

1. Inpatient Hospital services      Provided with limitations.  
Inpatient hospital services are covered when provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Reimbursement shall not be made for any hospital services not covered under the Medicaid program.  
The following require prior authorization:
- (1) any procedure ordinarily rendered on an outpatient basis when rendered on an inpatient basis
  - (2) psychiatric inpatient admissions
  - (3) rehabilitation, including substance abuse, inpatient admissions
  - (4) burn inpatient admissions
  - (5) out of state hospitalization
  - (6) nonemergent inpatient admissions
- The following are exempt from the prior authorization requirements:
- (1) Inpatient hospital admissions when covered by Medicare.
  - (2) Routine vaginal and cesarean section deliveries.
- If an inpatient procedure requires prior authorization and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.
- 2.a. Outpatient Hospital services      Provided with limitations.  
Outpatient hospital services are covered when provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Reimbursement shall not be made for any hospital services not covered under the Medicaid program. For general anesthesia services, documentation in the patient's record must include specific reasons why such services are needed, if such services are to be provided on an outpatient basis.
- 2.b. Rural Health Clinic services      Provided with limitations.  
Reimbursement is available to rural health clinics for medically necessary services provided by a physician, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, dentist, dental hygienist, podiatrist, optometrist, chiropractor, licensed clinical addiction counselor, licensed marriage and family therapist, or licensed mental health counselor employed by the rural health clinic. Reimbursement shall not be made for any services not covered under the Medicaid program.

2.c. Federally Qualified Health  
Center services

Provided with limitations.

Reimbursement is available to FQHCs for medically necessary services provided by a physician, as defined in 42 C.F.R. 405.2412, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, dentist, dental hygienist, podiatrist, optometrist, chiropractor, licensed clinical addiction counselor, licensed marriage and family therapist, or licensed mental health counselor. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by Medicaid. Any other ambulatory service included in the Medicaid state plan is considered a covered FQHC service if the FQHC offers such a service. Reimbursement shall not be made for any service not covered under the Medicaid program.

3. Other Laboratory and  
X-ray services

Provided with limitations.

All laboratory and x-ray services must be ordered by a physician or other practitioner licensed to do so under state law. Covered when necessitated by a condition-related diagnosis.

Only one (1) charge per day for each patient is allowed for venipuncture.

TN No. 20-003  
Supersedes  
TN No. 13-007

Approval Date: July 14, 2020Effective Date: October 1, 2020

3. a. Nursing Facility services Provided with limitations.
- for individuals 21 years of age or older
- Reimbursement is available for nursing facility services provided by a licensed and certified nursing facility in accordance with Attachment 4.19-D, when rendered to a recipient whose level of care has been approved by the Office of Medicaid Policy and Planning.
- Those services and products furnished by the nursing facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with State law.
- The per diem rate for nursing facilities includes the following services: room and board, room accommodations, all dietary services, and laundry services; nursing care provided by a registered nurse, licensed practical nurse, or nurse's aide; all medical and nonmedical supplies and equipment; durable medical equipment (DME), and associated repair costs routinely required for the care of patients; medically necessary therapy services which include physical, occupational, respiratory, and speech pathology services; transportation to vocational/habilitation service programs; the cost of both legend and non-legend water products in all forms and for all uses.
- 4.b Early **and** Periodic Screening, Diagnosis Treatment
- Provided in excess of federal requirements, Treatment services are covered subject to prior authorization requirements and reimbursement limitations.
- Any treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements for the services. However, if a service is not covered under the state plan, it is still available to EPSDT eligible recipients subject to prior authorization requirements in accordance with State law if it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services-.
- Medicaid reimbursement is available for medically necessary school nursing services rendered by a nurse who is employed by or under contract with a Medicaid participating school corporation provider when the services are: medically necessary; provided pursuant to a Medicaid enrolled student's educational program or plan as required by the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Federal Rehabilitation Act of 1973. 29 U.S.C. 794.
- 4.c. Family Planning services
- Provided with limitations.
- Family planning services are those services provided to individuals of childbearing age, who are not pregnant, to temporarily or permanently prevent or delay pregnancy. Family planning services includes: diagnosis and treatment of sexually transmitted diseases, if medically indicated; follow-up care for complications associated with contraceptive methods issued by the family planning provider; health education and counseling necessary to make informed choices and understand contraceptive methods; laboratory tests, if medically indicated as part of the decision making process for choice of contraceptive methods; limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; screening, testing, and counseling of members at risk for HIV and referral and treatment; tubal ligation or Essure device; and vasectomy.

4.d.1 Face-to-Face Tobacco  
Dependence Services

Provided with Limitations:  
Reimbursement is available for tobacco dependence treatment.

Tobacco dependence treatment includes covered legend or nonlegend drugs intended to reduce an individual's dependence on tobacco products as well as tobacco dependence counseling. A member prescribed a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products must engage in tobacco dependence counseling in conjunction with the receipt of said legend or nonlegend drug therapy.

Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program.

The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations set out in this state plan:

- (1) A physician.
- (2) A physician's assistant.
- (3) A nurse practitioner.
- (4) A registered nurse.
- (5) A psychologist.
- (6) A pharmacist.
- (7) A dentist.
- (8) An optometrist.
- (9) A clinical social worker.
- (10) A marital and family counselor.
- (11) A mental health counselor.
- (12) A licensed clinical addictions counselor.

5.a. Physicians' services

Provided with limitations.

Reimbursement is available for medically necessary services provided by a doctor of medicine or osteopathy for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within the scope of the practice of medicine, as defined by Indiana law, and subject to limitations.

Reimbursement is available for office visits limited to a maximum of office visits per rolling 12 months, per recipient, per provider without prior authorization. Additional office visits may be approved with prior authorization based on medical necessity. Office visits should be appropriate to the diagnosis and treatment given and properly coded. New patient office visits are limited to one per recipient, per provider within the last three (3) years. For purposes of this subsection, "new patient" means one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the last three (3) years.

A physician will not be reimbursed for the following: preparation of reports, missed appointments, writing or telephoning prescriptions to pharmacies, telephone calls to laboratories, any extra charge for after-hours services, mileage.

Reimbursement is available for a physician as an assistant surgeon and is limited to the procedures that generally require the skills and services of an assistant surgeon as set out in coding guidelines. When extenuating circumstances require an assistant surgeon when customarily one is not required, these circumstances must be well documented in the hospital record and documentation must be attached to the claim form. Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.

Reimbursement is not available to a physician for injecting medications that can be self-administered unless justified by the patient's condition. Possible noncompliance by a recipient to oral medication is insufficient justification to administer injections.

5.b. Medical and Surgical  
services furnished by a dentist

Provided with limitations.

Reimbursement is available only for those services listed below subject to limitations.

