Division of Mental Health and Addiction

Adult Mental Health

Habilitation Program

Provider Manual
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</tr>
</tbody>
</table>

Revision History
# Table of Contents

Table of Contents ................................................................................................. vi

Section 1: Introduction.......................................................................................... 1

Habilitation Versus Rehabilitation ................................................................. 1

Section 2: Adult Mental Health Habilitation (AMHH) Services ......................... 3

Home and Community-Based Setting Requirements .................................. 4

Length of Authorization Period ..................................................................... 4

Covered AMHH Service Requirements ....................................................... 4

Noncovered Services ...................................................................................... 4

Crisis Intervention Services ......................................................................... 5

Section 3: AMHH Service Providers................................................................. 7

Provider Agency Application ....................................................................... 7

Provider Agency Requirements ................................................................... 7

Provider Agency Expectations ................................................................... 8

Agency Staff Requirements ......................................................................... 8

Licensed Professional ................................................................................. 9

Qualified Behavioral Health Professional (QBHP) .......................................... 9

Other Behavioral Health Professional (OBHP) ........................................... 10

AMHH Clinical Supervision Standards ...................................................... 10

Section 4: AMHH Member Rights................................................................... 11

Grievance or Complaints ............................................................................ 11

Incident Reporting ....................................................................................... 11

Section 5: AMHH Program Member Eligibility ............................................ 13

Eligibility Determination and Conflict of Interest ....................................... 13

Member Eligibility Criteria ........................................................................ 13

Target Group Criteria ................................................................................ 13

Needs-Based Criteria .................................................................................. 14

Section 6: AMHH Member Home and Community-Based Settings Requirements ...................................................................................................................................................... 15

AMHH Members and Choice of Living Arrangement ................................ 16

FSSA/DMHA Certified Residential Facility Settings – Standards, Rights, and Definitions ................................................................. 16

Supervised Group Living Facility (SGL) ..................................................... 18

Transitional Residential Facility (TRS) ....................................................... 19

Semi-Independent Living Facility (SILP) .................................................. 19

Alternative Family for Adults (AFA) Program ........................................... 19

State Monitoring ......................................................................................... 20

Section 7: AMHH Referral and Application Process ....................................... 21

Referrals for AMHH Services .................................................................... 21

Provider Agency Responsibilities During the Application Process .......... 21

Informed Choice of Providers ................................................................... 21

Requirement for Face-to-Face Evaluations .............................................. 22

Behavioral Health Assessment Tool ....................................................... 23

Proposed AMHH Plan of Care ................................................................. 23
Completion and Processing the AMHH Member Application............................. 23

Section 8: Completing the AMHH Application .................................................. 25
Elements of the AMHH Application................................................................. 25
Page 1 – General .......................................................................................... 25
Page 2 – IICP Form ....................................................................................... 32
Reviewing and Submitting the Application..................................................... 39

Section 9: Person-Centered Planning and Individualized Integrated Care Plan
Development................................................................................................. 41
Staff Requirements......................................................................................... 41
Freedom of Choice......................................................................................... 41
Developing the Individualized Integrated Care Plan (IICP)............................ 42
Crisis Plan ...................................................................................................... 43
Member’s Refusal to Sign IICP ...................................................................... 44
Ongoing IICP Review..................................................................................... 44

Section 10: AMHH Eligibility Determination, Service Approval, and Utilization 45
The State Evaluation Team (SET) ................................................................. 45
SET Assessment and Determination of Member Eligibility ......................... 45
Determining a Start Date for AMHH Eligibility ......................................... 46
Communication of the SET Eligibility Determination ................................ 46
AMHH Services – Eligibility Period ............................................................ 47
Approval for AMHH Units of Services......................................................... 48
Interruption of AMHH Services .................................................................. 48
Termination of AMHH Services ................................................................. 48

Section 11: Request for Approval of Additional AMHH Services ................. 49

Section 12: Renewal of AMHH Program Member Eligibility ....................... 51

Section 13: Transitions During AMHH Eligibility Period ............................ 53
Transition Between AMHH Service Provider Staff Within an Agency .......... 53
Transition Between AMHH Provider Agencies ............................................ 53
Voluntary Transition from AMHH Services to MRO Services .................... 54
Default Transition from AMHH Services to MRO Services ........................ 54

Section 14: Clinical and Administrative Documentation ............................... 55
Service Location Specifications..................................................................... 55
General Documentation Requirements ........................................................ 55
Services Provided in a Group Setting ........................................................... 56
Services Provided Without the Member Present ........................................ 56
Service-Specific Documentation Requirements .......................................... 57
Adult Day Services ...................................................................................... 57
Respite Care Services .................................................................................. 57

Section 15: Adult Day Services ...................................................................... 59
Provider Qualifications ................................................................................. 59
Programming Standards .............................................................................. 60
Requirements for Clinical Oversight .......................................................... 60
Exclusions .................................................................................................... 60
HCPCS Codes .............................................................................................. 61
Service Unit Description and Limitations .................................................... 61
Section 16: Home and Community-Based Habilitation and Support Services

Provider Qualifications

Programming Standards

Exclusions

HCPCS Codes

Service Unit Description and Limitations

Section 17: Respite Care Services

Provider Qualifications

Programming Standards

Exclusions

HCPCS Codes

Service Unit Description and Limitations

Section 18: Therapy and Behavioral Support Services

Provider Qualifications

Programming Standards

Exclusions

HCPCS Codes

Service Unit Description and Limitations

Section 19: Addition Counseling Services

Provider Qualifications

Programming Standards

Exclusions

HCPCS Codes

Service Unit Description and Limitations

Section 20: Peer Support Services

Provider Qualifications

Programming Standards

Exclusions

HCPCS Codes

Service Unit Description and Limitations

Section 21: Supported Community Engagement Services

Provider Qualifications

Programming Standards

Exclusions

HCPCS Codes

Service Unit Description and Limitations

Section 22: Care Coordination Services

Provider Qualifications

Programming Standards

Exclusions

HCPCS Codes

Service Unit Description and Limitations

Section 23: Medication Training and Support Services

Provider Qualifications

Programming Standards
Exclusions ................................................................. 86
HCPCS Codes .......................................................... 87
Service Unit Description and Limitations ....................... 87

Section 24: AMHH Services Program Billing .................. 89
   Billing Standards .................................................... 89
   Claim Form ............................................................. 89
   Claim Format ........................................................ 89
   Facility Fees .......................................................... 90
   AMHH and the Healthy Indiana Plan (HIP) .................... 90
   Time Documentation ............................................... 91
   Converting Time Spent for Service Delivery to Billing Units 92
   15-Minute Unit ....................................................... 93
   One-Hour (60-Minute) Unit ...................................... 94
   Half-Day Units ........................................................ 95
   Respite Care and Single-Day Units ............................. 95
   Modifiers for AMHH Services ................................. 96
   Midlevel Provider Modifiers .................................. 96
   Third-Party Liability (TPL) Requirements .................... 96
   Place of Service Codes ............................................ 97
   Mailing Address for Claims ..................................... 97
   Additional Addresses and Telephone Numbers ............ 97

Appendix A: AMHH Acronyms and Definitions ................ 99
Appendix B: AMHH-Eligible Primary Mental Health Diagnoses ....... 105
Appendix C: AMHH Service Codes and Rates Table ............ 109
Appendix D: Sample AMHH Denial Notification ................. 111
Appendix E: Example Crisis Plan Format ........................ 115
Appendix F: CMHC Provider Application and Attestation to Provide AMHH Services ........................................ 117
Appendix G: AMHH Application Status Codes ................... 119
Section 1: Introduction

The Adult Mental Health Habilitation (AMHH) Program Provider Manual is a resource specifically for the Indiana Family and Social Services Administration’s Division of Mental Health and Addiction (FSSA/DMHA) approved Adult Mental Health Habilitation (AMHH) service providers. Section 6086 of the Deficit Reduction Act of 2005 (DRA), Public Law Number 109-171, expanded access to Home and Community-Based Services (HCBS) for the Elderly and Disabled, by adding a new section 1915(i) to the Social Security Act (“the Act”). Under section 1915(i), states have the option to amend their state plans to provide HCBS without regard to state-wideness or certain other Medicaid requirements. AMHH services are approved by the Centers for Medicare & Medicaid Services (CMS) as 1915(i) HCBS services and may be provided for five years following CMS’ approval of the State Plan Amendment (SPA) to provide AMHH services. CMS initially approved the AMHH SPA September 25, 2013, with an effective date of October 1, 2013, with an option to renew for an additional five years.

Indiana adopted the AMHH program to provide community-based opportunities for the care of adults with serious mental illness, with or without co-occurring substance use disorders, who may most benefit from a habilitation approach to care versus a rehabilitative approach.

Habilitation Versus Rehabilitation

The distinction of whether a service is rehabilitative versus habilitative is often more rooted in an individual’s level of functioning and needs than in the actual service provided. Federal law describes Medicaid rehabilitation services as any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a member to his or her best possible functional level. Habilitation services, by comparison, are defined as activities that are designed to assist individuals in acquiring, retaining, and improving the following skills necessary to reside successfully in a community setting:

- Self-help
- Socialization
- Adaptive skills

AMHH services are indicated as a service alternative for individuals who have achieved maximum benefit from Medicaid Rehabilitation Option (MRO) services and whose needs can better be met through habilitation. Possible candidates for AMHH services are individuals who have reached their capacity for improving their level of functioning but need to retain their current functional level to remain in the community. Habilitation services benefit the individuals by providing them with the skills and supports needed to safely remain in a community-based setting and reduce their risk for institutionalization. Eligibility for AMHH services is determined based on the individual’s meeting specific target and needs-based criteria outlined in this manual.

The AMHH Provider Manual documents the policies and procedures for the AMHH program, as well as State and federal expectations for AMHH service providers, and provides guidance regarding AMHH member eligibility determination, enrollment, service delivery, clinical documentation, and billing. The manual is intended to be used in conjunction with the following resources:

- 1915(i) AMHH State Plan Amendment TN 12-003, approved by the CMS
- 1915(b)(4) AMHH Waiver, approved by the CMS
- 405 IAC 5-21.6 (Indiana Administrative Code for AMHH services)
• Indiana Health Coverage Programs (IHCP) policies and expectations issued by the FSSA
• Any FSSA/DMHA updates or policy revisions to the AMHH program or requirements for AMHH providers
• Bulletins issued by the CMS or the FSSA

Approved AMHH service providers are expected to review, understand, and follow AMHH program policy and procedures, as well as any subsequent updates or revisions issued by the CMS or the FSSA/DMHA/OMPP. Failure to comply with state and federal regulations associated with the AMHH program and the expectations outlined in the provider manual will lead to formal corrective actions, state and federal sanctions, or termination as an AMHH service provider.
Section 2: Adult Mental Health Habilitation (AMHH) Services

Adult Mental Health Habilitation (AMHH) services refers to medical or remedial services recommended by a physician or psychologist endorsed as a health service provider in psychology (HSPP), within the scope of his or her practice, for the habilitation of a mental health disability and the restoration or maintenance of an individual’s best possible functional level. AMHH services are clinical and supportive behavioral health services provided for individuals, families, or groups of adults who are living in the community and who need aid on a routine basis for mental illness or co-occurring mental illness and addiction disorders. AMHH services are designed to assist in the habilitation of the individual’s optimum functional ability in daily living activities. This goal is accomplished by:

- Assessing the individual’s needs and strengths
- Developing an Individualized Integrated Care Plan (IICP) that outlines objectives of care, including how AMHH services will assist in delivering appropriate home and community-based habilitation services to the individual
- Assisting the individual in reaching their habilitative goals

AMHH services are intended to benefit the following individuals:

- Adults living in community-based settings who need routine help with managing serious mental illness (SMI) or co-occurring mental illness and addiction disorders.
- Adults who have reached the maximum benefit from a rehabilitative treatment approach and would be better served with access to a habilitation approach to services to help them maintain and enhance treatment gains
- Adults who have a high need for services and are considered at risk of institutionalization without access to intensive community-based services

Indiana has chosen to make available AMHH services for the following reasons:

- AMHH services will assist adults with SMI, with or without a co-occurring substance use disorder, in reaching or maintaining the highest level of independence and functioning possible through the reinforcement, management, adaptation, and retention of skills necessary to live successfully in the community.
- Individuals with SMI who are limited in their ability for self-care and independence are empowered to remain integrated in their community with an appropriate level of supervision, services, and supports.
- Services will improve “quality of life” for individuals with SMI living in the community and decrease the need for institutional care.
- AMHH services fill a gap between Medicaid Rehabilitation Option (MRO) and Medicaid Clinic Option (MCO) services.

The following AMHH services are available, according to the coverage criteria, limitations, and eligibility requirements specified in this manual, the AMHH SPA, and 405 IAC 5-21.6:

- Adult Day Service
- Home and Community-Based Habilitation and Support
• Respite Care
• Therapy and Behavioral Support Services
• Addiction Counseling
• Peer Support Services
• Supported Community Engagement Services
• Care Coordination
• Medication Training and Support

Home and Community-Based Setting Requirements

As mandated in the CMS-approved 1915(i) AMHH SPA and 405 IAC 5-21.6, AMHH services will be furnished to individuals who in their homes or other community-based settings, not in institutions. CMS has issued a final rule regarding home and community-based settings (CMS 2249-F/2296-F), which establishes requirements for the qualities of settings that are eligible for reimbursement for 1915(i) services. Additional information is available at the FSSA Home and Community-Based Services Final Rule website at www.in.gov/fssa/4917.htm.

See Section 6: AMHH Member Home and Community-Based Services Final Rule website in this manual for additional information.

Length of Authorization Period

An eligible AMHH member is authorized to receive AMHH services on an approved Individualized Integrated Care Plan (IICP) for one year (360 days) from the start date of AMHH eligibility, or as determined by the FSSA/DMHA State Evaluation Team (SET). Services may be provided according to the FSSA/DMHA-approved IICP as long as the member continues to meet AMHH eligibility criteria. After an applicant is determined eligible for AMHH services program, the SET approves AMHH services based on review of documentation and the IICP.

Covered AMHH Service Requirements

For a service to be reimbursable under the AMHH services program, it must meet the following minimum criteria:

• Be provided to an individual determined by the FSSA/DMHA SET as eligible for AMHH services
• Be a service proposed on the member’s IICP and approved by the SET
• Be a covered AMHH service, as described in this provider manual
• Be provided in a manner that is within the scope and limitations of the AMHH service, including provider qualifications
• Be supported in clinical documentation as a service that:
  − Continues to promote stability for the AMHH member
  − Enables the member to move toward obtaining the habilitative goals identified in the individual’s IICP

Noncovered Services

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

• A service provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, state, local, and private entities (for example, MRO, BPHC,
1915(c) waiver). For any service provided simultaneously with another service, only one of the services provided is billable.

- A service provided as a diversion, leisure, or recreational activity unless it is an identified component of an approved Respite Care service
- A service that is provided in a manner that is not within the scope and limitations of the AMHH service
- A service not on the member’s IICP
- A service that is on the member’s IICP but is not documented as a covered or approved service by the State Evaluation Team
- A service provided that exceeds the limits within the service definition, including service quantity or limit, duration, or frequency
- Any service provided on the same day that the member is receiving inpatient or partial hospitalization through Medicaid
- Time spent on the initial face-to-face assessment, referral form, and IICP may not be billed under AMHH.

Crisis Intervention Services

As noted in 405 IAC 5-21.5-8, services reimbursable as crisis intervention services are short-term emergency behavioral health services, available 24 hours per day, 7 days per week.

These services include 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 services is to resolve the crisis and transition the consumer to routine care through stabilization of the acute crisis and linkage to necessary services. This service may be provided in an emergency room, crisis clinic setting, or in the community.

Crisis intervention is a covered service for any Medicaid member; however, it is not a service that is defined in the AMHH SPA. If an AMHH member needs crisis intervention services, he or she may access these services.
Section 3: AMHH Service Providers

AMHH services may be delivered only by service provider agencies meeting specific state-defined criteria. FSSA/DMHA certifies agencies to provide AMHH services to eligible members. DMHA-approved providers must also be enrolled as authorized IHCP providers with the AMHH specialty.

AMHH-approved IHCP-enrolled providers must meet specific provider standards and criteria developed to ensure that AMHH members receive access to a full continuum of behavioral health services provided in a manner that will ensure the health and safety of those individuals. In Indiana, community mental health centers (CMHCs) in good standing with FSSA/DMHA are eligible to be approved as IHCP-enrolled AMHH service provider agencies.

