedure codes:

- H2034 U1 or U2 – *Low-intensity residential treatment*
- H0010 U1 or U2 – *High-intensity residential treatment*

Specific billing guidance for low-intensity and high-intensity residential treatment services is provided in Table 3 and Table 4, respectively.

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Table 3 – Low-Intensity Residential Treatment (ASAM Level 3.1) Billing Guidance

Services Included in Per Diem	Procedure Code	Description
• Individual therapy • Group therapy • Medication training and support • Case management • Drug testing • Peer recovery supports	H2034	Alcohol and/or drug abuse half-way house service, per diem

Table 4 – High-Intensity Residential Treatment (ASAM Level 3.5*) Billing Guidance

Services Included in Per Diem	Procedure Code	Description
• Individual therapy • Group therapy • Medication training and support • Case management • Drug testing • Peer recovery supports • Skills training and development	H0010	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
ASAM 3.5 is considered* ***medium**-intensity residential treatment for adolescents.*		

Reimbursement for the procedure codes in Tables 3 and 4 is limited to one unit per member per provider per day. Providers are required to include the following modifiers when billing H2034 or H0010:

- U1 – *Member is an adult (age 19 years and older)*
- U2 – *Member is a child (age 0 through 18 years old)*

SUD residential addiction treatment providers rendering services other than those included in the per diem payment associated with H2034 or H0010 must bill for those additional services using another, appropriate IHCP-enrolled provider type and specialty.

Services that are included under the per diem payment will not be reimbursed separately for a member for the same dates of service as the per diem payment is reimbursed. The following services are reimbursable outside the daily per diem rate, when billed by an appropriate provider specialty (**not** specialty 836):

- Physician visits
- Physician-administered medications

Residential substance use disorder treatment facilities are not eligible for hospital assessment fee (HAF) adjustments.