The following are covered medical and surgical services furnished by a dentist under the Indiana Medicaid program: oral biopsies, alveoplasty, excision of lesions, excision of benign tumor, nonodontogenic cyst removal, incise and drain abscess, fracture simple stabilize, compound fracture of the mandible, compound fracture of the maxilla, repair of wounds, suturing, , periodontal surgery limited to drug-induced periodontal hyperplasia, other medical and surgical services furnished by a dentist as medically necessary to treat recipients eligible for the EPSDT program, general anesthesia, intravenous (IV) sedation covered only for oral surgical services, and maxillofacial surgery

6.a. Podiatrists' Services

Provided with limitations.

(1) Are provided by a podiatrist who is licensed by the State and meets standards issued by the Secretary of Health and Human Services; and

(2) Consists of treatment that the podiatrist is legally authorized by the State to perform and services of a doctor of podiatric medicine, acting within the scope of his or her license, if the services would be covered as physicians' services when performed by a doctor of medicine or osteopathy.

(3) Reimbursement is limited to 1 office visit and up to 6 routine foot care services per recipient with systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous per 12 months. New patient office visits are limited to one (1) per recipient, per provider, within the last three (3) years. "New patient" is one who has not received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three (3) years. Reimbursement is available within the scope of the practice of podiatry as defined by Indiana law. Covered services include diagnosis of foot disorders and mechanical, medical or surgical treatment of these disorders. Reimbursement is not available for any podiatric service provided outside the scope of state licensure or for any podiatric service for which federal financial participation is not available.

Subject to prior authorization requirements, these limits do not apply to treatments found necessary for children under the age 21, after a diagnosis as a result an EPSDT service.

6.b. Optometrists' services

Optometrists' services are provided in accordance with 42 CFR 440.060.

Reimbursement is available for medically necessary services provided by an optometrist within the scope of practice as defined by Indiana law and subject to procedure code limitations.

6.c. Chiropractors' services

Chiropractors' services include only services that—

- (1) Are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary of Health and Human Services under 42 CFR 420.21(a); and
- (2) Consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform
- (3) Provided with limitations

Reimbursement is limited to 5 office visits and up to 50 therapeutic physical medicine treatments per recipient per year; however, the 5 office visits are included in the 50 visit/treatment maximum. DME and electromyography services are not covered.

Reimbursement is subject to the scope of service limitations set out in 405 IAC 5.

Reimbursement is not available for any chiropractic service provided outside the scope of IC 25-10-1-1, et seq., and 846 IAC 1-3-1, et seq., or for any chiropractic service for which federal financial participation is not available.

Subject to prior authorization requirements and 405 IAC 5-15-4 these limits do not apply to treatments found necessary for children under the age 21, after a diagnosis as a result of an EPSDT service.

6.d. Other Practitioners' services

Nurse Practitioners' services

Provided with limitations.

Reimbursement is available for medically necessary, reasonable and preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

Diabetes Self-Management  
And Training Services

Reimbursement is limited to a total of sixteen units (15 minutes each) per recipient, per rolling calendar year. Additional units may be prior authorized. Services must be medically necessary; provided by health care professionals who are licensed, registered or certified under applicable Indiana law and who have specialized training in the management of diabetes; and ordered in writing by a physician, podiatrist, nurse practitioner, clinical nurse specialist, certified nurse midwife and physician assistant.

Pharmacist Services

Licensed Pharmacists may provide services and prescriptions for contraceptives as defined under State law.

6.d. Other Practitioners' services  
(continued) Provided with limitations.

Physician Assistants' Services Licensed Physician Assistants may provide medically necessary healthcare services within their scope of practice according to state law.

Community Health Workers' Services Reimbursement is available for medically necessary health care services provided by a certified community health worker within the scope of the applicable certification program. The services within the applicable certification program of a certified community health worker should be within the scope of practice for each of the following supervising licensed practitioners: health services provider in psychology, advanced practice nurse, physician assistant, podiatrist, and chiropractor. Supervision of the certified community health worker is included in the scope of practice for each supervising licensed practitioner. Each supervising licensed practitioner shall assume professional responsibility for the services provided by the certified community health worker. Each supervising licensed practitioner shall bill for the services of the certified community health worker

Licensed Behavioral Health Practitioners Services Licensed Clinical Social Workers may provide medically necessary healthcare services within their scope of practice according to state law.

Licensed Marriage and Family Therapists may provide medically necessary healthcare services within their scope of practice according to state law.

Licensed Mental Health Counselors may provide medically necessary healthcare services within their scope of practice according to state law.

Licensed Clinical Addiction Counselors may provide medically necessary healthcare services within their scope of practice according to state law.



Psychologists' services Psychologists' services include only services that are provided by licensed psychologists within the scope of practice as defined under state law.

Coverage is available for outpatient mental health and substance abuse treatment services provided by a licensed psychologist endorsed as a health services provider in psychology (HSPP), subject to the following limitations:

- (1) Subject to prior authorization by the office or its designee, Medicaid will reimburse HSPP supervised outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:
  - (A) A licensed psychologist.
  - (B) A licensed independent practice school psychologist.
  - (C) A licensed clinical social worker (LCSW).
  - (D) A licensed marital and family therapist (LMFT).
  - (E) A licensed mental health counselor (LMHC).
  - (F) A licensed clinical addiction counselor (LCAC).
  - (F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
  - (G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.
- (2) A HSPP is responsible for certifying the diagnosis for the purpose of developing the plan of treatment and providing continuous supervision as follows:
  - (A) The supervising practitioner is responsible for seeing the patient during the intake process or reviewing information submitted by the other licensed professionals, qualified behavioral health provider (QBHP), or other behavioral health provider (OBHP) and approving the plan of treatment within seven (7) days.
  - (B) The supervising practitioner must provide face to face visits with the patient or review the plan of treatment submitted by the QBHP at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the supervising practitioner assuming responsibility for the plan of treatment.
- (3) Medicaid will reimburse for evaluation, psychological testing and group, family, and individual psychotherapy when provided by a licensed psychologist, licensed independent practice school psychologist, and a licensed psychologist endorsed as an HSPP.
- (4) Medicaid will cover for school psychologist testing services provided by a licensed independent practice school psychologist or school psychologist who holds the national school psychologist certification or the Indiana Accomplished Practitioner license who is employed or contracted with a school corporation that participates in Medicaid when such services are medically necessary and required to determine the health related services a public school corporation shall provide per a Medicaid enrolled student's educational program or plan as required by the Individuals with Disabilities Education Act (IDEA) or Section 504 of the federal Rehabilitation Act of 1973. 29 U.S.C. 794.
- (5) Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by an HSPP.
- (6) Prior authorization is required for mental health service provided in an outpatient or office setting that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time, except neuropsychological and psychological testing, which is subject to prior authorization.
- (7) The following are services that are not coverable by the Medicaid program:
  - (A) Daycare.
  - (B) Hypnosis.
  - (C) Biofeedback.
  - (D) Missed appointments.