Provider Agency Application

To become an AMHH service provider agency, the CMHC must complete and return a CMHC Provider Agency Application and Attestation to Provide Adult Mental Health Habilitation Services, acknowledging that the agency will adhere to AMHH program policy and state requirements for all AMHH service providers, as described in this section. (For a sample form, see Appendix F: CMHC Provider Agency Application and Attestation to Provide AMHH.) The completed provider application is returned to the FSSA/DMHA director’s office for review and approval or denial. FSSA/DMHA documents approval or denial of the CMHC’s application to become an AMHH provider agency. If the agency is approved as an AMHH provider agency, the FSSA/DMHA notifies the IHCP to add AMHH to the existing CMHC provider profile. Approvals are valid for three years. When possible, the FSSA/DMHA aligns the AMHH provider agency renewal process with the routine CMHC certification time line. Ongoing, CMHCs that are approved to provide AMHH need to be sure they comply with rules and regulations noted on the 1915(i) Home and Community-Based Services Programs page at indianamedicaid.com. If approved as an AMHH provider agency, the CMHC adds Specialty 115 – 1915(i) AMHH Service Provider to its provider profile.

Provider Agency Requirements

All provider agencies must be approved by the FSSA/DMHA and must meet the following AMHH provider agency criteria and standards:

- Be an FSSA/DMHA-certified Community Mental Health Center (CMHC) in good standing, including adherence to criteria required of all FSSA/DMHA-certified CMHCs
- Has acquired and maintains a national accreditation by an entity approved by the FSSA/DMHA
- Is an enrolled IHCP provider that offers a full continuum of care (See Chapter 4 of the IHCP Provider Manual at indianamedicaid.com.)
- Must attest that they are willing and able to provide AMHH services as described in the AMHH SPA, 405 IAC 1-5-1 and 405 IAC 1-5-3 and the AMHH provider manual. This includes but is not limited to:
  - Maintain documentation in accordance with IHCP requirements defined in 405 IAC 1-5-1 and 405 IAC 1-5-3, and outlined in the IHCP Provider Manual for all IHCP providers
  - Meet all AMHH provider agency criteria, as defined in the AMHH SPA and 405 IAC 5-21.6 of the Indiana Administrative Code
  - Employ individual providers that are eligible to provide AMHH services. See the following Agency Staff Requirements subsection for additional provider staff eligibility requirements.
Provider Agency Expectations

FSSA/DMHA approval of an agency as an IHCP-enrolled AMHH provider agency is contingent on that agency’s complying with all IHCP and AMHH program rules and policies. In addition to meeting the requirements for IHCP-enrolled providers for AMHH services, all AMHH provider agencies will ensure that members are provided access to all the services and supports needed to meet members’ individualized needs. AMHH provider agencies must:

- Provide information related to AMHH services, members, and provider staff, as required or requested by the FSSA/DMHA
- Ensure that all direct care agency staff members providing AMHH services to members meet all standards and qualifications required for the AMHH service being provided. CMHCs are responsible for maintaining accurate and up-to-date files for each staff member, including but not limited to proof of training.
- Actively participate in the FSSA/DMHA quality assurance program, ensuring compliance with all performance criteria set forth for the AMHH program. As required by the State, the agency must participate in any quality improvement initiatives as they relate to the AMHH program.
- Participate in AMHH provider agency meetings, trainings, conference calls, and webinars provided or authorized by the FSSA/DMHA
- Comply with FSSA/DMHA requirements regarding the reporting of critical incidents
- Provide a system throughout its agency and network for handling individual complaints and appeals, including informing members of the availability of a toll-free number for reporting complaints to the State and the telephone number for the Indiana Protection and Advocacy Services Commission
- Cooperate fully with the processing of any AMHH-related complaint or appeal, including any grievance plan or correction initiated by the State
- Be compliant with all federal Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 mandates and regulations in regards to consumer privacy and information sharing
- Meet all clinical and operational standards and state requirements for an FSSA/DMHA-certified community mental health center, as found in 440 IAC 4.1.
- Maintain written policies and procedures for timely intake, screening, and comprehensive evaluation from the time a referral for AMHH services is received to ensure that members have access to appropriate mental health and addiction treatment services in a timely manner
- If a service or support required to meet the member’s identified needs is not available or accessible by the member in a timely manner, the provider agency must provide or make provision for an alternative service or support to meet the member’s identified needs until the requested service becomes available.
- Reapply for approval as an AMHH provider agency every three years from the date of initial approval as an AMHH provider agency, as determined by the FSSA/DMHA.

Agency Staff Requirements

An FSSA/DMHA-approved AMHH provider agency must ensure that the agency staff members providing the AMHH service meet the specific criteria and standards required for the AMHH services they provide. The following agency staff members may provide AMHH services, as long as they meet the other service-specific criteria required (see Sections 15-23 of this manual for service-specific provider standards and requirements):
Licensed Professional

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

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

Qualified Behavioral Health Professional (QBHP)

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

- An individual who has had at least two years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as previously defined, with such experience occurring after the completion of a master’s degree or doctoral degree, or both, in any of the following disciplines:
  - In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana
  - In pastoral counseling from an accredited university
  - In rehabilitation counseling from an accredited university
- An individual who is under the supervision of a licensed professional, as previously defined, is eligible for and working toward licensure, and has completed a master’s or doctoral degree, or both, in any of the following disciplines:
  - In social work from a university accredited by the Council on Social Work Education
  - In psychology from an accredited university
  - In mental health counseling from an accredited university
  - In marital and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional, as previously defined.
- An authorized healthcare professional (AHCP) who is one of the following:
  - A physician’s assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5
  - A nurse practitioner or clinical nurse specialist with prescriptive authority and performing duties within the scope of that person’s license, under the supervision of or under a supervisory agreement with a licensed physician, pursuant to IC 25-23-1.
Other Behavioral Health Professional (OBHP)

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

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

- A licensed addiction counselor, as defined under IC 25-23.6-10.5, supervised by a licensed professional, as previously defined, or a QBHP, as previously defined.

AMHH Clinical Supervision Standards

Where clinical supervision for provider agency staff is required, it is expected that the provider has and implements clearly delineated policies and procedures for defining, implementing, and documenting clinical supervision as defined and required by AMHH service standards. Operational supervision is at the discretion of the AMHH provider agency to define and implement.
**Section 4: AMHH Member Rights**

AMHH provider agencies must ensure that all AMHH members in their care retain the following rights:

- To receive appropriate behavioral health services in accordance with standards of professional practice, appropriate to the member’s needs and designed to afford the individual a reasonable opportunity to maintain or improve his or her condition.
- To participate in the planning of the IICP, including receiving assistance in understanding and being informed of the nature of the treatment program proposed, the known effects of receiving and not receiving such treatment, and alternative treatments, if any.
- To refuse to submit to treatment, including medication or services as an adult voluntary patient.
- To be treated with consideration, dignity, and respect, free from mental, verbal, and physical abuse or neglect.
- To have freedom of choice regarding which FSSA/DMHA-approved AMHH provider agency (or agencies) delivers AMHH services, and the freedom to change AMHH provider agencies at any time during the AMHH services eligibility period.
- To be sure of confidentiality and protection of personal identifying and treatment-related information, as provided under HIPAA.

Each FSSA/DMHA-approved AMHH provider agency is required to ensure that each AMHH participant receives a written statement of rights. The statement shall include:

- The toll-free consumer service line number and the telephone number for the Indiana Protection and Advocacy Services Commission.
- Documentation that the provider agency provided both a written and an oral explanation of rights to each applicant or member.

**Grievance or Complaints**

The objective of the grievance or complaint reporting policy is to provide members with a formal process to ensure that the individual can voice concerns, complaints, and grievances regarding the AMHH services program to the FSSA/DMHA for review and resolution. Provider agencies are required to help members understand their rights and options regarding filing a grievance or complaint about AMHH services and service delivery to FSSA/DMHA. Provider agencies are required to follow the FSSA/DMHA policy for grievances and complaints.

**Incident Reporting**

Incident reporting provides a mechanism for reporting and responding to critical or sentinel incidents occurring in connection with the AMHH services program. Provider agencies are required to follow the FSSA/DMHA requirements on critical incident reporting.
Section 5: AMHH Program Member Eligibility

AMHH services are offered as part of a Medicaid State Plan option for providing 1915(i) home and community-based services (HCBS) to promote and empower independence and integration into the community and as an alternative to an institutional level of care. This 1915(i) option allows Indiana to offer home and community-based services to individuals who are enrolled in Medicaid and meet specific target-group and needs-based eligibility criteria. As defined in the AMHH SPA and in 405 IAC 5-21.6, Indiana elected to target the 1915(i) State Plan HCBS benefit to a specific population. Eligibility for the AMHH program is determined by the State Evaluation Team and is based on the following:

- Target group criteria
- Financial criteria (enrolled in Medicaid)
- Needs-based criteria

Eligibility Determination and Conflict of Interest

To prevent conflict of interest in the final AMHH eligibility determinations, the responsibility for AMHH program eligibility determination and approval of the proposed AMHH services is in all cases retained by the FSSA/DMHA SET. Members of the SET are prohibited from having any financial relationships with the applicant or member requesting AMHH services, their families, or the provider agency selected to provide AMHH services.

AMHH provider agencies are required to have written policies and procedures available for review by the State. These policies and procedures must clearly define and describe how conflict of interest requirements are implemented and monitored within the agency, protecting the individuals applying for AMHH services and the integrity of the AMHH program.

Member Eligibility Criteria

The applicant must meet the following target-group and needs-based criteria to be eligible to receive AMHH services.

Target Group Criteria

AMHH services are targeted for individuals who meet the all of following target group criteria:

- Individual is enrolled in an eligible IHCP (Medicaid) program.
- Individual is age 35 or older at time of initial application.
- Individual has an AMHH-eligible primary mental health diagnosis, which may include the following (See Appendix B for a full listing of AMHH-eligible diagnosis codes):
  - Schizophrenic disorders (295.xx)
  - Major depressive disorder (296.xx)
  - Bipolar disorders (296.xx)
  - Delusional disorder (297.1),
  - Psychotic disorder NOS (298.9)
  - Obsessive-compulsive disorder (300.3)
Needs-Based Criteria

In addition to meeting the AMHH target group criteria, the applicant must also meet all the following needs-based criteria to be eligible for AMHH services:

- Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist or health services provider in psychology (HSPP), the applicant is likely to deteriorate and be at risk of institutionalization (for example, acute hospitalization, or time spent in a state hospital, nursing home, or jail).

- The applicant must demonstrate the need for significant assistance in major life domains related to his or her mental illness (for example, physical problems, social functioning, basic living skills, self-care, and potential for harm to self or others). Significant means *an assessed need for immediate or intensive action due to a serious or disabling need*, and assistance means *any kind of support from another person (for example, mentoring, supervision, reminders, verbal cueing, or hands-on assistance) needed because of a mental health condition or disorder*.

- The applicant must demonstrate significant needs related to his or her behavioral health.

- The applicant must demonstrate significant impairment in self-management of his or her mental illness or demonstrate significant needs for assistance with mental illness management.

- The applicant must demonstrate a lack of sufficient natural supports to assist with mental illness management.

- The individual is not a danger to self or others at the time the application for AMHH services program eligibility is submitted for SET review and determination.

- The individual has a recommendation for intensive community-based care on the Adult Needs and Strengths Assessment (ANSA) tool, with a level four or higher. See *Section 7: AMHH Referral and Application Process* for additional information about the assessment tool.

An applicant not meeting the target-group and needs-based criteria as previously defined will not be eligible to receive AMHH services under the 1915(i) HCBS state plan. When applicable, ineligible applicants will be linked to services that may meet their needs.
Section 6: AMHH Member Home and Community-Based Settings Requirements

AMHH is a home and community-based service (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities are to be provided within the individual’s home (place of residence) or at other locations based in the community. Service activities cannot be provided in an institutional setting.

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid Home and Community-Based Services (HCBS). The HCBS Final Rule became effective March 17, 2014. The HCBS Rule, along with additional guidance and fact sheets, is available on the CMS Home and Community Based Services site.

To view the HCBS statewide transition plan, go to the Home and Community Based Services Final Rule page at FSSA.in.gov

Per the CMS final rule on HCBS, service settings must exhibit the following qualities to be eligible sites for delivery of HCBS:

- Are integrated in and support full access to the greater community
- Are selected by the individual from among setting options
- Ensure the individual’s rights of privacy, dignity, and respect, and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and who provides them

There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections
- The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit
- The individual controls his or her own schedule, including access to food at any time
- The individual can have visitors at any time
- The setting is physically accessible

The following are examples of settings that are not considered home or community-based:

- Nursing facility
- Institution for mental diseases
- Intermediate care facilities for individuals with intellectual disability
- Hospitals
- Any other location that has the qualities of an institutional setting. This may include, but is not limited to:
• A setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment
• A setting that is located in a building on the grounds of, or immediately adjacent to, a public institution
• Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

AMHH Members and Choice of Living Arrangement

Many persons choosing to participate in AMHH services live in their own homes, or with families or friends, in the same manner as any adult who does not have a mental illness. Among persons who may be eligible for AMHH services, though, are some who do not have family or friends with whom they can live, or are not functioning at a level in which their health and safety can be supported in a totally independent setting. Depending on a person’s level of need and functioning, he or she may choose to live in a full-time supervised setting, a setting that provides less than full-time supervision, or a setting that provides no on-site supervision.

Before an individual selects residential placement, the CMHC case manager discusses alternatives with the individual, family, and guardian, as applicable. The decision for the choice of placement is based on the individual’s identified needs, goals, and resources. After the individual selects his or her placement, an IICP is developed or updated with the individual. The IICP reflects the individual’s aspirations and goals for an independent lifestyle and how the residential setting contributes to empowering the individual to continue to live successfully in the community.

The FSSA/DMHA supports a permanent supportive housing model that refers to a housing unit that is linked with community-based services. The tenant holds the lease with a landlord and receives services based on need through a community mental health center or community service agency. The tenant’s housing is not contingent on the person participating in any mental health or addiction services. The individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord-tenant law of the state, county, city, or other designated entity. Each individual’s essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected.

FSSA/DMHA Certified Residential Facility Settings – Standards, Rights, and Definitions

The FSSA/DMHA-certified residential settings in which some individuals may choose to live promote opportunities that help each individual grow and develop skills needed to continue to live in the community. FSSA/DMHA-certified residential care settings are a component of an outpatient community-based continuum of care, designed to provide an array of living options that span the continuum from minimal oversight to highly supervised settings. These settings are not nursing facilities, intermediate care facilities for individuals with intellectual disability, or institutes for mental disease. The residential care settings do not have any qualities of an institution, nor would they be permitted to be located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. One of the primary goals of the AMHH service program is to provide services and support to individuals to ensure they live safely and as independently as possible in the community. The program intends to provide opportunities for individuals to have their needs met in community-based settings and to prevent need for and placement in institutional settings.

The FSSA’s DMHA and OMPP have a strong partnership with state housing agencies: Indiana Housing and Community Development Authority and Corporation for Supportive Housing. Together, these agencies have facilitated the development of supportive housing integrated into the community to meet the needs of individuals.
with mental health and addiction disorders. The FSSA/DMHA, through certification and licensure standards, require the individual to participate in planning his or her care, to supporting the recovery philosophy that promotes the least-restrictive, most-appropriate care to safely meet the individual’s identified needs and desires.

The FSSA/DMHA expects the following standards to be maintained for AMHH members living in an FSSA/DMHA-certified residential setting. (For specific information regarding standards for FSSA/DMHA-certified residential facilities, see 440 IAC 7.5, Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions.)

- Individual- or single-occupancy dwellings or residences which consist of multiple individual- or single-occupancy dwellings
- Residential settings should promote opportunities to help each individual grow and develop skills needed to continue to live in the community
- While the individual lives in an FSSA/DMHA-certified residential facility, the provider’s responsibility is to ensure the resident’s involvement in decisions that affect their care, daily schedules, and lifestyles.
- The overall atmosphere of the setting is conducive to the resident’s achieving optimal independence, safety, and development, with the resident’s input.
- The location of the facility provides reasonable access to the community at large, including but not limited to agency, medical, recreational, and shopping areas, by public or agency-arranged transportation.
- The location, design, construction, and furnishings of each residence shall be consistent with a family or personal home (homelike).
- The majority of services and behavioral healthcare is provided in locations outside the residence, such as in the community at large or in a clinic setting.
- Residents are afforded the opportunity to engage in community-based programs that assist them in achieving goals, including employment.

Within AMHH, the State defines homelike as an atmosphere with patterns and conditions of everyday life that are as close as possible to those of individuals without diagnoses of mental illness. This definition includes an environment designed to increase the resident’s involvement in decisions that affect his or her care, daily schedules, and lifestyles, so they are similar to those of the resident’s peers who live on their own. The overall atmosphere of the setting is conducive to the residents’ achieving independence. The location of the facility provides residents reasonable access to the community at large, including but not limited to the agency, medical, recreational, and shopping areas by public or agency-arranged transportation.

An AMHH member living in an FSSA/DMHA-certified residential setting has the following rights, as documented in 440 IAC 7.5:

- The environment is safe.
- Each resident is free from abuse and neglect.
- Each resident is treated with consideration, respect, and full recognition of the resident’s dignity and individuality.
- Each resident is free to communicate, associate, and meet privately with persons of the resident’s choice, as long as the exercise of these rights does not infringe on the rights of another resident. And any restriction of this right is a part of the resident’s individual treatment plan;
• Each resident has the right to confidentiality concerning personal information, including health information.