Telehealth

Coverage is available for health care services delivered via telehealth. Telehealth must be provided in accordance with Indiana state law.

The following services may not be delivered via telehealth:

- (A) Ambulatory surgical services.
- (B) Outpatient surgical services.
- (C) Radiological services.
- (D) Laboratory services.
- (E) Anesthesia services or nurse anesthetist services.
- (F) DME and HME services.
- (G) Transportation services.

For more information on telehealth monitoring reimbursement for home health care services, please refer to Attachment 4.19-B, Page 3c.1.1

TN: 21-003

Supersedes  
TN: 20-019

Approval Date: November 19<sup>th</sup>, 2021 Effective Date: July 11, 2021

## 7. Home Health Services

Home Health Services are provided in accordance with 42 CFR 440.70 and include:

- (1) Intermittent or part-time nursing services in accordance with 42 CFR 440.70(b)(1).
- (2) Home health aide services in accordance with 42 CFR 440.70(b)(2).
- (3) Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place in accordance with 42 CFR 440.70(b)(3).
- (4) Physical Therapy, Occupational Therapy, or Speech Pathology and Audiology services provided by a home health agency or medical rehabilitation facility in accordance with 42 CFR 440.70(b)(4) and 42 CFR 440.110.

Coverage for Home Health Services provided by a home health agency that meets the Medicare Conditions of Participation (COP) requirements, and are ordered in accordance with 42 CFR 440.70(a) with prior authorization, for medically necessary care.

All medically necessary Home Health Services will be provided to children under the age of 21.

Medically necessary and reasonable service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Home Health Services require medical necessity review through the prior authorization process by the Office of Medicaid Policy & Planning (OMPP). However, prior authorization is not required for home health under the following circumstances which are determined to be medically necessary:

- (1) Services are ordered in writing prior to inpatient hospital discharge provided by an RN, LPN, or home health aide, and the services do not exceed 120 units within 30 calendar days following hospital discharge. Services exceeding this amount must be reviewed for medical necessity through the prior authorization process.
- (2) Intermittent nursing or part-time nursing services which are not provided as emergency services are added to the plan of care and provided for a recipient for whom other home health services have been currently authorized. New nursing services provided to recipients who do not have home health services outlined in their plan of care must be reviewed for medical necessity through the prior authorization process.

Coverage is not available for:

- (1) Homemaker, chore services, and sitter/companion service.
- (2) Educational activities.
- (3) Out of state home health agency services except as required by 42 CFR § 431.52.
- (4) Therapy rendered for diversional, vocational, recreational, or avocational purposes.
- (5) Activities that can be conducted by non-medical personnel.
- (6) Community-base palliative care which does not meet the definition of home health services as defined above and provided in accordance with 42 CFR 440.70.
- (7) Medical social services which does not meet the definition of home health services as defined above and provided in accordance with 42 CFR 440.70.

All incontinence supplies must be provided by the one provider under contract with the Indiana Medicaid program to provide incontinence supplies.

TN: 23-0014

Supersedes

TN: 11-003

Approval Date: December 6, 2023

Effective Date: July 14, 2023

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- 7.d. Physical Therapy, Occupational Therapy, or Speech Pathology and Audiology services provided by a home health agency or medical rehabilitation facility
- Reimbursement is available only for medically necessary and reasonable therapy and is provided with limitations.
- Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology services provided by a home health agency in accordance with 42 CFR 440.70 (b) (4) and 42 CFR 440.110.
- Prior authorization is required by the OMPP for all therapy services except the following:
- (1) Initial evaluations.
  - (2) Any combination of therapy services ordered in writing prior to inpatient hospital discharge, if the services do not exceed 30 units in thirty 30 calendar days following hospital discharge.
  - (3) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators.
  - (4) Therapy services provided by a nursing facility or large private or small intermediate care facility for the mentally retarded (ICF/MR), which are included in the facility's per diem rate.
  - (5) Physical therapy and occupational therapy ordered in writing by a physician to treat an acute medical condition.
- Prior authorization is required by the OMPP for all audiology services except the following:
- (1) The initial assessment of hearing.
  - (2) Determination of suitability of amplification and the recommendation regarding a hearing aid.
  - (3) The determination of functional benefit to be gained by the use of a hearing aid.
  - (4) Audiology services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate.
8. Private Duty Nursing
- Private Duty Nursing services provided by a home health agency in accordance with 42 CFR 440.80.
- Reimbursement is available for medically necessary and reasonable services rendered by registered nurses, licensed practical nurses and home health agencies who are Medicaid providers, subject to prior authorization requirements applicable to home health agencies.

9. Clinic services Covered for medically necessary clinic services..
10. Dental services Covered subject to a \$1,000 cap per recipient per 12 month period for all Dental services. Coverage limits based on diagnostic and treatment services..
11. Physical Therapy and Related services Covered for medically necessary therapy services.  
Therapy provided for diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or for developmental activities which can be conducted by nonmedical personnel, is not covered.
- 11.a. Physical Therapy Provided in accordance with the requirements of 42 CFR 440.110.  
  
Therapy services will not be approved for more than one (1) hour per day per type of therapy. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. A certified physical therapist's assistant may provide services within scope of practice as defined by Indiana State law.
- 11.b. Occupational Therapy Provided in accordance with the requirements of 42 CFR 440.110.  
  
Therapy services will not be approved for more than one (1) hour per type of therapy. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. A certified occupational therapy assistant may provide services within scope of practice as defined by Indiana State law.
- 11.c. Services for individuals with speech, hearing and language disorders (provided by a speech pathologist or audiologist) Provided in accordance with the requirements of 42 CFR 440.110.  
Therapy services will not be approved for more than one (1) hour per day per type of therapy. Speech therapy evaluations and reevaluations are limited to three (3) hours of service per evaluation. A registered speech-language pathology aide may provide services within scope of practice as defined by Indiana State law.
- 11.d. Respiratory Therapy services Provided in accordance with the requirements of 42 CFR 440.185.  
  
Coverage is limited by diagnosis and medical necessity. A certified respiratory therapy technician may provide services within scope of practice as defined by Indiana State law.

## 12.a. Prescribed Drugs Provided with limitations.

Reimbursement is available for prescribed drugs subject to the limitations set out in 405 IAC 5. The following are not covered: anorectics or any agent used to promote weight loss; topical minoxidil preparations; fertility enhancement drugs; drugs used to treat sexual or erectile dysfunction, as set forth in section 1927( d)(2)(K) of the Act, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and such uses have been approved by the Food and Drug Administration; drugs prescribed solely or primarily for cosmetic purposes. All over-the-counter and non-legend items are subject to the limitations set out in 405 IAC 5-24.

Effective July 1<sup>st</sup>, 2023, the Medicaid Managed Care Plans contracted with the State of Indiana, will follow the statewide uniform preferred drug list (SUPDL) for covered outpatient drugs listed in the classes on the fee-for-service (FFS) preferred drug list (PDL). In accordance with Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990), Indiana Medicaid will fully participate in the manufacturer rebate program. In doing so, all applicable provisions and restrictions of the legislation, as well as that of any subsequent rules and/or regulations, will be strictly adhered to. Specifically, Indiana Medicaid will reimburse for all rebating manufacturers' (as identified to the agency by CMS) products fully in accordance with the specifications of the legislation. The program will also adhere to all reporting requirements of the legislation.

Supplemental Rebates--The State is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates. A rebate agreement between the State and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on June 28<sup>th</sup>, 2023 and entitled, State of Indiana Supplemental Rebate agreement, has been authorized by CMS, superseding the State of Indiana Supplemental Rebate agreement approved under IN SPA TN 20-018.

Effective July 1<sup>st</sup>, 2023, all supplemental rebates received for covered outpatient drug claims, pursuant to these agreements, are collected from manufacturers based on drug utilization for fee-for-service Medicaid beneficiaries and managed care Medicaid beneficiaries.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement. All drugs covered by the program, irrespective of prior authorization requirement, will comply with the provisions of the national rebate agreement.

Effective July 1<sup>st</sup>, 2023, the State may enter into value/outcomes-based contracts with manufacturers on a voluntary basis. The Value-Based Supplemental Rebate Agreement will

apply to the Medicaid drug benefit for both the fee-for-service and managed care entity (MCE) drugs in accordance with the Statewide Uniform Preferred Drug List for all covered outpatient drugs.

## 12.b. Dentures

Provided with limitations.

Prior review and authorization by the agency is required for all dentures, partials and repairs.

## 12.c. Prosthetic devices

Prior authorization by the Office of Medicaid Policy and Planning is required for all prosthetic devices, except for all customizing features once the basic prosthesis is approved.

Coverage is not available for prosthetic devices dispensed for purely cosmetic reasons.

## 12.d. Eyeglasses

Covered for medically reasonable and necessary eyeglasses, with the following limitations:

- (1) Eyeglasses provided to a recipient under 21 years of age will be limited to a maximum of 1 pair per year. Limits can be exceeded based on medical necessity.
- (2) Eyeglasses provided to a recipient 21 years of age or over will be limited to a maximum of 1 pair every 5 years.

Medically necessary and reasonable is defined as a covered service required for the care or wellbeing of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Coverage is not available for:

- (1) Lenses with decorative designs.
- (2) Fashion tints, gradient tints, sunglasses and photochromatic lenses.
- (3) Oversized lenses larger than 61 mm, except when medically necessary.

## 13. Other diagnostic, screening preventive and rehabilitative services

Covered for medically necessary diagnostic preventative, therapeutic, and rehabilitative services

Medically necessary is defined as a covered service required for the care or wellbeing of the patient and is provided in accordance with generally accepted standards of medical or professional practice

## 13.a. Diagnostic services

Covered for medically necessary diagnostic preventative, therapeutic, and rehabilitative services.

Coverage for environmental lead investigations is available for a one-time, on-site environmental lead investigation of a child's home or primary residence for a child with an elevated blood lead level. This environmental lead investigation will be provided by a licensed risk assessor or licensed lead inspector.

Medically necessary is defined as a covered service required for the care or wellbeing of the patient and is provided in accordance with generally accepted standards of medical or professional practice.



13.a.1 Face-to-Face Tobacco  
Dependence Services

Provided with Limitations:  
Reimbursement is available for tobacco dependence treatment.

Tobacco dependence treatment includes covered legend or nonlegend drugs intended to reduce an individual's dependence on tobacco products as well as tobacco dependence counseling. A member prescribed a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products must engage in tobacco dependence counseling in conjunction with the receipt of said legend or nonlegend drug therapy.

Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program.

The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations set out in this state plan:

- (1) A physician.
- (2) A physician's assistant.
- (3) A nurse practitioner.
- (4) A registered nurse.
- (5) A psychologist.
- (6) A pharmacist.
- (7) A dentist.
- (8) An optometrist.
- (9) A clinical social worker.
- (10) A marital and family counselor.
- (11) A mental health counselor.
- (12) A licensed clinical addictions counselor.

## 13.b. Screening Services

“Screening services” means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations.

Reimbursement is available for medically reasonable and necessary screening services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

## 13.c. Preventive Services

“Preventive services” means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—

- (1) Prevent disease, disability, and other health conditions or their progression;
- (2) Prolong life; and
- (3) Promote physical and mental health and efficiency.

Reimbursement is available for medically reasonable and necessary preventative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Indiana covers and reimburses all approved grade A and B preventive services and approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing. Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary to comply with revisions.

## 13.d. Rehabilitative Services

“Rehabilitative services,” includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

Reimbursement is available for medically reasonable and necessary rehabilitative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

The intensity of service criteria shall be as follows:

- (1) Multidisciplinary team evaluations should occur at minimum every two (2) weeks.
- (2) Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
  - (A) Occupational therapy.
  - (B) Speech therapy.
- (3) Participation in a rehabilitation program under the direction of a qualified physician.
- (4) Skilled rehabilitative nursing care or supervision required at least daily.

Discharge criteria may include, at minimum, the following:

- (1) Evidence in the medical record indicating the patient has achieved stated goals.
- (2) Medical complications precluding intensive rehabilitative effort.
- (3) Multidisciplinary therapy is no longer needed.
- (4) Additional functional improvement is not anticipated.
- (5) Patient's functional status has remained unchanged for fourteen (14) days.

Educational services are not covered.

#### 13.d.1. Medicaid Rehabilitation Option

Reimbursement is available for Medicaid Rehabilitation Option (MRO) services, which are defined as:

(1) Behavioral Health Counseling and Therapy services. Refers to a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan.