• Each resident is free to voice grievances and to recommend changes in the policies and services offered by the agency.

• Each resident has the right to manage personal financial affairs or to seek assistance in managing them, unless the resident has a representative payee or a court appointed guardian for financial matters.

• Each resident shall be informed about available legal and advocacy services, and may contact or consult legal counsel at the resident's own expense.

• Each resident shall be informed of the number of the FSSA/DMHA’s toll-free consumer service line.

• Each resident shall begin receiving AMHH services within a timely manner from the date of approval for services.

• Each resident has the right to privacy in their sleeping or living unit.

• Each resident has the right to units having lockable entrance doors, with appropriate staff having keys to doors.

• When sharing living units, each resident has a choice of roommates.

• Each resident has the freedom to furnish and decorate his or her sleeping or living unit.

• Each resident is able to have visitors of his or her choosing at any time.

• The setting is physically accessible to each resident.

• Each resident is free from restraints, restrictive interventions, and seclusion.

Any modification of the resident’s rights must be supported by a specific assessed need and documented in the person-centered IICP.

The community residential settings certified by the FSSA/DMHA and identified in the AMHH SPA as meeting the standard for community living include:

• A supervised group living facility

• A transitional residential services facility

• A semi-independent living facility defined under IC 12-22-2-3

• Alternative family homes operated solely by resident householders

**Supervised Group Living Facility (SGL)**

A supervised group living facility is defined by the FSSA/DMHA as a residential facility that provides a therapeutic environment in a home-like setting to persons with a psychiatric disorder or addiction who need the benefits of a group living arrangement as post-psychiatric hospitalization intervention or as an alternative to hospitalization. “Therapeutic environment” means a living environment in which the staff and other residents contribute, and that presents no physical or social impediments to the habilitation and rehabilitation of the resident. This setting is designed to assist individuals in their recovery process by offering a safe, supportive, homelike environment. On-site supervision is required 24 hours a day, 7 days a week in this setting. Individuals may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times where individuals may eat together. Menus are
developed by dieticians to provide healthy meals that are consistent with each individual’s dietary needs and restrictions (for example, diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers have input in meal planning. A certified supervised group living facility serves up to 10 consumers in a single family dwelling and up to 15 consumers in an apartment building (three or more living units) or in a congregate residence.

**Transitional Residential Facility (TRS)**

A transitional residential facility is defined by the FSSA/DMHA as a 24-hour per day service that provides food, shelter, and other support services to individuals with a psychiatric disorder or addiction who are in need of a short-term supportive residential environment. Individuals in this setting are likely preparing for, or already participating in, work or school activities and are not supervised 24 hours a day. They have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual’s dietary needs and restrictions (for example, diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers have input in meal planning. A certified transitional residential facility serves 15 or fewer persons.

**Semi-Independent Living Facility (SILP)**

A semi-independent living facility is defined by the FSSA/DMHA as a facility:

- That is not licensed by another state agency and serves six or fewer individuals who have psychiatric disorders or an addiction, or both, per residence, who require only limited supervision
- In which the agency or its subcontractor provides a resident living allowance to the resident; or owns, leases, or manages the residence.

These settings are typically homelike. This setting is intended to prepare individuals for independent living settings. Individuals in this type of setting are provided with a minimum of oversight (that is, one hour per week). Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual’s dietary needs and restrictions (for example, diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers have input in meal planning.

**Alternative Family for Adults (AFA) Program**

An alternative family for adults program is defined by the FSSA/DMHA as a program that serves six or fewer individuals who have psychiatric disorders or addictions, or both, and reside with an unrelated householder. These settings are homelike. This setting is intended to prepare individuals for independent living, or may become permanent housing if this best meets the individual’s needs and a less restrictive setting is not wanted or deemed appropriate by the individual or treatment team. Individuals in this type of setting are provided with a minimum of oversight (that is, two hours per month). Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual’s dietary needs.
or restrictions (for example, diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers have input in meal planning. The program serves six or fewer residents.

**State Monitoring**

The FSSA/DMHA retains the authority to monitor and enforce adherence to standards by conducting on-site visits to ensure compliance with standards and respond to any complaint or incident reported. In addition to consumer feedback and site visits, data is collected and analyzed per the *Quality Indicator* section of the AMHH SPA. There are also facility requirements for compliance with fire and safety codes, which must be up-to-date. The FSSA/DMHA conducts site visits to ensure standards are met. Individuals residing in any FSSA/DMHA-certified residential setting have the freedom to choose how they live and residents’ rights are respected and honored.
Section 7: AMHH Referral and Application Process

In order for an individual to receive AMHH services, an FSSA/DMHA-approved AMHH provider agency, in collaboration with the individual seeking services, must refer the individual for evaluation by the SET via a web-based application process in the manner required by the FSSA (FSSA/OMPP and FSSA/DMHA). AMHH services will not be authorized for any individual who has not successfully completed the AMHH application process or does not meet all AMHH eligibility criteria, as determined by the FSSA/DMHA SET. This section outlines the referral process and provider agency responsibilities during the application process. For specific instructions for completing the AMHH application, see Section 8: Completing the AMHH Application in this manual.

Referrals for AMHH Services

Referrals to AMHH services may come from any source within the community:

- CMHCs or other treatment providers may identify individuals who appear to meet the AMHH target group and needs-based eligibility criteria.
- Individuals may notify an FSSA/DMHA-approved AMHH provider of their interest in AMHH services.
- Family members or caregivers may inquire about the services and assist their family member in contacting an FSSA/DMHA-approved AMHH provider.

Note: The AMHH referral process may begin while an applicant is in an institutional setting (for example, in a state-operated facility, or SOF) as part of discharge planning and continuity of care. However, AMHH services may not begin until the individual has been discharged to a community-based setting.

Information about AMHH services may be obtained on the FSSA/DMHA public website at in.gov/fssa/dmha/2876.htm. The website provides a summary of eligibility criteria and a description of all available AMHH services, as well as a list of AMHH service provider agencies, locations where potential enrollees may apply, and information about how to access AMHH assessments or services. In addition, any individual may contact the state for information about AMHH eligibility and the application process. In those cases, to help with the application process, the FSSA/DMHA provides the individual with a list of FSSA/DMHA-approved AMHH provider agencies.

Before completing the AMHH application process, the FSSA/DMHA-approved AMHH provider explains the benefits and purpose of the AMHH program and services with the interested applicant. Next, the provider helps determine whether the applicant meets the AMHH target group and needs-based criteria. If the applicant meets initial eligibility criteria and is interested in pursuing an application for AMHH services, the AMHH provider works with the applicant to complete the AMHH application process.

Provider Agency Responsibilities During the Application Process

Informed Choice of Providers

The FSSA/DMHA-approved AMHH provider agency is responsible for informing the applicant of his or her right to select an AMHH provider. During the AMHH application process, the provider agency is responsible for performing
the following tasks and documenting the activities intended to educate the applicant regarding the applicant’s informed choice of providers:

- Explain the applicant’s right to an informed choice of providers (meaning the applicant is informed of his or her right to interview potential AMHH service providers and choose to decide which service provider staff within that agency will provide the AMHH services documented on the proposed IICP, and to choose which family members or caregivers, if any, will be involved as members of the individual’s care team).

- Provide a list of FSSA/DMHA-approved AMHH provider agencies in the applicant’s county of residence and in counties contiguous to the applicant’s county of residence. The agency provides a randomized list of FSSA/DMHA-approved AMHH provider agencies for the applicant to select from when developing the application. This choice is documented via an attestation in the AMHH application.

- Inform the applicant that an AMHH provider agency listing is also posted on the Indiana FSSA/DMHA AMHH website at in.gov/fssa/dmha/2876.htm.

- Inform the applicant of his or her right to change the AMHH provider staff or agency any time during the applicant’s AMHH program eligibility. The current AMHH provider is expected to assist the individual in transitioning service delivery to the newly selected AMHH provider.

**Requirement for Face-to-Face Evaluations**

Every AMHH applicant is required to receive an individual face-to-face evaluation as the foundation of the application process, using both the FSSA/DMHA-approved behavioral health assessment tool (ANSA) and the application form developed by the FSSA (FSSA/OMPP and FSSA/DMHA). A comprehensive biopsychosocial evaluation is conducted by provider agency staff qualified to conduct AMHH assessments (see Behavioral Health Assessment Tool). The results of the evaluation and the ANSA assessment are included with the AMHH application. Documentation of the individual face-to-face evaluation in the applicant’s clinical record must include the following:

- Review, discussion, and documentation of the applicant’s desires, needs, and goals. Goals are habilitative in nature with outcomes specific to the habilitative needs identified by the applicant.

- Review of psychiatric symptoms and how they affect the applicant’s functioning and ability to attain desires, needs, and goals.

- Review of the applicant’s skills and the level of support needed for the applicant to participate in a long-term recovery process, including stabilization in the community and ability to function in the least-restrictive living, working, and learning environments.

- Review of the applicant’s strengths and needs, including medical, behavioral, social, housing, and employment.

Only qualified and trained staff from FSSA/DMHA-approved AMHH provider agencies may conduct the face-to-face evaluation required for the AMHH application process. The AMHH provider agency must ensure that the agency staff member providing the face-to-face AMHH evaluation meets the following minimum qualifications:

- Possesses at least a bachelor’s degree in social sciences or related field, with two or more years of clinical experience.

- Has completed the FSSA (FSSA/DMHA and FSSA/OMPP)-approved training for AMHH eligibility determination, application process, and service delivery standards. It is the responsibility of the CMHC to ensure appropriate documentation is in the staff file demonstrating compliance with training requirements.
• Is a certified Adult Needs and Strengths Assessment (ANSA) user receiving supervision from an ANSA SuperUser.

Behavioral Health Assessment Tool

The Adult Needs and Strengths Assessment (ANSA) is the FSSA/DMHA-approved behavioral health assessment tool used to identify an applicant’s strengths and needs at the time of application, and is used to help identify an individual’s level of need for AMHH services. The tool consists of items grouped into categories (domains) that the provider agency staff member assesses and discusses with the applicant during the face-to-face biopsychosocial assessment. The combined ratings resulting from the completed ANSA tool generate a level-of-care recommendation that may be used to support a recommendation for AMHH services.

The level-of-need recommendation from the ANSA tool is not intended to be a mandate for the level of services that an individual receives but is one element used in the final eligibility decision made by the SET. Many factors, including an individual’s preferences and choice, influence the actual intensity of the treatment services recommended on the applicant’s proposed IICP.

Note: To be considered current, the DMHA-approved behavioral health assessment tool (ANSA) must be completed and submitted in Data Assessment Registry Mental Health and Addiction (DARMHA) within 60 days before submitting the initial or renewal AMHH application. Data from the most recent ANSA at the time the application is created populates the AMHH application, regardless of the “age” of that ANSA. If the ANSA is more than 60 days old, the application will be denied by the SET.

Providers may obtain additional information about the ANSA tool, and ANSA training, support, and certification by contacting the FSSA/DMHA. The ANSA user’s manual is available online at dmha.fssa.in.gov/DARMHA/Documents/ANSAManual_712011.pdf.

Proposed AMHH Plan of Care

The agency provider staff member and the applicant, as well as individuals the applicant chose to be an active part of the team, jointly develop a proposed IICP. The proposed IICP includes the applicant’s identified strengths and needs, desired goals, and choice of providers and services (including proposed AMHH services) deemed necessary to address the documented goals. For additional information regarding person-centered planning and the AMHH IICP requirements and expectations, see Section 9: Person-Centered Planning and Individualized Integrated Care Plan Development.

Completion and Processing the AMHH Member Application

The AMHH agency provider staff member completes and submits the AMHH application via the FSSA/DMHA’s web-based DARMHA system. The application must be complete and submitted in its entirety for eligibility determination by the SET. Elements of the AMHH application include:

• The applicant’s identifying and eligibility information
• A description of the applicant’s living situation
• Justification of the need for AMHH service
• The applicant’s strengths
• The applicant’s needs
• The applicant’s goals
• The applicant’s objectives
• The applicant’s requested services
• Attestations

**Note:** The AMHH application must be submitted with attestations that the required signatures have been obtained. The required signatures must be maintained in the AMHH member’s clinical record and are subject to review by the SET during AMHH quality assurance site visits.

For further information about required attestations, as well as instructions on how to complete the AMHH application, see Section 8: Completing the AMHH Application.

After a complete AMHH application is submitted through the DARMHA, the SET evaluates the application and determines whether the applicant meets eligibility for the AMHH program. Eligibility determinations for the AMHH program are made exclusively by the SET to avoid any potential conflicts of interest. For specific information about SET determinations, see Section 10: AMHH Eligibility Determination, Service Approval, and Utilization.
Section 8: Completing the AMHH Application

In order for an individual to receive AMHH services, an AMHH provider agency, in collaboration with the individual seeking services, must submit an application as required by the FSSA (FSSA/OMPP and FSSA/DMHA). This section provides instructions for completing the AMHH application in DARMHA.

Elements of the AMHH Application

Page 1 – General

The following screen shot shows the upper half of the first page of the AMHH application. The information required in each section follows.

Figure 8.1 – Page 1 of AMHH Application (top half)
Applicant Information: The current home address and telephone number must be entered in the AMHH application (please note that the consumer’s email address is NOT required). This address is the home mailing address to which the consumer’s AMHH approval or denial notice is sent; therefore, it is critical that this information is accurate. Consumers must be asked where they prefer to receive AMHH notices. If the consumer is homeless or does not have or is unwilling to provide an address, the CMHC address may be entered, if the consumer consents.

When “YES” is selected for the Medicaid enrolled item, the Current MRO Service Package Level must be selected from the pull-down menu.

The Current MRO Package End Date field is required if MRO Service Package Level 3, 4, 5, or 5A is chosen, and a calendar box pops up to assist.

Information in the top-left box is automatically imported from the consumer’s DARMHA record, so all of that information must be checked for accuracy and, if necessary, corrections made before submission.

Please note: A green check mark next to an item means the AMHH eligibility criteria is met for that item.

A red X next to an item means the AMHH eligibility criteria is not met for that item.
**HCBS Waiver:** A consumer must be asked if he or she is participating in an HCBS waiver. As described in Section 2: Adult Mental Health Habilitation Services, AMHH service providers are responsible, in collaboration with waiver providers, for monitoring services of AMHH members also enrolled in a 1915(c) waiver program to prevent service duplication. Using the pull-down menu, the AMHH provider must select from the following options:

- Community Integration and Habilitation Waiver
- Family Supports Waiver
- Aged and Disabled Waiver
- Traumatic Brain Injury Waiver
- Money Follows the Person
- Consumer is on waiver, unsure which waiver
- Unknown whether consumer is on waiver. (NOTE: This option should be selected only if the question has been asked of the applicant, and he or she is uncertain. All AMHH applicants must be asked this question.)
- Not on a waiver

**Figure 8.2 – Current Living Situation**

<table>
<thead>
<tr>
<th>Community-based Settings</th>
<th>Institutional Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Living</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>Homeless</td>
<td>Hospital</td>
</tr>
<tr>
<td>Residential Facility</td>
<td>Institution for Mental Disease (IMD)</td>
</tr>
<tr>
<td>Supported Living</td>
<td>ICF/IID</td>
</tr>
<tr>
<td></td>
<td>Jail or Correctional Facility</td>
</tr>
</tbody>
</table>

**Current Living Situation:** Select and mark the circle next to the applicable current living situation (see the following descriptions).

Community-based Settings are defined as the following:

- **Independent Living:** Living with nonfoster family without supportive community service being received in the home setting; living in a house, apartment, trailer, hotel, dormitory, barrack, single-room occupancy, or in the residence of parents, relatives, legal guardians, or other primary caregivers; no routine or planned supportive community service intervention received to maintain independence in the living situation.

- **Homeless:** Homeless, alone or with family: A person is considered homeless if he or she lacks a fixed, regular, and adequate nighttime residence or his or her primary nighttime residence is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations for a period of three months or less; (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (for example, on the street).

- **Residential Facility:** Twenty-four hours a day, seven days a week; may include short- and long-term residential placement including supervised group home, board and care, room, board and assistance (RBA), rehabilitation center, halfway house, therapeutic group home, agency-operated residential care facilities.
• **Supported Living**: Living with nonfoster family and receives supportive community service in the home setting; living in a house, apartment, trailer, dormitory, barrack, single-room occupancy, or in the residence of parents, relatives, legal guardians, or other primary caregivers; receives routine of planned supportive community services and/or financial support for the living arrangement. Includes semi-independent living. There is community support services intervention.

| Note: Supportive community services are individualized services to promote recovery, manage crises, perform activities of daily living, and manage symptoms, and are not public entitlements. Public entitlements are funding sources that a consumer qualifies for based on income, disability, and so on. Public entitlements include, but are not limited to, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). Consumers can receive public entitlements and be considered to be living independently. |

Institutional Settings are defined as the following:

• **Nursing Home**: Twenty-four hours a day, seven days a week care in a skilled nursing facility

• **Hospital**: Twenty-four hours a day, seven days a week care; inpatient psychiatric hospital, psychiatric health facility (such as a stress center), general hospital, private adult psychiatric hospital, Veterans Affairs hospital, state-operated facility (SOF), or transitional care hospitals

• **IMD**: Institute for mental disease

• **Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)**: Twenty-four hours a day, seven days a week in an intermediate care facility for individuals with intellectual disabilities

• **Jail/Correctional Facility**: Home detention, detention centers, work release, weekend jail, boot camp, jail, correctional facility, prison
The following screen shot shows the lower half of the first page of the AMHH application. The information required in each section is described in detail:

**Figure 8.3 – Page 1 of AMHH Application (Lower Half)**

**Description of the Living Situation (Required for all living situations):**

Describe the applicant’s current living situation (as of the date of application), including the features of the housing situation that ensure it meets criteria for a home and/or community-based setting. If the applicant is currently in an institutional setting but is being discharged to the community within 90 days, please provide anticipated discharge date and expected living situation post-discharge.