These services include the following:

- Individual counseling and therapy
- Family/Couple (Individual) with the consumer present counseling and therapy
- Family/Couple (Individual) without the consumer present counseling and therapy
- Group counseling and therapy
- Family/Couple (Group) with the consumer present counseling and therapy
- Family/Couple (Group) without the consumer present counseling and therapy

Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed professional, except for a licensed clinical addiction counselor, defined as: Individuals wishing to be addiction counselors or clinical addiction counselors must meet the education, counseling experience, examination and exemptions, renewal of licensure, and temporary permit requirements of the State of Indiana.
- Qualified Behavioral Health Professional (QBHP)

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5	Individual Counseling and Therapy	48
5A	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5	Group Counseling and Therapy	60
5A	Group Counseling and Therapy	60

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5 /6	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5 /6	Group Counseling and Therapy	60

(2) Medication Training and Support services. Refers to monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing/medical assessments. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed physician
- Authorized health care professional
- Licensed physician assistant (PA)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical Assistant (MA) who has graduated from a two (2) year clinical program

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5	Medication Training and Support	104
5A	Medication Training and Support	104

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5 /6	Medication Training and Support	104

(3) Skills Training and Development services. Refers to the development and/or restoration of skills (i.e., self-care, daily life management, or problem solving skills) directed toward restoring an individual to his best possible functional level, eliminating psychosocial barriers, and restoring a consumer's abilities that are essential to independent living. Development and/or restoration of skills is provided

TN No. 10-005  
Supersedes  
TN No. New

**AUG 08 2011**

Approval Date: \_\_\_\_\_

Effective Date: July 1, 2010

through structured interventions for attaining recovery goals identified in the individualized integrated care plan and the monitoring of progress in achieving those skills. Services may be provided for persons who are living in the community, or who are residing in an ASAM 3.1 Substance Use Disorder Residential Treatment Facility, and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5	Skills Training and Development	900
5A	Skills Training and Development	1000

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5 /6	Skills Training and Development	900

- (4) Behavioral Health Level of Need Redetermination. Refers to services required to assess an individual's functional needs and strengths, determine level of need, and make changes to the individualized integrated care plan. The assessment is used as a clinical guide and a treatment planning tool which assists providers in creating a person-centered plan of care. The redetermination includes face-to-face contact with the consumer and face-to-face or telephone collateral contacts with family members or non-professional caretakers, which results in a completed redetermination. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction.

The following providers are qualified to deliver this service:

- Individuals meeting the Division of Mental Health and Addiction's (DMHA) training competency standards for the performance of the DMHA approved assessment tool.

Limitations:

- Reimbursement is allowed for one redetermination per 180 days for Adults LON 3-5A and Children/Adolescents LON 3-6.

- Care Coordination services. Refers to the coordination of services to manage a mental health or substance use disorder. Care coordination services include the assessment of the eligible consumer to determine mental health and substance abuse treatment service needs, development of an individualized integrated care plan, referral and related activities to help the consumer obtain needed services, monitoring and follow-up, and evaluation. Care coordination is a service on behalf of the consumer, not to the consumer, and is management of the case, not the consumer.

The following providers are qualified to deliver this service:

- A licensed professional
- A QBHP
- An OBHP

Limitations:

- Activities billed under behavioral health level of need redetermination.
- The actual or direct provision of medical services or medical treatment.

(5) [Crisis Intervention services has been moved to Attachment 3.1-A, Addendum Page 9c.2].

(6) Child and Adolescent Intensive Resiliency Services (CAIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an individualized integrated care plan. CAIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. CAIRS is designed to alleviate emotional or behavioral problems with the goal of reintegrating the child into the community setting and restore a beneficiary to his best possible functional level. CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS is time-limited, curriculum-based, with goals that include reintegration into age appropriate community settings (e.g., school and activities with pro-social peers). Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, or addiction. Children who do not meet the medical necessity criteria for CAIRS will receive comparable treatment services under Early and Periodic Screening, Diagnostic and Treatment.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

## Limitations:

- The program is required to operate 2-4 hours per day and 3-5 days per week.
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	252-Limited to 90 consecutive days
5 /6	CAIRS	252-Limited to 90 consecutive days

(7) Adults Intensive Rehabilitative Services (AIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting for consumers who require structured rehabilitative services to maintain the consumer on an outpatient basis. AIRS is curriculum based and designed to alleviate emotional or behavior problems with the goal of reintegrating the consumer into the community, increasing social connectedness beyond a clinical setting, and/or employment. AIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness, or addiction.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

## Limitations:

- The program is required to operate 2-6 hours per day and 3-5 days per week
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	270-Limited to 90 consecutive days
5 /6	CAIRS	270-Limited to 90 consecutive days

(8) [Intensive Outpatient Treatment (IOT) has been moved to Attachment 3.1-A, Addendum Page 9c.2].

(9) Addiction Counseling services. Refers to a planned and organized service where addiction professionals and clinicians provide counseling intervention. Addiction counseling services to the beneficiary's family and caretakers is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery. In addition to individual, group, and family addiction counseling, other activities included are: education on addiction disorders and skills training in communication, anger management, stress management and relapse prevention. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5	Addiction Counseling	32
5A	Addiction Counseling	50

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5 /6	Addiction Counseling	32



(10) [Peer Recovery Services has been moved to Attachment 3.1-A, Addendum Page 9c.3].

(11) Psychiatric Assessment and Intervention services. Refers to face-to-face and non-face-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to consumers who are receiving services from an interdisciplinary team. Services may be provided for persons with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community.

The following providers are qualified to deliver this service:

- Physician
- Authorized healthcare professional

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
5	Psychiatric Assessment and Intervention	25
5A	Psychiatric Assessment and Intervention	100

**MRO SERVICES WILL CONTINUE ON PAGE 9d****Opioid Treatment Services**

Opioid treatment services refers to rehabilitative services for an individual to administer opioid treatment medication and to alleviate the adverse medical, psychological, or physical effects incident to opioid addiction. Opioid treatment services consist of the following Medicaid service components:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medication
- Dispensing and administration of MAT medications
- Substance use disorder counseling
- Toxicology testing
- Individual and group therapy
- Intake Activities
- Periodic Assessments

Other services not defined as OTP services in this section may be covered by an opioid treatment program provider if deemed appropriate by the Office of Medicaid Policy and Planning (OMPP) and complying within coverage specifications listed in 3.1-A Addendum: Page 2.1, Item 5.a; Page 3, Item 6.d; and Page 7, Item 12.a. Any individual providing opioid treatment services that is not licensed by the State must instead be credentialed in addictions counseling by a nationally recognized credentialing body approved by the Division of Mental Health and Addiction. All opioid treatment services furnished by these credentialed individuals must be recommended by a physician or other licensed practitioner of the healing arts.

Counseling services provided by an OTP may be rendered via audio-visual and audio-only telehealth.

**Limitations:**

- Services must be rendered in an Opioid Treatment Program that has been certified under 42 C.F.R. 8 (regarding the process and standards by which SAMHSA determines that an opioid treatment program is qualified to provide opioid treatment under the Federal opioid treatment standards), and approved by the Family and Social Services Administration's Division of Mental Health and Addiction.

**MRO SERVICES WILL CONTINUE ON PAGE 9d**

**MRO SERVICES WILL CONTINUE ON PAGE 9d****Crisis Intervention Services**

Refers to short-term emergency behavioral health services, available twenty-four (24) hours a day, seven (7) days a week. Crisis Intervention includes, but is not limited to crisis assessment planning and counseling specific to the crisis, intervention at the site of the crisis (when clinically appropriate), and pre-hospital assessment. The goal of Crisis Intervention is to resolve the crisis, and transition the consumer to routine care through stabilization of the acute crisis and linkage to necessary services. Crisis Intervention may be provided in an emergency room, clinic setting, or within the community. Services may be provided to any Medicaid eligible individual in need of crisis services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

There are no limitations on this service.