**Justification of Need for Program (Current/Historical Physical and Behavioral Health):**

**Assessment of progress toward meeting treatment goals during existing AMHH eligibility period:**

**Contact Person:**

- Edit Case Manager
- Edit Alternate Provider Contact
- Edit Psychiatrist
- Edit Caregiver/Guardian

**Figure 8.4 – Description of the Living Situation**

**Description of the Living Situation (Required for all living situations):**

Describe the applicant’s current living situation (as of the date of application), including the features of the housing situation that ensure it meets criteria for a home and/or community-based setting. If the applicant is currently in an institutional setting but is being discharged to the community within 90 days, please provide anticipated discharge date and expected living situation post-discharge.

*Description of the Living Situation: Required for all living situations!* Applicants must be currently living in a CMS-defined home and community-based setting. OR they may be in an institutional setting, as long as an anticipated discharge date is within 90 days and the applicant will be discharged to a home or community-based setting. The anticipated discharge date must be included in this section.
Figure 8.5 – Justification of Need for Program

Justification of Need for Program: This section is crucial for establishing how and why the consumer will benefit more from a habilitative, rather than a rehabilitative, approach to care. The narrative may resemble a condensed biopsychosocial summary and must establish and demonstrate that the applicant meets the AMHH target and needs-based criteria. It may include (but is not limited to) the following information:

- Historical and current health status
- Behavioral health issues
- Current living situation
- Functional needs
- Family functioning
- Vocational/employment status
- Social functioning
- Living skills
- Self-care skills
- Capacity for decision making
- Potential for self-injury or harm to others
- Substance use or abuse
- Experience and response to rehabilitative services and the outcomes from those services
- Medication adherence

Information regarding the applicant’s participation in any prior rehabilitative services and the outcomes from participation in those services must also be documented in this section of the application.
Figure 8.6 – Assessment of Progress

Assessment of progress toward meeting treatment goals during existing AMHH eligibility period: This narrative box appears only on renewal applications for members who are already enrolled in AMHH and are applying for another annual eligibility period. For additional information about what providers are expected to include in this narrative box, see Section 12: Renewal of AMHH Program Member Eligibility.

Figure 8.7 – Contact Person

Contact Person: Primary and alternate case managers, as well as the attending psychiatrist, must be identified. The Caregiver/Guardian field must be completed, if applicable. Choose Edit next to each member role, enter name, telephone number, and email, and then choose Update to save the information. The application may not be submitted until all required information is entered.
Page 2 – IICP Form

Following are screen shots of each section of the second page of the application – the IICP Form. The sections are accessed by clicking on the blue underlined “wizard” links on the left side of the application.

Strengths: An expanded view of the Strengths wizard follows. It displays all items imported from the Strengths domain of the ANSA attached to the application that were scored as 0 or 1, indicating the most stable and useful strengths identified by the applicant. The person completing the application must provide a narrative summary (see “Strengths Statement”) of the applicant’s most relevant and supportive strengths when living in the community.

Figure 8.8 – Page 2 of AMHH Application – IICP Form - Strengths

The display may be toggled between expanded and collapsed views by clicking the plus (to expand) or minus (to collapse) sign next to “Strengths Domain.”
Functional Needs: A partially expanded view of the Needs wizard follows. It displays all items imported from the Life Functioning, Acculturation, Behavioral Health Needs, and Risk Behaviors domains of the ANSA attached to the application that were scored as 2 or 3, indicating the most troubling or problematic needs identified by the applicant. The person completing the application must provide a narrative summary ("Needs Statement") of the three to four most immediate, significant, or impairing needs the applicant faces regularly when living in the community.

Figure 8.9 – Page 2 of AMHH Application – IICP Form - Needs

The display may be toggled between expanded and collapsed views by clicking the plus (to expand) or minus (to collapse) sign next to each Functional Need domain.
**Goal and Objectives narrative boxes:** Goals and objectives for AMHH applicants and members must be habilitative. They are intended to promote stability and potential movement toward independence and integration into the community, treatment of mental illness symptoms, and habilitating areas of functional deficits related to the mental illness. Goals are ideally presented in the consumer’s own words, and must reflect the consumer’s desires and choices. Objectives are intended to support maintenance of previously learned skills and preservation of the individual’s current (best) level of functioning.

**Figure 8.10 – Goal and Objectives**
Services: Each service requested by and on behalf of the applicant is selected here. Additional information about the scope of each service is provided in Sections 15-23 of this manual. For each service selected, the person completing the application must provide a narrative summary of how the service will help the applicant attain one or more of the goals and objectives specified in the previous section of the IICP. All IICPs must be developed with the applicant and individualized to meet their identified needs (see Section 9 for additional information on IICP development). The “Provider Name” will default to the provider agency submitting the application. If the applicant chooses a different provider agency to provide the requested services, the chosen agency must be selected from the “Provider Name” pull-down menu.

Figure 8.11 – Services Being Requested
Attestations: There are eight required activities that must be completed before the application is submitted. Included in the application is the required acknowledgement that the following attestations have been fulfilled and signed. The date the signatures were obtained by the applicant, legal guardian (if applicable), referring care coordinator, ANSA SuperUser, and attending psychiatrist/HSPP must be entered on the application. AMHH provider agencies must maintain the actual documentation with signatures in the clinical record.

Figure 8.12 – Treatment Team Attestation
A description of each attestation, and who must sign for verification, follows:

- The applicant has been given a choice of providers. This applies to choice in both the provider agency and providers within an agency itself. The applicant and case manager/referring care coordinator must sign.
- The individual has been given choice of services to be provided. The applicant and case manager/referring care coordinator must sign.
- The proposed IICP is individualized to meet the applicant’s needs. The applicant and case manager/referring care coordinator must sign.
- The applicant has participated in the development of the IICP. The applicant’s attestation verifying his or her participation in the development of the IICP and determining which AMHH services are included appears on the plan of care. The applicant and case manager/referring care coordinator must sign.
- Program requirements, including financial requirements, have been reviewed with the applicant. The applicant and case manager/referring care coordinator must sign.
- The services proposed on the IICP are deemed appropriate and medically necessary by the appropriate authority. The psychiatrist or HSPP must sign.
- The psychiatrist or HSPP attestation regarding the imminent likelihood that without ongoing habilitation services, the applicant will likely deteriorate and be at risk of institutionalization (for example, acute hospitalization, state hospital, nursing home, or jail). The psychiatrist or HSPP must sign.
- The applicant is not a danger to self or others at the time this application is submitted. The psychiatrist or HSPP must sign.

Note: In addition to the previous attestations, a signature from the ANSA SuperUser reviewing the ANSA must be documented. The date the SuperUser signs the attestation documenting his or her review must be entered in the application.
Transition to MRO: This wizard is visible only after a member’s AMHH application is approved by the SET and processed by HP. It is used if a consumer opts to transition to MRO services from AMHH services.

Figure 8.13 – Request for Transition to MRO

An ANSA must be completed in DARMHA NO MORE THAN 60 days prior to the transition date in order for MRO eligibility to be determined and an MRO package assigned. If it has been more than 60 days, HP will not assess for MRO eligibility and the consumer may lose ALL services.

The person completing the application must check the box attesting that an ANSA has been completed and submitted in DARMHA no more than 60 days before the request to transition to MRO. The person completing the application must also check the “Transition to MRO” box and enter the date the member requested to transition to MRO in the “Date of Attestation” field. Brief information about the reason for the transition must be included in the “Support Summary” narrative box. See Section 13: Transitions During AMHH Eligibility Period for additional information.

Note: The consumer’s attestation of his or her choice to transition to MRO must be captured via hard copy or electronic signature.
Reviewing and Submitting the Application

After completing the AMHH member application (including but not limited to the clinical evaluation, ANSA, electronic application, and proposed IICP), the provider agency staff must review the application in its entirety to ensure complete and accurate information has been included. Special attention must be paid to the following areas:

- Ensure that each data element in the applicant data section that is automatically populated from DARMHA has a green check mark beside it. A red “X” by any of the elements indicates that the applicant does not meet the criteria and does not meet the eligibility requirements for the AMHH program. Applications submitted with any red “X” will be denied by the FSSA/DMHA SET.
- Be sure that all narrative boxes are complete, with sufficient required information.
- Be sure that all required attestations have been checked and physical signatures obtained before submitting the application. A copy of the signed attestations must be maintained in the AMHH member’s clinical record.

The completed, reviewed application is submitted by clicking Submit at the bottom of the IICP Form page. If any outstanding items need to be addressed, a warning message pops up, alerting the staff completing the application that additional items need correction before submission.

Note: If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. The provider agency has seven calendar days from date the application was pended to submit the required information in DARMHA. If the provider agency does not submit the required information or documentation within seven calendar days, the AMHH application is denied.

To ensure no conflict of interest in AMHH eligibility determinations, the DMHA SET must in all cases retain the authority to determine an applicant’s eligibility for AMHH services and to authorize the use of the AMHH services documented on the approved IICP. For more information about the SET review of the AMHH application, eligibility determination and services authorization, see Section 10: AMHH Eligibility Determination, Service Approval and Utilization.
Section 9: Person-Centered Planning and Individualized Integrated Care Plan Development

Person-centered planning is an existing FSSA/DMHA expectation for provider agencies in Indiana. This requirement is supported by CMHC certification rules, requirements for national accreditation, and contracts connected to FSSA/DMHA funding. The member has the freedom to choose who is included in the IICP planning and development process. IICPs require staff and member signatures, as well as clinical documentation verifying the member’s participation. This section outlines the requirements for the proposed IICP developed during the AMHH member application process and maintained throughout the member’s enrollment in AMHH services.

Staff Requirements

All AMHH IICPs must be developed in collaboration with an AMHH provider agency staff member who meets one of the following minimum certification requirements:

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

For details regarding minimum staffing requirements, see Section 3: AMHH Service Providers.

AMHH services psychiatrists or HSPPs must be enrolled in the IHCP as rendering providers and be linked to the AMHH provider agency. The State expects the psychiatrist or HSPP to complete the following:

- Review the AMHH member application and assess the information for accuracy
- Approve and certify the proposed AMHH diagnosis
- Attest and deem that the recommended AMHH services on the proposed IICP are clinically indicated and medically necessary
- Attest that without ongoing habilitation services, the applicant will likely deteriorate and be at risk of institutionalization (for example, acute hospitalization, State hospital, nursing home, or jail).
- Attest that the applicant is not a danger to self or others at the time of this application

Freedom of Choice

The AMHH member has freedom of choice regarding the following:

- The goals and objectives documented on the proposed IICP
- The AMHH services requested on the proposed IICP, as supported by the member’s documented needs
- The selection of FSSA/DMHA-approved AMHH service providers who will deliver AMHH services.

Reminder: AMHH members have the right to request a change of AMHH providers at any time during the AMHH eligibility period.
Developing the Individualized Integrated Care Plan (IICP)

A proposed AMHH IICP must be developed for each member through a collaboration that includes the applicant or member, identified community supports, family and nonprofessional caregivers, and all individuals and agency staff involved in assessing and providing care for the applicant or member. The IICP is a habilitative plan of care that integrates all components and aspects of care that:

- Are clinically indicated and deemed medically necessary
- Are supported by the member’s identified needs
- Are provided in the most appropriate, least-restrictive setting for achieving the applicant or member’s goals
- Include all indicated medical and support services needed by the recipient to remain in the community and function at the highest possible level of independence

The provider agency staff must ensure the IICP development is driven by a person-centered planning process that incorporates the following IICP standards:

- Identifies the member’s physical and behavioral health support needs, strengths, and preferences and desired outcomes
- Takes into account the extent of, and need for, any family or other supports for the individual
- Prevents the provision of unnecessary or inappropriate services or care
- Is guided by best practices and research on effective strategies for improved health and quality of life
- Reflects a plan of care developed for the member with the member and represents the member’s desires and choices for care

The IICP must include all identified services medically necessary to help the applicant or member continue to reside in the community, to function at the highest level of independence possible, and to achieve his or her goals. The following must be documented on the IICP:

- The goals the member chose that promote stability and support continued integration into the community, treatment of mental illness, and habilitation of functional deficits related to the mental illness (including co-occurring SMI and substance use disorders)
- Individuals and teams responsible for treatment, coordination of care, linkage, and referrals to internal as well as external resources and care providers to meet identified needs
- Identifies by title the AMHH services the applicant or member needs and has indicated as a desired service on the proposed IICP
- A list of all other services and supports that will be delivered in conjunction with the proposed AMHH services
Note: The primary distinction between the AMHH habilitation services and the MRO rehabilitation services is the IICP treatment goals. The MRO program’s philosophy is that the individual will improve his or her level of functioning over time. The AMHH philosophy is that the IICP goals address reinforcement, management, adaptation, and retention of a level of functioning.

As part of the completed IICP, the State also requires documentation, signed by the applicant and provider participating in the development of the IICP, that attests to the following:

- The applicant has been given choice of providers. This requirement applies to choice in both the provider agency and providers within an agency itself.
- The individual has been given a choice of services to be provided.
- The proposed IICP is individualized to meet the applicant’s needs.
- The applicant has participated in the development of the IICP. The applicant’s attestation verifying his or her participation in developing the IICP and determining which AMHH services he or she will receive is included on the plan of care.
- Program requirements, including financial requirements, have been reviewed with the applicant.
- The services proposed on the IICP are deemed appropriate and medically necessary, as verified by the psychiatrist or HSPP.
- The psychiatrist’s or health services provider in psychology’s (HSPP’s) attestation regarding the imminent likelihood that without ongoing habilitation services, the applicant will likely deteriorate and be at risk of institutionalization (for example, acute hospitalization, State hospital, nursing home, or jail).
- The applicant is not a danger to self or others at the time this application is submitted.

Crisis Plan

AMHH members must be deemed stable enough to benefit from intensive home and community-based habilitation services. However, the target population is generally considered vulnerable and susceptible to crises. To ensure a member’s safety and successful utilization of AMHH services, a crisis plan is an important part of treatment planning and a requirement for all members receiving AMHH services. The crisis plan is created based on consumer-focused triggers and identifies means to deal with potential crises that put the member at risk of hospitalization or institutionalization if the crisis is not mitigated or averted. The plan puts in place supports that help the member avoid or cope with identified triggers that typically result in crises for the member. The AMHH provider agency, in conjunction with the member, must develop a crisis plan to address any identified potential crises that may interfere with the member’s ability to remain in the community. The information and resources in this section will help providers guide the member in developing an individualized crisis plan.

The following is required of the provider agency when developing the crisis plan:

- The crisis plan must be developed with the member (and family or caregiver, if applicable).
- The plan should reflect the choice and preferences of the member (and family or caregiver, if applicable).
- Submission of the crisis plan document to the SET is optional, but in all cases, the crisis plan must be maintained in the clinical record and made available for review by the FSSA/DMHA.
Although the format of the crisis plan is at the discretion of the AMHH provider agency, the following components must be included in a comprehensive crisis plan:

- Potential crises that have been identified and documented during the face-to-face evaluation and while developing the proposed IICP, as well as the member’s, family’s, or caregiver’s reports of past crisis situations, if applicable
- Indicators of emerging risks, impending crises, and increased levels of risk
- Crisis-defusing strategies to which the member has responded well in the past, as well as action steps to prevent or mitigate potential identified crises
- Individuals and resources that can help the member complete the steps documented in the crisis plan (for example, family, natural supports, community resources, and formal supports). These resources should also include a contingency plan if an identified resource or individual cannot be accessed during the crisis.
- AMHH services (for example, respite, peer support) may be added to the proposed IICP to build coping skills, defuse crises, or provide support during a crisis

An example crisis plan is included in Appendix E of this manual.

**Member’s Refusal to Sign IICP**

The IICP must reflect the applicant’s or member’s desires and choices. The applicant’s or member’s signature, demonstrating his or her participation in the development of initial and ongoing IICP reviews, is required on the proposed IICP submitted to the SET for review and approval. Infrequently, an applicant or member may request services but refuse to sign the IICP for various reasons (thought disorder, paranoia, and so on). If a member refuses to sign the IICP, the agency staff member is required to document on the plan of care that the member agreed to the plan but refused to sign it. The agency staff member must also document in the clinical record progress note that a planning meeting with the member did occur and that the IICP reflects the member’s choice of services and his or her agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the member refused to sign the plan and how those issues will be addressed in the future.