**Intensive Outpatient Treatment (IOT)**

Reimbursement is available for intensive outpatient treatment when provided to treat substance abuse or psychiatric disorders, subject to prior authorization. IOT must operate at least three (3) hours per day, at least three (3) days per week and must be based on an individualized integrated care plan.

The Medicaid covered service components are covered by the State through licensed professionals under 42 C.F.R. 440.60 and are as follows:

- Individual/Family Therapy (Attachment 3.1-A Addendum Page 3.1); and
- Group Therapy (Attachment 3.1-A Addendum Page 3.1).

The Medicaid covered service components and the practitioners who are qualified to provide them are as follows:

- Skills Training (Attachment 3.1A Addendum Page 8b and 8c);
- Medication Training and Support (Attachment 3.1A Addendum Page 8b);
- Peer Recovery Services (Attachment 3.1A Addendum Page 9c.3); and
- Care Coordination (Attachment 3.1A Addendum Page 9).

Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Therapy services to the beneficiary's family and caretakers are for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.

The following providers are qualified to deliver Individual/Family Therapy; Group Therapy; Skills Training; Medication Training and Support; Peer Recovery Services; and Care Coordination.

- Licensed professional
- QBHP
- OBHP

**MRO SERVICES WILL CONTINUE ON PAGE 9d**

**MRO SERVICES WILL CONTINUE ON PAGE 9d****Peer Recovery Services**

Refers to individual face-to-face services that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services which may be provided include:

- Assisting the consumer with developing self-care plans, and other formal mentoring activities aimed at increasing active participation in person-centered planning and delivery of individualized services.
- Assisting the consumer in the development of psychiatric advanced directives.
- Supporting day-to-day problem solving related to normalization and reintegration into the community.
- Education and promotion of recovery and anti-stigma activities associated with mental illness and addiction.

Peer Recovery Services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan (IICP). An IICP is developed with the consumer and must reflect the consumer's desires and choices. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness or addiction. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Individuals certified in Peer Recovery Services. Individuals providing Peer Recovery Services must be under the supervision of a Licensed professional or QBHP and must be self-identified consumers who are in recovery from mental illness and/or substance use disorders, are trained in a basic set of competencies necessary to perform the peer support function, have demonstrated the ability to support the recovery of others from mental illness and/or substance use disorders, and receive continuing and ongoing education as administered by agencies certified by the Department of Mental Health and Addiction (DMHA).

**MRO SERVICES WILL CONTINUE ON PAGE 9d**

## Mobile Crisis Services

Mobile crisis services, authorized under 42 CFR 440.130(d), are mobile, face-to-face, home and community-based interventions that serve individuals experiencing a mental health or substance use-related crisis. Mobile crisis services must be recommended by a physician or other licensed practitioner and consist of a multidisciplinary team of trained providers who arrive and respond to mental health/substance use crises in the community operating 24-hours, 7 days per week. Services must be provided to individuals outside of a hospital or other facility settings including community mental health centers.

Mobile crisis services are tailored to meet the needs of the individual and may include:

- Triage/Screening: Screening to determine the level of risk faced by the individual in crisis and assessing the most appropriate response.
- Assessment: Collects information on the circumstances of the crisis event, safety and risk related to the individual and others involved, medication and substance use, strengths and resources of the individual, recent inpatient hospitalizations or mental health services, mental health conditions, medical history, and other pertinent information.
- De-escalation through brief counseling: Brief counseling techniques specific to the crisis that aims to lower risks and resolve the crisis so that a higher level of care is not needed.
- Care Coordination: Linkage of the individual in crisis to ongoing services to address the identified need(s). Services may include referrals for crisis stabilization, inpatient hospitalization, acute detoxification services, residential treatment services, recovery support services, medication services, home-based services, outpatient services, respite services, housing, and follow-up contacts.
- Crisis Intervention: Crisis assessment, crisis planning, and counseling specific to the crisis.
- Safety Planning: Engagement of the individual in a crisis planning process, resulting in the creation or update of planning tools, including an individualized safety plan. The safety plan aims to keep an individual in crisis and their environment safe and may include lethal means counseling, and other evidence-based interventions.
- Peer Recovery Support: Support provided by paraprofessional with lived experience with mental health and/or substance use disorder concerns.
- Medication Training and Support: Monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other

nursing/medical assessments. Allows for monitoring of medication-assisted treatment (MAT) and/or psychotropic medication services.

- Follow-up stabilization services: Follow up contacts in-person, via phone, or telehealth up to 14 days following initial crisis intervention. These services include coordination/warm hand-offs with identified resource needs (such as insurance navigation, housing, benefits and entitlements, physical health concerns, educational and/or vocational supports) which are intended to address precipitating mental health or substance use disorder factors leading to the crisis.

Mobile crisis teams are designated by the Division of Mental Health and Addiction (DMHA) and may include law enforcement-based co-responder behavioral health teams. Mobile crisis teams must include a minimum of two individuals with one individual able to perform an assessment within their scope of practice under Indiana state law. In accordance with Indiana state law mobile crisis teams must include:

- Individuals certified in Peer Recovery Services: Self-identified consumers who are in recovery from mental illness and/or substance use disorders, are trained in a basic set of competencies necessary to perform the peer support function, have demonstrated the ability to support the recovery of others from mental illness and/or substance use disorders, and receive continuing and ongoing education as approved by the DMHA; and
- At least one of the following:
  - Behavioral health professional licensed under Indiana state law, including marriage and family therapists, social workers, mental health counselors, addiction counselors and clinical addiction counselors
  - Other behavioral health professional (OBHP) as defined in Indiana Administrative Code working under a community mental health center (CMHC).
  - Emergency medical services personnel licensed in accordance with Indiana state law
  - Teams may include Community Health Workers certified by national certification programs that meet the state established Community Health Workers core competencies.

Mobile crisis services must be provided under the supervision of:

- Behavioral health professional licensed in accordance with Indiana state law;
- Licensed physician; or
- Licensed advanced practice nurse or clinical nurse specialist.

Supervision may be performed remotely.

All members of a mobile crisis team must complete state training on

person-centered care, trauma-informed care, de-escalation strategies, and harm reduction.

(12) Psychosocial rehabilitation services. Refers to Medicaid Rehabilitation Option (MRO) services provided in a community based Clubhouse setting in which the member, with staff assistance, is engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member services such as employment training, housing assistance, and educational support. These activities are designed to alleviate emotional or behavior problems with the goal of transitioning to a less intense level of care, reintegrating the member into the community, and increasing social connectedness beyond a clinical or employment setting. The Clubhouse setting is tailored to address the social isolation and social stigma experienced by many persons suffering from mental illness. Psychosocial rehabilitation services are covered when provided under the authority of an approved Division of Mental Health and Addiction (DMHA) Medicaid Rehabilitation Option (MRO) provider as authorized by a physician or health service provider in psychology (HSPP). Psychosocial rehabilitation services consist of the following Medicaid covered service component:

- Skills Training and Development: Refers to the development and/or restorations of skills (i.e., self-care, daily life management, or problem solving skills) directed toward restoring an individual to his best possible functional level, eliminating psychosocial barriers, and restoring a consumer's abilities that are essential to independent living.