**Ongoing IICP Review**

The provider agency is responsible to ensure that a member’s progress and movement toward attaining the IICP goals is monitored on a regular basis, and that the IICP continues to reflect the member’s identified strengths, needs, goals, and preferences. At minimum, the ICP must be reviewed every 90 days as part of the member’s regular 90-day treatment review. If additional AMHH services are warranted, an updated proposed IICP requesting new service authorizations must be submitted to the SET. Delivery of the proposed new AMHH services may not commence until SET approval has been granted. For more information, see Section 11: Request for Approval of Additional AMHH Services.


Section 10: AMHH Eligibility Determination, Service Approval, and Utilization

Under the direction and supervision of the FSSA (FSSA/DMHA and FSSA/OMPP), the SET is exclusively responsible for determining AMHH eligibility and approving AMHH services on the proposed IICP. This section describes the SET processes for determining AMHH eligibility and approving AMHH services.

The State Evaluation Team (SET)

The SET assesses all AMHH applications for program and services eligibility. The team is responsible for determining the following:

- Eligibility for enrollment/reenrollment in the AMHH program
- Appropriateness of proposed IICP and requested services in meeting the applicant’s needs
- Clinical authorization of approved AMHH services

SET Assessment and Determination of Member Eligibility

The AMHH provider agency submits the AMHH application to the SET for independent review and assessment of the applicant’s AMHH eligibility. The SET reviews all applications and approves or denies authorization for the specific AMHH services submitted on the proposed IICP.

After receiving the AMHH application, the SET engages in the following activities to determine whether the applicant meets eligibility for AMHH services:

- Review the AMHH application for completeness
- Verify that the applicant meets all target group and needs-based eligibility criteria for AMHH services (see Section 5: AMHH Program Member Eligibility for additional information)
- Ensure that the AMHH IICP includes all required attestations.
- Review the proposed IICP to ensure that the plan meets the following criteria and supports the need for AMHH services:
  - The IICP includes the applicant’s strengths and needs, as supported by the clinical documentation and ANSA.
  - Goals and objectives are linked to the applicant’s identified needs.
  - Strategies support the applicant’s goals, objectives, and needs.
  - Evidence is provided that the applicant will benefit from habilitation services.
  - Evidence is provided that the IICP submitted is individualized and driven by the applicant’s needs and preferences.
  - The proposed AMHH services are supported by the IICP, and clinical documentation is submitted with the AMHH application.
  - The IICP includes a list of non-AMHH services and supports that will help meet the applicant’s identified needs that are not met by AMHH services.
If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. The provider agency has seven calendar days from date the application was pended to submit the required information in DARMHA. If the provider agency does not submit the required information or documentation within seven calendar days, the AMHH application is denied.

Following evaluation and review of the application, the SET makes one of three potential AMHH eligibility determinations:

- Approves AMHH program eligibility with full approval of services
- Denies eligibility for AMHH program and/or all requested services
- Approves AMHH program eligibility with partial approval of services

Note: AMHH services are requested individually, based on the member’s identified needs documented on the proposed IICP. In some cases, certain requested services on a single IICP may be approved or denied by the SET, based on the independent evaluation of the applicant’s needs and the justification provided for the service requested.

### Determining a Start Date for AMHH Eligibility

The start date for AMHH program and services eligibility is determined by the SET. For approved applicants whose MRO package ends within 60 days of the date of SET approval, the AMHH start date is the day following the end date of the current MRO service package. This approach ensures that there is no lapse in services for the member.

For approved applicants whose MRO package ends beyond sixty days from date of the SET approval, the start date is set at 15 calendar days from the date the SET approves the AMHH application.

Note: There may be circumstances in which an applicant and provider identify a need to initiate AMHH services sooner than the start date normally determined by the SET. These requests are considered on a case-by-case basis and the start date assigned as needed.

For members already receiving AMHH services, the start date for the new AMHH service package is the day following the end date of the current AMHH service package. This ensures that there is no lapse in services for the member.

### Communication of the SET Eligibility Determination

Approval or denial of AMHH eligibility or services is communicated to the referring provider agency and the applicant or authorized representative in the following manner:

- Approval of AMHH program eligibility with full approval of services: If an applicant is determined eligible for the AMHH program and for all services requested on the IICP, HP sends an authorization notification to the referring AMHH provider and the applicant or authorized representative. This notification includes the following information:
  - Start and end dates for AMHH program eligibility and services
  - AMHH services approved by the SET, including the procedure code, modifiers, and number of units approved
• **Denial of AMHH program and/or services eligibility:** If an applicant is determined ineligible for the AMHH program, or the SET denies all of the AMHH services requested on the proposed IICP, a denial notification is sent to both the applicant or authorized representative and the referring AMHH provider. This denial notification is generated by the SET and includes the following information:
  - Notification of the reason(s) the SET determined the applicant is not eligible for the AMHH program, and/or
  - Notification of the reasons the specific services requested on the proposed IICP are denied
  - Information regarding the applicant’s fair hearing and appeals rights

• **Approval of AMHH program eligibility with partial approval of services:** If an applicant is determined eligible for the AMHH program, but one or more (though not all) of the services requested on the proposed IICP are denied, both an authorization notification and a denial notification are sent to the referring AMHH provider agency and the applicant or authorized representative. HP sends the authorization notification and includes the following information:
  - Start and end dates for AMHH program eligibility and services
  - AMHH services approved by the SET, including the procedure code, modifiers, and number of units approved

The SET sends the denial notification and includes the following information:

• Notification of the reasons the specific services requested on the proposed IICP are denied
• A list of requested services that are approved by the SET
• Information regarding the applicant’s fair hearing and appeals rights

The referring AMHH provider agency is responsible for alerting the applicant or member of the SET’s eligibility determination and, in the event of a denial notification, assisting the member in understanding the reasons for the denial and pursuing the fair hearing and appeals process, as applicable.

Providers may access information regarding the status of AMHH eligibility determination and approval of AMHH services via DARMHA, and authorization of AMHH service units via Web interChange at interchange.indianamedicaid.com/Administrative/logon.aspx.

**AMHH Services – Eligibility Period**

The AMHH services eligibility period is one year (360 days) from the start date documented on the AMHH eligibility authorization notification, or as determined by the SET. AMHH service delivery may not begin until the service approval from the SET is authorized, and HP assigns the member the AMHH services package. AMHH provider agencies will not receive reimbursement for any AMHH services provided without SET approval and authorization, or for services provided outside the AMHH eligibility period, as documented on the authorization notification. The provider agency is required to:

• Continually monitor the member’s progress in and benefit from AMHH services, and notify the FSSA/DMHA if there is any change in status that impacts the member’s eligibility for AMHH services.
• When the member’s needs change, requiring new or different AMHH services, the provider must update the IICP and submit it to the SET for review and approval of the requested AMHH services (see Section 11: Request for Approval of Additional AMHH Services for information regarding requests for additional AMHH services).
• Track the end date of the member’s AMHH program and services eligibility, and submit an AMHH renewal application at least 30 days (but no more than 60 days) before the end date of the existing AMHH eligibility period – see Section 12 for additional information.

Note: The AMHH provider agency is responsible to ensure that the AMHH services renewal application is submitted to the SET at least 30 days before the expiration date of the member’s current AMHH eligibility period. In addition, a new ANSA must be completed and submitted within 60 days of the AMHH renewal application creation.

Approval for AMHH Units of Services

The SET authorizes AMHH services for an AMHH-eligible member, based on review and acceptance of the proposed IICP submitted in DARMHA. The AMHH services approval provides a maximum number of service units for each AMHH service approved. AMHH providers must coordinate service delivery to ensure that the AMHH service units approved by the SET are managed in a way to ensure continued service delivery throughout the AMHH eligibility period, based on the member’s needs. No additional units of service for an approved service can be requested during the authorized eligibility period. However, if the member’s needs change, an additional AMHH service (one not already authorized) may be requested. See Section 11: Request for Approval of Additional AMHH Services for information about requesting additional AMHH services.

 Interruption of AMHH Services

When AMHH services are interrupted because the member is leaving the community to enter an institutional setting (for example, incarceration, hospitalization, and so on), AMHH services are not reimbursable or billable during the service interruption. The AMHH eligibility and authorized service units remain available to the member, in the originally authorized AMHH eligibility period, for immediate access when the member returns to the community from the institutional setting and chooses to restart AMHH services.

If, however, the member does not return to the community during the AMHH eligibility period, the member must reapply for AMHH services before or upon reintegrating into the community, with the assistance of an FSSA/DMHA-approved AMHH provider agency. To retain continuity of care, AMHH program eligibility and service requests may be applied for while an individual is in an institutional setting and preparing for discharge back into the community, so long as the request includes a specific discharge date within 90 days of submitting the application. If approved, AMHH services are not reimbursable until the applicant has returned to a community-based setting.

Termination of AMHH Services

If AMHH services must be terminated before the end of the AMHH eligibility period because the member has asked to terminate AMHH services or no longer meets AMHH criteria, the provider agency must help link the member to services that may be able to meet the individual’s needs. (For information about transitioning to MRO services, see Section 13: Transitions During AMHH Eligibility Period.)

If the provider agency’s efforts to facilitate a transition in services for the member are not successful, the provider agency must document in the clinical record the attempts made to coordinate transition to other services.
Section 11: Request for Approval of Additional AMHH Services

If an AMHH member’s needs change and additional AMHH services are indicated to meet the member’s needs, the provider agency may request approval of additional AMHH services not already approved by the SET in the member’s current AMHH eligibility period. Additional AMHH service units are not authorized for services already approved within the member’s AMHH eligibility period.

A request for additional AMHH services is initiated when the AMHH provider agency submits a request to the SET, as follows:

- The provider agency completes an updated IICP (with “AMHH Modification” indicated on the application form) and submits it to the SET via DARMHA.
- After receiving the AMHH Modification Application, the SET reviews the modified IICP and supporting documentation, as described in Section 10 of this manual.
- After evaluation and review of the modified IICP, the SET makes a determination regarding the request to add new AMHH services.
- Approval or denial of requested additional AMHH services is communicated to the referring provider agency and the applicant or authorized representative in the following manner:
  - Approval of additional AMHH services: If the SET approves the requested additional AMHH services, an authorization notification is sent to the referring AMHH provider and the member or authorized representative, notifying them of the approval. HP sends an authorization notification that includes the following information:
    - The AMHH services approved, including the procedure code, modifiers, and number of units approved
    - Start and end dates for the approved AMHH services. When additional services are approved, the start date is the date the SET approves the requested service. The end date is the same as the member’s current AMHH eligibility period end date.
  - Denial of additional AMHH services: If the SET denies one or more requested additional AMHH services on the modified IICP, the SET sends a denial notification to the member and referring AMHH provider, notifying them that the AMHH services requested were denied. The denial notification includes the reasons for denial and information regarding the applicant’s fair hearing and appeals rights.

- Note: The AMHH provider agency is responsible for alerting the applicant or member of the SET’s eligibility determination and, in the event of a denial notification, helps the member understand or pursue the fair hearing and appeals process, as applicable.

The additional authorized AMHH services are subject to applicable AMHH service unit limitations for those services and have an expiration date that matches the member’s existing AMHH eligibility period expiration date. Information regarding assignment of additional AMHH service packages may be accessed by providers on Web interChange at interchange.indianamedicaid.com/Administrative/logon.aspx.

Service delivery for the requested additional AMHH services may not begin until approval and authorization from the SET is complete and the services are assigned by HP. AMHH provider agencies do not receive reimbursement.
for any AMHH services provided without SET approval and authorization, or for services provided outside the AMHH eligibility period documented on the authorization notification.

Figure 11.1: Request for Additional AMHH Services

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**Example: Request for Additional AMHH Services**

An AMHH member receives an eligibility approval determination for AMHH services on January 1 (for 360 days). In June, the applicant begins to decompensate due to increased alcohol consumption and poor judgment in time utilization during the day when the member’s caregiver (roommate) is at work. Additional services are indicated to support the AMHH member in the community. The additional services are requested by the AMHH provider and are approved by the SET on June 20. The newly approved services have the same expiration date as the AMHH eligibility period and services authorized in January.

<table>
<thead>
<tr>
<th>AMHH Service Requested</th>
<th># Units Authorized</th>
<th>Authorization Period (360 days)</th>
<th>Reason for Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>The initial AMHH eligibility authorization is granted on January 1 with the following services authorized on the IICP:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCB Habilitation and Support</td>
<td>2920</td>
<td>Jan 1 – Dec 26</td>
<td></td>
</tr>
<tr>
<td>Therapy and Behavioral Support Services</td>
<td>96 (individual), 126 (group)</td>
<td>Jan 1 – Dec 26</td>
<td></td>
</tr>
<tr>
<td>Medication Training and Support</td>
<td>728</td>
<td>Jan 1 – Dec 26</td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>800</td>
<td>Jan 1 – Dec 26</td>
<td></td>
</tr>
<tr>
<td>The AMHH applicant has increased symptoms and decompensated functioning. The provider requests additional services to support the member so he or she may continue to live safely in the community. Authorization of additional AMHH services is granted on June 20:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Day Services</td>
<td>2 half-day units/day, 5 days/week</td>
<td>June 20 – Dec 26</td>
<td></td>
</tr>
<tr>
<td>Addiction Counseling</td>
<td>64</td>
<td>June 20 – Dec 26</td>
<td></td>
</tr>
<tr>
<td>Therapy and Behavioral Support Services</td>
<td>0</td>
<td>Request Denied</td>
<td>*Service already authorized within the same eligibility period</td>
</tr>
</tbody>
</table>
Section 12: Renewal of AMHH Program Member Eligibility

The member’s AMHH program and services eligibility period expires one year (360 days) from the date of the AMHH start date, or as otherwise determined by the SET. To continue AMHH services and prevent a lapse in service delivery for an eligible member, the AMHH member, in conjunction with the AMHH provider agency, must reapply for AMHH program eligibility at least 30 days (and not more than 60 days) before the eligibility expiration date.

The AMHH renewal application and evaluation process is the same as the initial AMHH application process outlined in Sections 7-9 of this manual, including the following:

- Completing a face-to-face holistic clinical and biopsychosocial assessment by a qualified FSSA/DMHA-approved AMHH service provider that evaluates the member’s strengths, needs, and functional impairments
- Completing the clinical assessment and ANSA tool to assess whether the member meets the level of need recommendation and needs-based criteria for AMHH services. The assessment and the ANSA must be completed within 60 days of creating the AMHH renewal application
- Updating the IICP, crisis plan, and attestations
- Evaluating the member’s progress towards meeting established habilitative treatment goals
- Determining if and how the member is receiving benefits from AMHH services
- Submitting the renewal application in DARMHA

Note: The member, with assistance from the AMHH service provider, must reapply for AMHH services program eligibility at least 30 days (but not more than 60 days) before the eligibility expiration date to prevent an interruption in service delivery.

If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. The provider agency has seven calendar days from the date the application was pended to submit the required information in DARMHA. If the provider agency does not submit the required information or documentation within seven calendar days, the AMHH application is denied.

Approval or denial of continued AMHH eligibility and services is communicated to the referring provider agency and the applicant or authorized representative as described in Section 10.
Figure 12.1: AMHH Services Program – Renewal Application Timeline

- Initial AMHH Services Program Approval (Month 1)
- Clinical Assessment and Completion of ANSA for Renewal Application (Month 10-11)
- Submit AMHH Renewal Application (Month 10-11)
- Initial AMHH Eligibility Period Expires (Month 12)
Section 13: Transitions During AMHH Eligibility Period

The AMHH provider agency must respect the member’s right to freedom of choice regarding program participation and choice of AMHH service providers. The AMHH provider agency must provide the greatest assistance possible to facilitate a transition or change in AMHH service providers at the member’s request. It is the responsibility of the AMHH provider agency to coordinate any transition in services for an AMHH member, such as:

- Transition between AMHH provider staff members within the same AMHH provider agency
- Transition between AMHH provider agencies
- Transition from AMHH services to other programs, such as MRO, as applicable

Transition Between AMHH Service Provider Staff Within an Agency

AMHH members have the right to choose who provides their services within an agency. Members may request specific agency staff provide AMHH services, so long as those staff members are appropriately qualified and trained to provide the service. All requests must be honored, whenever possible, to ensure member choice.

Transition Between AMHH Provider Agencies

To assist in a transition between provider agencies, the current AMHH provider agency must engage in the following to maintain continuity of care for the member:

- Provide the member with a randomized listing of AMHH provider agencies in the member’s county of residence and contiguous counties, so the member is able to make an informed choice in the selection of a new AMHH provider agency.
- Assist in linking the member with the new AMHH provider agency, which includes the transfer of clinical information to coordinate care (with a signed consent if the transfer is between provider agencies and not an internal transfer within the same agency). The information transferred may include the member’s last assessment, current treatment plan and progress notes, crisis plan, and so on, that will assist the new provider agency in continuing care with minimum disruption in service delivery.
- Communicate with the new provider agency regarding service unit utilization during the existing AMHH eligibility period.

Note: Authorization for AMHH services belongs to and follows the AMHH member, not the provider agency. The number of approved AMHH service units do not change due to a transfer between provider agencies. If additional AMHH services are indicated to meet the member’s needs (other than the ones originally approved by the SET), the new provider agency must follow the process for requesting additional services. See Section 11: Request for Approval of Additional AMHH Services.
Voluntary Transition from AMHH Services to MRO Services

If AMHH program members choose, they may request to be transitioned to (or back to) an MRO service package. To assist in a transition to MRO, the AMHH provider agency must engage in the following to maintain continuity of care for the member:

- Complete and submit an ANSA reassessment within 60 days of the requested date of transition to MRO. A current (within 60 days) ANSA is necessary for determining MRO eligibility and service package assignment.
- Complete and submit a modified AMHH application in DARMHA, including the Transition to MRO wizard under the “IICP Form” tab on the application. The requested date of transition must be no earlier than the date the transition request is submitted, and no later than the end of the current AMHH eligibility period. See Section 8: Completing the AMHH Application for instructions.

The SET evaluates the transition request and, when approved, DARMHA sends an AMHH end date to HP. The following day, DARMHA auto-generates an MRO eligibility request file and sends that to HP for MRO eligibility determination. If the MRO eligibility criteria and Medicaid status are met (current level of need, active Medicaid ID, and diagnosis), HP generates and authorizes an MRO service package with an effective date the day after the AMHH end date. If the date on the most recent ANSA is more than 60 days before the AMHH package end date provided by DARMHA, HP does not generate an MRO service package because the date of assessment does not qualify, which may result in a lapse in service authorization for the member. The provider agency will not receive authorization or payment for services delivered between the end of the AMHH service authorization and the beginning of an MRO service package.

Providers may not submit claims for MRO services and AMHH services simultaneously. Services under these two programs are mutually exclusive. Providers may bill only AMHH services during an AMHH program eligibility period even if an MRO service package is also noted as active. After the AMHH service eligibility and service authorization is end-dated, the member can utilize MRO services if there is an authorized service package in place.

Default Transition from AMHH Services to MRO Services

If the current AMHH eligibility period ends without an approved AMHH renewal request and the most recent ANSA is less than 60 days old, an MRO eligibility request file auto-generates from DARMHA and is sent to HP for MRO eligibility determination. If the MRO eligibility criteria and Medicaid status requirements are met (including the level of need, active Medicaid ID, and diagnosis), HP generates and authorizes an MRO service package with an effective date the day after the AMHH end date (which will become the AMHH eligibility end date). If the ANSA is more than 60 days old (from AMHH eligibility end date), the provider must complete a new ANSA and submit it to DARMHA to trigger the MRO eligibility request file being sent to HP for MRO eligibility determination. If neither AMHH nor MRO eligibility is established, the result is a lapse in the member’s program eligibility and service authorization. The provider agency will not receive payment for services delivered outside an authorized eligibility period for either program.

Note: MRO eligibility determination is contingent on current assessments. Providers are strongly encouraged to complete an ANSA reassessment within the required time frame (no more than 60 days before the end date of the current service package eligibility end date) to support ongoing or re-establish program eligibility. For additional information regarding MRO eligibility and service packages, see the Medicaid Rehabilitation Option (MRO) Provider Manual at indianamedicaid.com.
Section 14: Clinical and Administrative Documentation

The AMHH provider agency must comply with documentation requirements, as defined by the CMS, FSSA (FSSA/OMPP/DMHA), the AMHH Provider Manual, and 405 IAC 1-5. All clinical record documentation must contain information that reflects the AMHH services provided to the member. The documentation required to support billing for AMHH services must include the following:

- Focus on the member
- Emphasize the member’s strengths
- Reflect the member’s progress toward the habilitation goals reflected in the IICP
- Be present in the member’s medical record for every member encounter for which billing is submitted for reimbursement
- Be written and signed by the provider rendering services (and cosigned if applicable)
- Follow all documentation requirements outlined in this manual

For complete service definitions, provider qualifications, program standards, and exclusions, see AMHH services outlined in this manual (Sections 15-23).

Service Location Specifications

It is essential that the location where an AMHH service is provided is clearly documented in the member’s clinical record. AMHH is a 1915(i) Home and Community-Based Services program, so with few exceptions, AMHH services must be provided in home and community-based settings to be eligible for reimbursement. Additional information can be found in Section 6 and Sections 15-23 of this manual, and on the FSSA Home and Community-Based Services Final Rule website at in.gov/fssa/4917.htm.

General Documentation Requirements

The AMHH provider agency must comply with the standards for documentation required for each AMHH service provided. While each AMHH service may have its own unique documentation requirements in addition to the general requirements listed here, this section provides information about general documentation requirements that apply to all AMHH services. Documentation standards specific to each AMHH service are detailed, along with the service definition, scope, limitations, and exclusions, in subsequent sections of this manual (see Sections 15-23). Providers are responsible for understanding and adhering to the requirements and limitations for each service they are qualified and authorized to provide. Questions about a service and its requirements may be directed to the SET, which is responsible for completing AMHH quality assurance activities in support of CMS and FSSA/OMPP requirements for the delivery of AMHH services. The following applies to each AMHH service that is claimed for reimbursement:

- All AMHH service and eligibility documentation is subject to review by the CMS and the State, or their designees.
- The provider is subject to denial of payment or recoupment for paid claims if the provider does not have adequate documentation to support the AMHH service billed.
The following documentation requirements apply for each AMHH service encounter:

- Type or title of service provided
- Name and qualifications of the staff member providing the service
- Location or setting where the service was provided
- Description of the focus on the member and of the session or service delivered to or on behalf of the member
- Symptoms or issues addressed during the session
- Duration of the service (actual time spent with the member or completing the activity)
- Start and end time of the service
- Member’s IICP goals addressed during the session
- Progress made toward the habilitation goals
- Date of service rendered (including month, day, and year)

Note: Individualized goals are habilitative in nature. Progress may be described as sustained maintenance of skills or functioning, allowing the individual to live in the community in the least-restrictive environment possible.

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

**Services Provided in a Group Setting**

For members participating in AMHH services provided in a group setting (for example, Adult Day Service; can also apply to Home and Community-Based Habilitation and Support, Therapy and Behavioral Support Services, Addiction counseling, and Medication Training and Support), documentation provided for each encounter must include:

- All items described under General Documentation Requirements.
- Focus or topic of the group or session and how it applied to the specific member’s goals.
- Member’s level of engagement and participation in the group session. Simply noting whether or not the member was present in the group does not constitute adequate documentation.

**Services Provided Without the Member Present**

For services provided without the member present (can apply to home and community-based habilitation and support, therapy and behavioral support, addiction counseling, care coordination, and medication training and support), documentation provided for each encounter must include:

- All items described under General Documentation Requirements
- The persons who attended the session and their relationship with the member
- How the session addresses the goals of the member
Service-Specific Documentation Requirements

The following services have additional documentation requirements, as described. For all other AMHH services, only the general documentation requirements apply.

Adult Day Services

Adult Day Services is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured habilitative services to maintain their outpatient status. Adult Day Services is curriculum-based and designed to alleviate emotional or behavior problems, with the goal of transitioning the member to a less-restrictive level of care, reintegrating the member into the community, and increasing the member’s social connectedness beyond a clinical setting and/or employment. For a complete definition of Adult Day Services, see Section 15 of this manual.

Documentation requirements include, at minimum, weekly reviews with details of daily activities and progress updates that include details of services provided each day per the following:

- All items under General Documentation Requirements
- All requirements noted in Services Provided in a Group Setting
- Member’s goals and a transitional plan to reintegrate the member into the community

Note: Providers may opt to use daily documentation versus a weekly review as long as the agency is consistent about which method is used. Daily reviews require all the same documentation elements weekly reviews do.

Respite Care Services

Respite Care services are services provided to members who are unable to care for themselves. These services are furnished on a short-term basis because of a nonprofessional caregiver’s absence or need for relief. For a complete definition of respite care services, see Section 17 of this manual. Documentation requirements include:

- All items under General Documentation Requirements
- The primary location where services are rendered and the reason for the respite service
- Nature of the services delivered to the member
- Documentation of the activities that the member engaged in during the respite and how the member responded
Section 15: Adult Day Services

AMHH Adult Day Services consists of community-based group programs designed to meet the needs of adults with significant behavioral health impairments, as identified in members’ IICPs. These comprehensive, nonresidential programs provide health, wellness, social, and therapeutic activities in a structured, supportive environment. The services provide supervision, support services, and personal care, as required by the member’s IICP. AMHH Adult Day Services may include:

- Care planning
- Behavioral health treatment
- Monitoring weight, blood glucose level, and blood pressure
- Medication administration
- Nutritional assessment and planning
- Individual or group exercise training
- Training in activities of daily living
- Skill reinforcement for established skills

Adult Day Services may also include other social activities, as indicated, to meet identified needs and goals established in the IICP.

Provider Qualifications

The staff that provides AMHH Adult Day Services must have the following qualifications:

- Licensed professional, except for licensed clinical addiction counselors
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)
- Medication administration provided as part of AMHH Adult Day Services must be delivered by a provider who meets one of the following qualifications:
  - A licensed physician
  - An authorized healthcare professional (AHCP)
  - A registered nurse (RN)
  - A licensed practical nurse (LPN)
  - A medical assistant (MA) who has graduated from a two-year clinical program
- Nutritional assessment and planning services provided as part of AMHH Adult Day Services activity must be provided by a certified dietician as defined in IC 25-14.5-1-4.

See Agency Staff Requirements in Section 3: AMHH Service Providers for additional information about staff member qualifications.
Programming Standards

Programming standards for AMHH Adult Day Services include the following:

- The service requires face-to-face contact with the member, and the member must be the focus of the service delivered.
- The member’s goals must be designed to facilitate community integration and use natural supports.
- Therapeutic services include clinical therapies, psychoeducational groups, and habilitative activities.
- Documentation must support how the service benefits the member, including when the service is provided in a group setting.
- Medication administration must be provided within the scope of practice of the provider staff member, as defined by federal and state law. See the Indiana Professional Licensing Agency for additional information.
- Nutritional assessment and planning services must be delivered by a certified dietician and provided within the scope of practice, as defined in state and federal law. See the Indiana Professional Licensing Agency for additional information.
- Each day of service must be appropriately documented in the member’s clinical record.
- At a minimum, a weekly review and update of the member’s progress toward habilitative goals must occur and be documented in the member’s clinical record. Providers may opt to use daily documentation versus a weekly review summary, as long as the agency is consistent about which method is used. Daily reviews require all the same documentation weekly reviews do.

Requirements for Clinical Oversight

Program standards for AMHH Adult Day Services require that a licensed physician provides clinical oversight of the program. This licensed physician must be on-site at least once a week and available to program staff when not on-site. This requirement is in addition to the general requirement that approved agency staff (QBHP, OBHP, and so on) must be supervised by a licensed professional.

Exclusions

General AMHH program exclusions are outlined in Non-Covered Services in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following exclusions apply and are nonreimbursable or noncovered for AMHH Adult Day Services:

- Formal educational or vocational services are considered nonreimbursable or non-covered.
- Adult Day Services are not eligible for reimbursement if provided in a residential setting, as defined by the FSSA/DMHA.
- For services provided simultaneously with other services, only one of the services provided is billable.
HCPCS Codes

Table 15.1 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Adult Day Services.

Table 15.1 – HCPCS Codes for Adult Day Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5101</td>
<td>UB</td>
<td>Adult Day Services; half-day unit</td>
</tr>
</tbody>
</table>

Service Unit Description and Limitations

The basic unit of service for AMHH Adult Day Services is a half-day unit. A single half-day unit is defined as providing service for a minimum of three hours to a maximum of five hours per day.

- Two units are defined as the service provided for more than five hours to a maximum of eight hours per day.
- A maximum of two half-day units per day is allowed, up to five days per week, with a maximum of 10 units in a five-day period. A second half-day unit may be billed only when a previous entire half-day unit (five hours, plus 60-minute break) has been provided to the member.

For additional guidance about calculating and billing service time for Adult Day Services, see Section 24: AMHH Services Program Billing.
Section 16: Home and Community-Based Habilitation and Support Services

AMHH Home and Community-Based Habilitation and Support Services are individualized face-to-face services focused on the health, safety, and welfare of the member. These services are intended to:

- Provide skills training to reinforce established skills (may include activities of daily living)
- Help members manage, adapt, and retain skills necessary to support their ability to live successfully in the community-integrated settings most appropriate to their needs
- Help members manage their behavioral and medical health conditions

Services are provided in the member’s home (living environment) or other community-based settings outside clinic or office environments.

Home and Community-Based Habilitation and Support Services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present
- An “individual setting” means that the activity is meant to benefit one consumer, even though the activity may include family members and nonprofessional caregivers, and the consumer may or may not be present during the activity. A “group setting” means the activity is meant to benefit more than one consumer, even though, again, the activity may include family members and professional caregivers of multiple consumers, and the consumers may or may not be present during the activity. The benefit to the consumer must be in accordance with each consumer’s individual treatment goals.

Example 1: An AMHH consumer, “John,” attends a family counseling session with his siblings and mother. Because the session is intended to benefit only John, it is considered an individual setting, even though multiple people are present.

Example 2: The families of several consumers meet for an orientation session for an upcoming AMHH skills development group, which will be attended by several AMHH consumers. Because the group includes and will benefit more than one consumer, the activity is considered a group setting.

Provider Qualifications

Provider staff of AMHH Home and Community-Based Habilitation and Support Services must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For additional information on staff member qualifications, see Section 3: AMHH Service Providers.
Programming Standards

Programming standards for AMHH Home and Community-Based Habilitation and Support Services include:

- The services require face-to-face contact. The contact may be with or without the member present, with or without family members and nonprofessional caregivers present, in an individual or group setting.
- The member is expected to show benefit from the services.
- Services must be goal-oriented and related to the IICP.
- When provided to family members or caregivers, services must be focused on the member and improve the ability of the parent, family member, or primary caregiver to provide care to or for the member.
- Activities include:
  - Implementation of the IICP
  - Assistance with personal care
  - Coordination and facilitation of medical and nonmedical services to meet healthcare needs
  - **When family members and nonprofessional caregivers are present:** Training and education to instruct parents or other family members identified in the IICP, or primary (nonprofessional) caregivers about the treatment regimens appropriate to the member
- Services may include, but are not limited to, the following:
  - Skills training in food planning and preparation, money management, and maintenance of the living environment
  - Medication-related education and training by nonmedical staff
  - Training in appropriate use of community-based activities, such as riding the bus, going to the library, and participating in natural support systems, such as faith-based or social activities in the community
  - Training in skills needed to locate and maintain a home, including:
    - Landlord and tenant negotiations
    - Budgeting to meet housing and housing-related expenses
    - Locating and interviewing prospective roommates
    - Renter’s rights and responsibilities

**Note:** Activities allowed under Home and Community-Based Habilitation and Support Services are intended to focus on the maintenance of basic skills to live in the community. Activities allowed under Supported Community Engagement Services are intended to engage a member in meaningful community involvement through activities such as volunteerism or community service.

Exclusions

Exclusions to the general AMHH program are outlined in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Home and Community-Based Habilitation and Support Services:

- Job coaching
- Academic tutoring
- Services provided to professional caregivers
• Skill-building activities not identified in the IICP
• Activities billed under AMHH Supported Community Engagement Services, such as skills training and support related to community engagements (for example, obtaining or maintaining a meaningful purpose or role in the community)

HCPCs Codes

Table 16.1 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Home and Community-Based Habilitation and Support Services.

Table 16.1 – HCPCS Codes for Home and Community-Based Habilitation and Support Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifiers</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2014</td>
<td>UB</td>
<td>Home and Community-Based Habilitation and Support Services-Individual Setting; 15 minute unit</td>
</tr>
<tr>
<td>H2014</td>
<td>UB; HR</td>
<td>Home and Community-Based Habilitation and Support Services-Family/Couple with the Member Present (Individual Setting); 15 minute unit</td>
</tr>
<tr>
<td>H2014</td>
<td>UB; HS</td>
<td>Home and Community-Based Habilitation and Support Services-Family/Couple without Member Present (Individual Setting); 15 minute unit</td>
</tr>
<tr>
<td>H2014</td>
<td>UB; U1</td>
<td>Home and Community-Based Habilitation and Support Services- (Group Setting); 15 minute unit</td>
</tr>
<tr>
<td>H2014</td>
<td>UB; U1; HR</td>
<td>Home and Community-Based Habilitation and Support Services- Family/Couple with Member Present (Group Setting); 15 minute unit</td>
</tr>
<tr>
<td>H2014</td>
<td>UB; U1; HS</td>
<td>Home and Community-Based Habilitation and Support Services- Family/Couple without Member Present (Group Setting); 15 minute unit</td>
</tr>
</tbody>
</table>

Service Unit Description and Limitations

The basic unit of service for AMHH Home and Community-Based Habilitation and Support Services is a 15-minute unit. Home and Community-Based Habilitation and Support Services, including all sub-types (individual or group setting, with or without family/couple or nonprofessional caregivers, with and without member present), may be provided for up to a total of two hours or eight units per day, each day, throughout the eligibility period. See Section 24: AMHH Services Program Billing for additional information.
Section 17: Respite Care Services

AMHH Respite Care services are provided to members who are unable to care for themselves and who are living with nonprofessional caregivers. The service is provided on a short-term basis because of the nonprofessional caregiver’s absence or need for relief. This service is intended to provide support, supervision, and services necessary to ensure members’ health and safety if they are not able to provide for themselves while their primary caregivers are unavailable for a short and defined period.