The following providers are qualified to provide these services:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)
- Authorized health care professional (AHCP)

Limitations:

- Services may only be rendered in an internationally accredited Clubhouse setting certified by DMHA.
- Services are available for individuals with an Adult Needs and Strengths Assessment (ANSA) level of need (LON) of 3, 4, 5 or 5A.
- Service packages authorize the following units of service for 180 days for any member with a level of need LON of 3 or above. Any additional medically necessary units of service may be prior authorized.

Level of Need	Service Type	Units per 180 days (15 min.)
3, 4, 5, 5A	Clubhouse psychosocial rehabilitation services	1,820



Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
5	Psychiatric Assessment and Intervention	25
5A	Psychiatric Assessment and Intervention	100

#### Service Packages and Prior Authorization

MRO service packages are assigned to persons with a behavioral health need as demonstrated by a qualifying diagnosis and level of need. Services packages are designed to authorize a set of services and units of service necessary for the majority of persons with similar functional needs to achieve recovery. Service packages are assigned for 180 days based on the level of need assessment. Within the last 30 days of an assigned service package, a provider may reassess the person and a new service package will be assigned to start the day after the existing service package ends.

- Prior authorization is available under the following circumstances: A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
- A member requires a medically necessary MRO service not authorized in his or her MRO service package.
- A member does not have one or more qualifying MRO diagnoses and/ or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
- A member is newly eligible to the Medicaid program, or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive request for prior authorization is appropriate for MRO services provided during the retroactive period.

Providers must demonstrate that the service requested is medically necessary.

#### Individualized Integrated Care Plan Requirements

The following providers are able to certify a diagnosis for the purpose of developing an individualized integrated care plan (IICP) and approve the IICP for MRO services:

- A physician
- A licensed psychologist endorsed as a health service provider in psychology (HSPP)
- An advanced practice registered nurse (APRN)
- A licensed clinical social worker (LCSW)
- A licensed marriage and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A licensed clinical addiction counselor (LCAC)

The supervising practitioner is responsible for seeing the patient during the intake process or reviewing information submitted by the other licensed professionals, qualified behavioral health provider (QBHP), or other behavioral health provider (OBHP) and approving the individualized integrated care plan within seven (7) days. Services included in an individualized plan of treatment must commence within two (2) weeks upon completion of a patient's intake assessment. The supervising practitioner must provide face to face visits with the patient or review the individualized integrated care plan submitted by the QBHP at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the supervising practitioner assuming responsibility for the care plan.

## Provider Qualification Definitions

A licensed professional is defined as:

- (1) A licensed psychiatrist.
- (2) A licensed physician.
- (3) A licensed independent practice school psychologist.
- (4) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
- (5) A licensed clinical social worker (LCSW).
- (6) A licensed mental health counselor (LMHC).
- (7) A licensed marriage and family therapist (LMFT).
- (8) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

A “qualified behavioral health professional” (QBHP) means any of the following persons:

- (1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:

- (a) In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana.
- (b) In pastoral counseling from an accredited university.
- (c) In rehabilitation counseling from an accredited university.

- (2) An individual who is under the supervision of a licensed professional, as defined above, is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:

- (a) In social work from a university accredited by the Council on Social Work Education.
- (b) In psychology from an accredited university.
- (c) In mental health counseling from an accredited university.
- (d) In marital and family therapy from an accredited university.

- (3) An authorized healthcare provider (AHCP), defined as follows:

- (a) a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of their scope of practice as defined by the Indiana Professional Licensing Agency (IPLA) (IC 25-27.5-5)/.
- (b) a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician as stated in the section of state law (IC 25-23-1) related to advanced practice nurse collaboration with a licensed practitioner.

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

- (1) An individual with an associate or bachelor degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by either a licensed professional, as defined above, or a QBHP, as defined above.

may include: twenty-four (24) hour a day crisis intervention; care coordination to fulfill individual patient needs, including assertive care coordination when indicated; outpatient services, including intensive outpatient services, substance abuse services, counseling, and treatment; acute stabilization services, including detoxification services; residential services; day treatment; family support services; medication evaluation and monitoring; and services to prevent unnecessary and inappropriate treatment and hospitalization.

- (c) Community Mental Health Centers wishing to provide MRO services must be certified to provide a continuum of care to Medicaid consumers. These providers may subcontract for services as appropriate.
- (d) This MRO State Plan service is to run concurrently with the 1915(b)(4) fee-for-service selective contracting waiver (IN.03).

14. Services for individuals  
age 65 or older in  
institutions for  
mental diseases

Provided with limitations.

14.a.

Inpatient hospital services Reimbursement is available for medically reasonable and necessary inpatient psychiatric hospital services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Prior authorization is required for all inpatient psychiatric admissions including admissions for substance abuse

Reimbursement is available for emergency admissions only in cases of 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 (1) of the following:

- (1) Danger to the individual.
- (2) Danger to others.
- (3) Death of the individual.

Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization or stay in a psychiatric residential treatment facility is found not to have been medically necessary.

- 15.a. Intermediate Care Facility Services  
Provided with limitations.  
Reimbursement is available for medically reasonable and necessary services provided by a certified intermediate care facility for the mentally retarded (ICF/MR), subject to prior authorization.
- 15.b. Including such services in a public institution for the mentally retarded  
Provided with limitations.  
Reimbursement is available for medically reasonable and necessary services provided by a certified intermediate care facility for the mentally retarded (ICF/MR), subject to prior authorization.
16. Inpatient Psychiatric Facility Services for Individuals under Age 21  
Provided with limitations.  
Reimbursement is available for medically reasonable and necessary services for inpatient psychiatric hospital and psychiatric residential treatment facility services for individuals under age 21 years of age subject to prior authorization.
17. Nurse-Midwife Services  
Provided with limitations.  
Medicaid reimbursement is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services the nurse-midwife is legally authorized to perform, including well-woman gynecological healthcare, family planning, and care to the normal and expanding family throughout pregnancy, labor, delivery, and post-delivery.
18. Hospice Care  
Provided with limitations.  
Medicaid reimbursement is available for hospice services subject to prior authorization.  
Hospice services consist of the following:  
(1) Palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program patient during the final stages of the patient's terminal illness.  
(2) Care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death. In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing the individual is terminally ill and expected to die from that illness within six (6) months.
- For recipients twenty-one (21) years of age and older, In order to receive hospice services, a recipient must elect hospice services. Election of the hospice benefit requires the recipient to waive Medicaid coverage for other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness.
- For recipients less than twenty-one (21) years of age who elect hospice care, the recipient may receive concurrent curative treatment in conjunction with hospice services for the terminal illness. This allows the recipient or the recipient's representative to elect the hospice benefit, without forgoing any curative service the recipient is entitled to under Medicaid for treatment of the terminal condition.