AMHH Respite Care services may be provided in any of the following locations:

- Member’s home or place of residence
- Caregiver’s home
- Nonprivate residential setting (such as a group home or adult foster care)

Provider Qualifications

 Providers of AMHH Respite Care services, except for medication administration and medical support services provided as part of Respite Care, must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Medication administration and medical support services provided through the AMHH Respite Care service must be within the scope of practice, as defined by federal and state law, by an agency staff member who meets one of the following qualifications:

- A licensed physician
- An advanced practice nurse (APN)
- A physician assistant (PA)
- A registered nurse (RN)
- A licensed practical nurse (LPN)

See Section 3: AMHH Service Providers for additional information about qualifications for provider agency and staff members.
Programming Standards

Programming standards for AMHH Respite Care services include the following:

- The member must be living with a nonprofessional (unpaid) caregiver.
- The location where service is provided and the level of professional care are based on the needs of the member receiving the service, and may include regular monitoring of medications or behavioral symptoms, as identified in the IICP.
- Services must be provided in the least-restrictive environment available and ensure the health and welfare of the member.
- Services must not be used as substitutes for regular care to allow the member’s caregiver to:
  - Attend school
  - Hold a job
  - Engage in employment- or employment search-related activities
- Medication administration and medical support services provided with respite care must be provided within the scope of practice, as defined by federal and state law.
- Services must be provided by an FSSA/DMHA-approved provider.
- Respite care must not duplicate any other service being provided under the member’s IICP.

Exclusions

General AMHH program exclusions are outlined in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following specific exclusions apply and are nonreimbursable or noncovered as AMHH Respite Care services:

- Services provided to members living in FSSA-/DMHA-certified residential facilities
- Services provided to members living in supportive housing
- Services provided to members who receive in-home support from professional caregivers, rather than nonpaid caregivers
- Respite care provided by either of the following:
  - Any relative who is the primary caregiver of the member
  - Anyone living in the member’s residence
- Services provided to members by family or friends (respite services must be provided by FSSA/DMHA-approved providers)
- Any service that meets the definition of hospice services
HCPCS Codes

Table 17.1 shows the Healthcare Common Procedure Coding System codes for Respite Care services.

Table 17.1 – HCPCS Codes for Respite Care Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5150</td>
<td>UB</td>
<td>Hourly Respite Care Services, for billing up to 7 hours in the same day; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>S5151</td>
<td>UB</td>
<td>Daily Respite Care Services, for billing 8 – 24 hours in the same day; 1 Unit = 1 day</td>
</tr>
</tbody>
</table>

Service Unit Description and Limitations

There are two basic units of service for AMHH Respite Care services: hourly or daily. The available number of units per AMHH eligibility period depends on whether the Respite Care service is provided hourly or daily:

- **Hourly Respite Care**: The basic unit is a 15-minute unit, which applies to services provided up to seven hours, or 28 units, per day. Hourly Respite Care is available for a maximum of 75 hours (300 units) per the member’s AMHH eligibility period.

- **Daily Respite Care**: The basic unit is a single-day unit, which applies to services provided between eight and 24 hours within the same calendar day. Daily Respite Care may be provided for up to 14 consecutive days for a maximum of 28 days per eligibility period.

**Hourly and Daily Respite Care may not be billed on the same calendar day.**
Section 18: Therapy and Behavioral Support Services

AMHH Therapy and Behavioral Support Services consist of a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the IICP. Services must be provided at the member’s home (living environment) or at a location outside the clinic setting.

AMHH Therapy and Behavioral Support Services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present

See Appendix A for the definitions of individual and group settings as they apply to this service.

Provider Qualifications

Providers of Therapy and Behavioral Support Services must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)

For additional information about qualifications for provider agency and staff members, see Section 3: AMHH Service Providers.

Programming Standards

Programming standards for AMHH Therapy and Behavioral Support Services include the following:

- Services must be provided face-to-face with the member and their family members or nonprofessional caregivers.
- The member must be the focus of the treatment, and documentation must support how the service benefits the member.
- Services must address one or more goals identified in the IICP, and these goals must be habilitative.
- Documentation must demonstrate progress toward and achievement of treatment goals.
- Therapy and behavioral support services include, but are not limited to, the following:
  - Observing the member and environment to help develop the IICP
  - Developing a person-centered behavioral support plan and subsequent revisions, which may be a part of the IICP
  - Implementing the behavior support plan for staff, family members, roommates, and other appropriate individuals
  - Training in assertiveness and/or relationship building
  - Addressing and managing behavioral health symptoms or impairment
  - Teaching stress-reduction techniques
Developing and retaining socially accepted behaviors

Exclusions

Exclusions to the general AMHH program are outlined in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following exclusion applies and is nonreimbursable or non-covered for AMHH Therapy and Behavioral Support Services:

- Service provided in a clinic setting is not billable as an AMHH service (but may qualify for reimbursement under the Medicaid Clinic Option).

HCPCS Codes

Table 18.1 shows Healthcare Common Procedure Coding System (HCPCS) codes for Therapy and Behavioral Support Services.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifiers</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004</td>
<td>UB</td>
<td>Therapy and Behavioral Support Services – Individual Setting; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>UB; HR</td>
<td>Therapy and Behavioral Support Services – Family/Couple with Member Present (Individual Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>UB; HS</td>
<td>Therapy and Behavioral Support Services – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>UB; U1</td>
<td>Therapy and Behavioral Support Services – Group Setting; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>UB; U1; HR</td>
<td>Therapy and Behavioral Support Services – Family/Couple with Member Present (Group Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>UB; U1; HS</td>
<td>Therapy and Behavioral Support Services – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes</td>
</tr>
</tbody>
</table>

Service Unit Description and Limitations

The basic unit of service for AMHH Therapy and Behavioral Support Services is a 15-minute unit. The available number of units per AMHH eligibility period is determined according to the setting (individual or group) in which the service was provided:

- When provided in an individual setting, including a combination of all three subtypes (member only, family/couple or caregivers with and without the member present), the service may be provided for a maximum of 24 hours (96 units) per year.
- When provided in a group setting, including combination of all three subtypes (multiple members, family/couple or caregivers with and without the member present), the service may be provided for a maximum of 30 hours (120 units) per year.
Section 19: Addition Counseling Services

AMHH Addiction Counseling Services consist of a series of planned and organized face-to-face services in which addiction professionals and other clinicians provide counseling interventions that work toward the member’s recovery goals identified in the IICP, as they pertain to substance-related disorders. Services must be provided at the member’s home (living environment) or at other locations outside the clinic setting. Services under this section may be provided for members with a substance-related disorder with any of the following:

- Minimal or manageable medical conditions
- Minimal withdrawal risk
- Emotional, behavioral, and cognitive conditions that do not prevent the member from benefiting from this service

Note: When requesting Addiction Counseling Services, the provider must ensure that a substance-use diagnosis is reflected in the applicant’s DARMHA record.

AMHH Addiction Counseling Services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present

See Appendix A for definitions of individual and group settings as they apply to this service.

Provider Qualifications

AMHH Addiction Counseling Services must be provided by qualified addiction professionals or other clinicians that have either of the following qualifications:

- Licensed professional, including a licensed clinical addiction counselor (LCAC)
- Qualified behavioral health professional (QBHP)

For additional information about qualifications for provider agency and staff members, see Section 3: AMHH Service Providers.

Programming Standards

Programming standards for AMHH Addiction Counseling Services include:

- Services must be provided face-to-face with the member, family members, or nonprofessional caregivers supporting the member
- The member must always be the focus of addiction counseling.
- Addiction counseling must consist of regularly scheduled sessions.
• Documentation must support how addiction counseling benefits the member and must demonstrate progress toward and achievement of goals identified in the IICP.

• Addiction Counseling Services may include the following activities:
  − Education about addiction disorders (combined with other addiction-treatment activities)
  − Skills training in:
    ➢ Communication
    ➢ Anger management
    ➢ Stress management
  − Relapse prevention
  − Referral to community recovery support programs, as available

Exclusions

Exclusions to the general AMHH program are outlined in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Addiction Counseling Services:

• Services provided to members with withdrawal risk or symptoms
• Services provided to members whose needs cannot be managed safely with AMHH services
• Services provided to members who require detoxification services
• Services provided to members who are determined to be at imminent risk of harm to the self or to others
• Addiction counseling sessions that consist only of education services
• Services provided to professional caregivers

HCPCS Codes

Table 19.1 shows Healthcare Common Procedure Coding System (HCPCS) codes for Addiction Counseling Services.

Service Table 19.1 – HCPCS Codes for Addiction Counseling Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifiers</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2035</td>
<td>UB</td>
<td>Addiction Counseling – Individual Setting; 1 Unit = 1 hour</td>
</tr>
<tr>
<td>H2035</td>
<td>UB; HR</td>
<td>Addiction Counseling – Family/Couple with Member Present (Individual Setting); 1 Unit = 1 hour</td>
</tr>
<tr>
<td>H2035</td>
<td>UB; HS</td>
<td>Addiction Counseling – Family/Couple without Member Present (Individual Setting); 1 Unit = 1 hour</td>
</tr>
<tr>
<td>H2035</td>
<td>UB; U1</td>
<td>Addiction Counseling – Group Setting; 1 Unit = 1 hour</td>
</tr>
<tr>
<td>H2035</td>
<td>UB; U1; HR</td>
<td>Addiction Counseling – Family/Couple with Member Present (Group Setting); 1 Unit = 1 hour</td>
</tr>
<tr>
<td>H2035</td>
<td>UB; U1; HS</td>
<td>Addiction Counseling – Family/Couple without Member Present (Group Setting); 1 Unit = 1 hour</td>
</tr>
</tbody>
</table>
Service Unit Description and Limitations

The basic unit of service for AMHH Addiction Counseling Services is a one-hour unit. Addiction Counseling Services, including all subtypes (individual or group setting, family/couple, with and without member present) may be provided for a maximum of 64 hours (64 units) per year.
Section 20: Peer Support Services

AMHH Peer Support Services is a face-to-face individual service, typically provided by a certified recovery specialist (CRS) and consisting of structured, scheduled activities promoting the following:

- Socialization
- Habilitation
- Recovery
- Self-advocacy
- Development of natural supports
- Maintenance or acquisition of community living skills

Provider Qualifications

Staff providers of Peer Support Services must have both the following qualifications:

- Meet the FSSA/DMHA training and competency standards for a certified recovery specialist (CRS)
- Be under the supervision of a licensed professional or a qualified behavioral health profession (QBHP)

For additional information about qualifications for provider agency and staff members, see Section 3: AMHH Service Providers.

Programming Standards

Standards for AMHH Peer Support Services programming include:

- The service must be provided face-to-face with the member in an individual setting only.
- The service must be a structured and scheduled activity.
- The service must help the member obtain a specific treatment goal in the IICP (that is, the IICP must contain a specific goal or objective to be directly addressed by peer support services).
- Documentation must support how the service specifically benefits the member.
- The service includes, at a minimum, one or more of the following components:
  - Helping the member develop a self-care plan (which may be included in the IICP), as well as other formal mentoring activities aimed at increasing the member’s active participation in person-centered planning and delivery of individualized services
  - Helping the member develop psychiatric advanced directives
  - Supporting the member in problem-solving related to reintegration into the community
  - Educating the member about and promoting habilitation, the recovery process, and anti-stigma activities
Exclusions

Exclusions to the general AMHH program are outlined in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Peer Support Services:

- Services that are purely recreational or diversionary and do not support community integration goals
- Services provided in group settings
- Activities billed under AMHH Home and Community-Based Habilitation and Support Services or AMHH Care Coordination services

HCPCS Codes

Table 20.1 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Peer Support Services.

Table 20.1 – HCPCS Codes for Peer Support Services

<table>
<thead>
<tr>
<th>Codes</th>
<th>Modifier</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0038</td>
<td>UB</td>
<td>Peer Support Services; 1 Unit = 15 minutes</td>
</tr>
</tbody>
</table>

Service Unit Description and Limitations

The basic unit of service for AMHH Peer Support Services is a 15-minute unit. Peer Support Services may be provided for a maximum of 130 hours (520 units) per AMHH eligibility period.
Section 21: Supported Community Engagement Services

AMHH Supported Community Engagement Services are face-to-face activities delivered on an individual basis and in a community setting. This service is designed to engage members in meaningful community involvement activities, such as volunteerism or community service. Services are habilitative in nature and are aimed at developing skills and opportunities that lead to members’ improved integration into the community through increasing community engagement. AMHH Supported Community Engagement Services may not, however, include explicit employment objectives.

Provider Qualifications

Staff providers of Supported Community Engagement Services must have one of the following qualifications:

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

For additional information about qualifications for provider agency and staff members, see Section 3: AMHH Service Providers.

Programming Standards

Programming standards for AMHH Supported Community Engagement Services include the following:

- The service requires face-to-face contact with the member in a community setting.
- The service is provided to members who may benefit from community engagement and are unlikely to achieve this level of community integration without the provision of support.
- The service includes helping the member develop a relationship with community organizations specific to that individual’s interests and needs.
- The service involves collaboration with a community organization to develop an individualized plan that identifies specific supports required, organizational expectations, training strategies, time frames, and responsibilities.
- Allowable activities are geared to achieving a generalized skill or behavior that may prepare the member for community engagement and may include (but not be limited to) teaching concepts such as:
  - Attendance
  - Task completion
  - Problem solving
  - Safety
- Services must be explicitly identified in the IICP and related to goals identified by the member, and may include activities such as:
  - How to use public transportation to get to and from the designated community setting
  - Work environment/modification analysis
Work-task analysis – an activity intended to enhance the member’s functioning in a volunteer (community) setting and not an employment-related goal

Use of assistive technology device/adaptive equipment

**Note:** Activities allowed under Supported Community Engagement Services are intended to engage members in meaningful community involvement through activities such as volunteerism or community service.

Activities allowed under Home and Community-Based Habilitation and Support Services are intended to focus on the maintenance of basic skills needed to live in the community.

**Exclusions**

Exclusions to the general AMHH program are outlined in *Section 2: Adult Mental Health Habilitation (AMHH) Services*. The following specific exclusions apply and are nonreimbursable or non-covered for AMHH Supported Community Engagement Services:

- Reimbursement or compensation paid by the provider agency to the member for performing activities covered under the service. If a provider chooses to compensate a member for job-related activities, the provider must use non-Medicaid funding and must be able to document the funding source.
- Training in specific job tasks
- Services provided to members who are currently competitively employed
- Any service that is available as vocational rehabilitation services funded under the *Rehabilitation Act of 1973*
- Services provided in a group setting
- Services that include explicit employment objectives

**HCPCS Codes**

Table 21.1 shows Healthcare Common Procedure Coding System (HCPCS) codes for Supported Community Engagement Services.

**Table 21.1 – HCPCS Codes for Supported Community Engagement Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97537</td>
<td>UB</td>
<td>Supported Community Engagement Services; 1 Unit = 15 minutes</td>
</tr>
</tbody>
</table>

**Service Unit Description and Limitations**

The basic unit of service for AMHH Supported Community Engagement Services is a 15-minute unit. Supported Community Engagement Services may be provided up to a maximum of 18 hours (72 units) per month.
Section 22: Care Coordination Services

AMHH Care Coordination services consist of activities that help a member access needed medical, social, educational, and other services. These services include direct assistance in gaining access to services, coordination of care, oversight of the member’s care in the AMHH program, and linkage to appropriate services.

AMHH Care Coordination includes the following activities:

- **Assessment to determine service needs**: Includes identifying the member’s needs for medical, educational, social, or other services. Activities necessary to form a complete needs assessment of the member may include the following:
  - Documenting the member’s history
  - Identifying the individual’s needs
  - Completing related documentation
  - Gathering information from other sources, such as family members and medical providers

- **Development of the IICP**: Includes the development of a written IICP based on the information collected through the needs assessment. The IICP identifies the habilitative activities and assistance needed to accomplish the member’s identified goals and objectives.