19. Targeted Case Management for:  
Recipients with  
Elevated Blood Lead Levels

Reimbursement is available for targeted case management when provided in accordance with 42 CFR 440.169 and for individuals, who, through a blood lead screening conducted in accordance with the EPSDT periodicity schedule, are found with a confirmed elevated blood lead level, as defined by the Centers for Disease Control and Prevention. Reimbursement is limited to no more than 26, 15 minute units, per recipient, per twelve month period of time. Prior authorization is required for additional units of medically necessary targeted case management.

20. Extended Services for  
Pregnant Women

Reimbursement is available for extended services for pregnant women with limitations and include the following:

- Pregnancy-related and postpartum services for 60 days after the pregnancy ends
- Services for any other medical conditions that may complicate pregnancy

Services must be medically necessary and reasonable and defined as a covered service required for the care or well being of the patient and provided in accordance with generally accepted standards of medical or professional practice.

20.a. Pregnancy-related and postpartum  
services for 60 days after the  
pregnancy ends

Coverage is limited to legend and non-legend drugs, prescribed for indications directly related to the pregnancy and routine prenatal, delivery and postpartum care, including family planning services. Additionally, transportation services, to and from the aforementioned services, will be provided. Payment for pregnancy-related services is subject to prior authorization.

20.b. Services for any other  
medical conditions that  
may complicate pregnancy

Reimbursement is available for services provided to a pregnant woman for the treatment of a chronic condition or other abnormal condition related to the pregnancy or complicates the medical management of the mother during pregnancy, childbirth and Puerperium including those conditions associated with fetal abnormalities and conditions.

A condition that may complicate the pregnancy, is any condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the patient's condition or a need for a higher level of care. Reimbursement is available subject to prior authorization.

TN No. 12-007  
Supersedes  
TN No. 08-009

Approval Date: APR 25 2013

Effective Date: July 1, 2012

23. Pediatric or Family Nurse Practitioners' services  
Provided with limitations.  
Reimbursement is available for medically necessary and preventive health care services provided by a licensed, certified nurse practitioner within the scope of practice of the applicable license and certification.
24. Any other medical or remedial care recognized by state law  
Provided as described in 24a – 24d.
- 24.a. Transportation services  
Reimbursement is available for emergency and nonemergency transportation to or from a Medicaid covered service. Providers located within Indiana or in a designated out of state area may be reimbursed for up to twenty (20) one-way trips of less than fifty (50) miles each, per recipient, per twelve (12) month period, without prior authorization. Designated out-of-state areas are the following:
- |                          |                         |
|--------------------------|-------------------------|
| (A) Louisville, Kentucky | (F) Sturgis, Michigan   |
| (B) Cincinnati, Ohio     | (G) Watseka, Illinois   |
| (C) Harrison, Ohio       | (H) Danville, Illinois  |
| (D) Hamilton, Ohio       | (I) Owensboro, Kentucky |
| (E) Oxford, Ohio         |                         |
- Prior authorization is required for the following:
- (1) More than 20 one-way trips, per recipient, per rolling 12-month period.
  - (2) Trips of 50 miles or more one way
  - (3) In-state train or bus transportation services, including out-of-state designated areas.
  - (4) Transportation services provided by a provider located in a non-designated, out-of-state area.
  - (5) Airline, air ambulance, and interstate transportation
  - (6) Family member transportation
  - (7) Medically necessary school-based specialized transportation
    - (a) School-based specialized transportation is defined as transportation to a medically necessary service (as outlined in the Individualized Education Plan (IEP)/Individualized Family Service Plan (IFSP) of an enrolled Medicaid beneficiary) provided in a specially adapted (e.g., specially adapted school bus or van) that has been physically adjusted or designed to meet the needs of the individual student under the Individuals with Disabilities Education Act (IDEA) (e.g., special harnesses, wheelchair lifts, ramps, specialized environmental controls, etc.,) to accommodate students with disabilities in the school-based setting.
    - (b) School-based specialized transportation is available to “Medicaid-eligible beneficiaries for whom the transportation services are medically necessary and documented in IEP/IFSP. School-based specialized transportation must be provided on the same date of service that a Medicaid covered service required by the student’s IEP/IFSP is received
    - (c) The Medicaid enrolled student’s IEP/IFSP as required by IDEA serves as the prior authorization for medically necessary school-based specialized transportation services when provided by a Medicaid participating school corporation. No additional prior authorization is required.
    - (d) School-based specialized transportation is provided by personnel who are employed by or under contract with a Medicaid-participating school corporation provider.
- Trip limits can be exceeded based on prior authorization review and confirmation of a covered services associated with the trip.

Except for trips over 50 miles, the following services are exempt from the numeric trip cap and prior authorization requirements:

- (1) Emergency ambulance services
- (2) Transportation to or from a hospital for an inpatient admission
- (3) Transportation for patients on renal dialysis or residing in a nursing home
- (4) Accompanying parent or recipient attendant
- (5) Return trip from emergency room in an ambulance

24.b. Services provided in  
Religious Nonmedical  
Health Care Institutions

Provided within the limitations of 42 CFR 440.170(b).

24.c

Reserved

24.d. Skilled Nursing Facility  
Services for Patients under

Reimbursement is available for skilled nursing services provided by a licensed and certified nursing facility when rendered to a Medicaid recipient whose level 21 Years of Age of care has been approved by the Medicaid agency.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE  
AND SERVICES TO THE CATEGORICALLY NEEDY

28. (i) Freestanding Birth Center services: Reimbursement is available for licensed or otherwise State-approved freestanding birthing centers

Provided: ☐ No limitations ☒ With limitations ☐ None licensed or approved

Provided with limitations:

- 1) Recipients must be considered low-risk, normal or having an uncomplicated pregnancy;
- 2) Delivery shall be performed by a:
  - a. Certified nurse midwife; or
  - b. Physician
- 3) Surgical services are limited to episiotomy and episiotomy repair; and shall not include operative obstetrics or cesarean sections;
- 4) Labor shall not be inhibited, stimulated or augmented with chemical agents during the first or second stage of labor;
- 5) Systemic analgesia may be administered and local anesthesia for prudential block and episiotomy repair may be performed;
- 6) General and conductive anesthesia shall not be administered at birthing centers;
- 7) Recipients shall not routinely remain in the facility in excess of twenty-four (24) hours.

28 (ii ) Licensed or Otherwise recognized State-Recognized covered professionals providing services in the Freestanding Birth Center

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).