- **Referral and Linkage**: Includes activities that help link the member with programs and services that are capable of providing needed habilitative services that meet the member’s needs, including but not limited to:
  - Medical providers
  - Social service providers
  - Educational providers

- **Monitoring and Follow-up**: Includes contacts and related activities necessary to ensure the IICP is effectively implemented and adequately addresses the member’s needs. Such activities and contacts may include the following:
  - The member
  - Family members or individuals who have a significant relationship with the member
  - Nonprofessional caregivers
  - Providers
  - Other entities

- **Evaluation**: Includes face-to-face contact with the member at least every 90 days for the following reasons:
  - To determine if services are being furnished in accordance with the IICP
  - To assess the adequacy of the services in the IICP
  - To assess any changes in the member’s needs or status
  - To make changes or adjustments to the IICP to meet the member’s ongoing needs
  - To evaluate or reevaluate the member’s progress toward achieving the IICP’s objectives

**Note:** Time devoted to formal supervision of the case between the care coordinator and a licensed supervisor to review the member’s care and treatment is considered an included Care Coordination activity. The supervision must be documented appropriately and billed under one provider only.
Provider Qualifications

Provider staff delivering AMHH Care Coordination services must have one of the following qualifications:

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

For additional information about qualifications for provider agency and staff members, see Section 3: AMHH Service Providers.

Programming Standards

Programming standards for AMHH Care Coordination services include the following:

- Care Coordination includes:
  - Development of the IICP
  - Limited referrals to services
  - Activities or contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the mental health or addiction needs, or both, of the member
- Care Coordination does not include direct delivery of medical, clinical, or other direct services. It is provided on behalf of the member, not to the member.
- Care Coordination must provide direct assistance to the member in gaining access to necessary medical, social, educational, and other services.
- The care coordinator must reevaluate the member’s progress via face-to-face contact with the member at least every 90 days to:
  - Ensure that the IICP is effectively implemented and adequately addresses the needs of the member
  - Determine whether the services are consistent with the IICP
  - Make changes or adjustments to the IICP to meet the member’s ongoing needs
  - Evaluate or reevaluate the member’s progress toward achieving the IICP’s objectives

Exclusions

Exclusions to the general AMHH program exclusions are outlined in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Care Coordination services:

- Activities billed under behavioral health level of need redetermination (by a nonphysician)
- Services provided in a group setting
- Direct delivery of medical, clinical, or other direct services, including but not limited to the following:
  - Training in daily living skills
  - Training in work or social skills
  - Grooming and other personal services
  - Training in housekeeping, laundry, or cooking
  - Transportation services
− Individual, group, or family therapy
− Crisis intervention services
− Services that go beyond assisting the member in gaining access to needed services, including but not limited to the following:
  ➢ Paying bills and balancing the member’s checkbook
  ➢ Traveling to and from appointments with members

**HCPCS Codes**

Table 22.1 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Care Coordination services.

Table 22.1 – HCPCS Codes for Care Coordination Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1016</td>
<td>UB</td>
<td>Care Coordination Services; 1 Unit = 15 minutes</td>
</tr>
</tbody>
</table>

**Service Unit Description and Limitations**

The basic unit of service for AMHH Care Coordination services is a 15-minute unit. Care Coordination services may be provided for a maximum of 200 hours (800 units) per eligibility period.

Some members who receive AMHH Care Coordination services will also be enrolled in the Behavioral and Primary Healthcare Coordination (BPHC) Program. This program provides specialized case management to assist in the coordination, referral, and linkage needs of a member with co-occurring mental and physical health concerns. For those members approved for both AMHH and BPHC, the number of AMHH Care Coordination service units, or BPHC service units, will be adjusted as follows:

- For individuals who have active AMHH service package assignments at the time of BPHC application, the number of BPHC units is authorized based on the time left until the AMHH evaluation is due as outlined in the following table. If the AMHH end date is less than six months away, the BPHC end date is aligned with the AMHH end date. If the AMHH end date is more than six months away, the BPHC service is authorized for six months. In both scenarios, the active AMHH authorization period remains unchanged.

Table 22.2 shows the BPHC units authorized with active AMHH.

Table 22.2: BPHC Units Authorized with Active AMHH

<table>
<thead>
<tr>
<th>Months Until AMHH Expires</th>
<th>Units of BPHC Authorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-12</td>
<td>48</td>
</tr>
<tr>
<td>5</td>
<td>40</td>
</tr>
<tr>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>
• If an individual applies for AMHH after he or she already has an active BPHC service package assignment, the number of authorized AMHH Care Coordination units (T1016 UB) is reduced to account for the BPHC service package assignment. The AMHH approval end date is aligned with the existing BPHC approval period.
Section 23: Medication Training and Support Services

AMHH Medication Training and Support services involve face-to-face services provided to the member, in an individual or group setting, for the purpose of:

- Monitoring medication compliance
- Providing education and training about medications
- Monitoring medication side effects
- Providing other nursing or medical assessment

AMHH Medication Training and Support services may also include training family members and nonprofessional caregivers to assist with the member’s medication management. When provided to family members or other nonprofessional caregivers (with or without the member present), the service:

- Must focus on and be on behalf of the member
- May include training family members or nonprofessional caregivers to:
  - Monitor the member’s medication compliance
  - Assist with the administration of prescribed medications
  - Monitor side effects, including:
    - Weight
    - Blood glucose level
    - Blood pressure

AMHH Medication Training and Support services can be provided to:

- Members individually in individual or a group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present

For definitions of individual and group settings as they apply to this service, see Appendix A.

In addition to face-to-face services provided to a member or a member’s family, some AMHH Medication Training and Support services are not required to be provided face-to-face. These services may be provided only in an individual setting and include:

- Transcribing medication orders of a physician or AHCP
- Setting or filling medication boxes
- Consulting with the attending physician or AHCP regarding medication-related issues
- Ensuring that lab and other prescribed clinical orders are sent
- Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders
- Follow-up reporting of lab and clinical test results to the member and physician
Provider Qualifications

Provider staff delivering AMHH Medication Training and Support services must be one of the following qualifications:

- Licensed physician
- Authorized healthcare professional (AHCP)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical assistant (MA) who has graduated from a two-year clinical program

For additional information about qualifications for provider agency and staff members, see Section 3: AMHH Service Providers.

Programming Standards

Programming standards for AMHH Medication Training and Support services include the following:

- Services must be provided within the scope of practice, as defined by federal and state law.
- Services provided that are not face-to-face with the member must meet the following standards:
  - The member must be the focus of the service.
  - Documentation must support how the service benefits the member.
- When provided in a clinic setting, AMHH Medication Training and Support services may complement, but not duplicate, activities associated with medication management activities as defined by and available under the Medicaid Clinic Option.
- When provided in a residential treatment setting, AMHH Medication Training and Support services may include components of medication management services as defined under the Medicaid Clinic Option.
- Services must be habilitative in nature and demonstrate movement toward and achievement of the member’s treatment goals identified on the IICP.

Exclusions

Exclusions to the general AMHH program are outlined in Section 2: Adult Mental Health Habilitation (AMHH) Services. The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Medication Training and Support services:

- If medication management, counseling, or psychotherapy is provided through the Medicaid Clinic Option, and medication management is a component of the service, then AMHH Medication Training and Support services may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding member self-administration of medications is not reimbursable under AMHH Medication Training and Support, but may be eligible for reimbursement under Home and Community-Based Habilitation and Support Services skills training and development.
- Services provided to paid, professional caregivers are excluded.
- When provided in a group setting, the following activities are not covered:
• Transcribing physician or AHCP medication orders
• Setting or filling medication boxes
• Consulting with the attending physician or AHCP regarding medication-related issues
• Ensuring that a lab or other prescribed clinical orders are sent
• Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders
• Follow-up reporting of lab and clinical test results to the member and physician

HCPCS Codes

Table 23.1 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Medication Training and Support services.

Table 23.1 – HCPCS Codes for Medication Training and Support Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifiers</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0034</td>
<td>UB</td>
<td>Medication Training and Support – Individual Setting; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; HR</td>
<td>Medication Training and Support – Family/Couple with Member Present (Individual Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; HS</td>
<td>Medication Training and Support – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; U1</td>
<td>Medication Training and Support – Group Setting; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; U1; HR</td>
<td>Medication Training and Support – Family/Couple with Member Present (Group Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; U1; HS</td>
<td>Medication Training and Support – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes</td>
</tr>
</tbody>
</table>

Service Unit Description and Limitations

The basic unit of service for AMHH Medication Training and Support services is a 15-minute unit. AMHH Medication Training and Support services, including all subtypes (individual or group setting, family/couple, with and without member present), may be provided for a maximum of 182 hours (728 units) per AMHH eligibility period.
Section 24: AMHH Services Program Billing

This section outlines AMHH billing guidelines, claim format, and necessary billing-related information. Explanation of billing specifics, such as actual time spent conducting service versus time billed, modifiers, and other helpful billing-related items, are included with examples. For more information about general billing, see 405 IAC 7 and Chapter 8: Billing Instructions of the IHCP Provider Manual. IHCP providers are responsible for reading and understanding applicable IAC and IHCP manuals.

Billing Standards

AMHH provider agencies that are enrolled IHCP providers must adhere to all IHCP rules, policies, and processes required of IHCP-enrolled members.

In regards to AMHH services, the following applies:

- IHCP rendering provider numbers are assigned to physicians or HSPPs. The rendering provider numbers are linked to the group provider number of the participating billing group.
- Reimbursement is 100% of the rate for all staff meeting provider qualifications for each service.
- Providers are responsible for internally tracking AMHH service utilization to ensure that service units are available. Providers can confirm service unit availability via Web interChange, the State’s recognized final reference for this information.
- Units of AMHH services, as displayed in Web interChange, are decremented based on adjudicated claims. Failure to submit claims in a timely fashion may place the provider at risk for nonpayment.
- For an AMHH provider to receive reimbursement for the delivery of AMHH services, a member must have been deemed eligible for AMHH services and received an authorization notification confirming the AMHH services authorized on the IIIP. The FSSA/DMHA SET retains final authority for determining AMHH eligibility and authorizing AMHH services.
- AMHH approval and authorization dates may be accessed by providers on Web interChange.
- Providers of AMHH services are IHCP providers and therefore are responsible for complying with IHCP billing practices outlined at indianamedicaid.com.

Claim Form

Each line of the CMS-1500 claim form is individually priced at the IHCP-allowed rate for the procedure billed. The IHCP-allowed rate is the lower of the submitted charge or the IHCP maximum fee for that procedure.

Each line on the CMS-1500 claim form accommodates a rendering provider number. Multiple rendering provider numbers can be reflected on one claim to indicate the individual practitioner in the group that performed each service billed on the claim form. The rendering provider’s National Provider Identifier (NPI) and taxonomy (optional) is included in field 33b of the claim form. The group’s billing provider NPI is included in field 33a, and taxonomy (optional) is included in field 33b of the claim form. The group provider number is used for billing and incorporates all the individual provider services on the group Remittance Advice (RA). A provider who is not a physician or HSPP is not assigned an individual IHCP provider number. For detailed, line-by-line billing instructions for the CMS-1500 (02/12), see Chapter 8 of the IHCP Provider Manual.
**Claim Format**

AMHH service claims can be billed using the CMS-1500 paper claim format or the HIPAA-compliant electronic 837P claim format. Additional procedures for billing with the CMS-1500 claim form are provided in Chapter 8 of the IHCP Provider Manual.

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

- The provider agency billing group’s NPI must be entered in field 33a of the CMS-1500 claim form.
- Each line of the CMS-1500 claim form must include the rendering or supervising psychiatrist, physician, or HSPP’s NPI in field 24J.

```
Note: Submit claims for reimbursement on a timely basis:
- Units of AMHH services as displayed in Web interChange are decremented based on adjudicated claims.
- Timely submission of claims ensures that the data accessible on Web interChange accurately reflects remaining units of service for each member.
- Failure to submit claims timely may place the provider at risk for nonpayment.
```

AMHH services may be billed with other IHCP-covered services on the same claim. Updated information is disseminated through IHCP provider bulletins posted at indianamedicaid.com. Each provider is responsible for obtaining the information, and implementing new or revised policies and procedures as outlined in these notices.

**Facility Fees**

No facility fees are paid for AMHH services.

**AMHH and the Healthy Indiana Plan (HIP)**

Individuals who are enrolled in the Healthy Indiana Plan (HIP) 2.0 and who are determined to be medically frail have access to coverage established under the Indiana Medicaid State Plan. The state plan services include intensive behavioral health Medicaid programs such as MRO/BPHC/AMHH. The intensive community-based behavioral health service programs are carved out from the HIP managed care entities (MCEs) benefit responsibilities and are billed to the IHCP through the fee-for-service claims payment system.

HIP members deemed medically frail receive HIP State Plan coverage and are enrolled in HIP State Plan - Plus. These members are required to make monthly POWER Account contributions. HIP State Plan - Plus members are not subject to copays for most services, including all AMHH behavioral health services. Medically frail members enrolled in HIP State Plan – Plus who do not pay their monthly POWER Account contributions will be enrolled in HIP State Plan – Basic, and will be required to pay a $4 copay for outpatient services, including many AMHH services. Table 24.1 identifies the AMHH service types that do not require copayment under HIP State Plan - Basic.
Table 24.1 – AMHH Procedure Codes with Modifiers That Do Not Require a Copayment under HIP State Plan – Basic

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Modifiers</th>
<th>Service title</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2014</td>
<td>UB; HS</td>
<td>Home and Community-Based Habilitation and Support Services- Family/Couple without the Member Present (Individual Setting); 15 minute unit</td>
</tr>
<tr>
<td>H2014</td>
<td>UB; U1; HS</td>
<td>Home and Community-Based Habilitation and Support Services- Family/Couple without Member Present (Group Setting); 15 minute unit</td>
</tr>
<tr>
<td>H0004</td>
<td>UB; HS</td>
<td>Therapy and Behavioral Support Services – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>UB; U1; HS</td>
<td>Therapy and Behavioral Support Services – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H2035</td>
<td>UB; HS</td>
<td>Addiction Counseling – Family/Couple without Member Present (Individual Setting); 1 Unit = 1 hour</td>
</tr>
<tr>
<td>H2035</td>
<td>UB; U1; HS</td>
<td>Addiction Counseling – Family/Couple without Member Present (Group Setting); 1 Unit = 1 hour</td>
</tr>
<tr>
<td>H0038</td>
<td>UB</td>
<td>Peer Support Services; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>T1016</td>
<td>UB</td>
<td>Care Coordination Services; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB</td>
<td>Medication Training and Support – Individual Setting; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; HR</td>
<td>Medication Training and Support – Family/Couple with Member Present (Individual Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; HS</td>
<td>Medication Training and Support – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; U1</td>
<td>Medication Training and Support – Group Setting; 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; U1; HR</td>
<td>Medication Training and Support – Family/Couple with Member Present (Group Setting); 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>H0034</td>
<td>UB; U1; HS</td>
<td>Medication Training and Support – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes</td>
</tr>
</tbody>
</table>

More information about the HIP program can be found at the [FSSA HIP website](http://www.fssa.gov/hip).  

**Time Documentation**

Staff must document actual time spent delivering services in a given 24-hour period in the member’s clinical record. For billing purposes, a provider agency must total the actual time spent delivering the same service on the same day by all provider types for each member. Minutes of service do not have to be consecutive to be billed together. When
services are provided in group settings, it is appropriate to bill for each member in the group for the time spent in the group.

Figure 24.1 – Examples of Time Documentation

Example A-1:
A member receives five minutes of Home and Community-Based Habilitation and Support Services from a staff member, four minutes of Home and Community-Based Habilitation and Support Services from a second staff member, and nine minutes of Home and Community-Based Habilitation and Support Services from a third staff member on the same day. The member’s clinical record notes that three staff members provided Home and Community-Based Habilitation and Support Services on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 18 minutes.

\[ 5 \text{ minutes} + 4 \text{ minutes} + 9 \text{ minutes} = 18 \text{ minutes of Home and Community-Based Habilitation and Support Services} \]

Example A-2:
A member receives 15 minutes of Therapy and Behavioral Support Services, individual, from a licensed clinical social worker (LCSW) and 25 minutes of Therapy and Behavioral Support Services, individual, from a master’s level practitioner on the same day. The member’s clinical record notes that two staff members provided Therapy and Behavioral Support Services, individual, on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 40 minutes. Even though the two staff members have different provider qualifications, they must add their time spent with the member together.

\[ 15 \text{ minutes} + 25 \text{ minutes} = 40 \text{ Minutes of Therapy and Behavioral Support Services, individual} \]

Converting Time Spent for Service Delivery to Billing Units

Providers must determine the total actual time spent delivering a service in a given 24-hour period, as previously described in Time Documentation (see Figure 24.1). The total time spent is then converted into billing units for that service. Providers should refer to the HCPCS code for each service for information on the unit increment that is used for each service. Providers should round the total actual time each day to the nearest whole unit when calculating reimbursement, described as follows.
15-Minute Unit

Services billed in 15-minute units include:

- Home and Community-Based Habilitation and Support Services
- Therapy and Behavioral Support Services Peer Support Services
- Supported Community Engagement Services
- Care Coordination
- Medication Training and Support

See the following subsection for unique billing guidance for Respite Care services. If staff delivers one of these services for eight or more minutes, or the total daily minutes for the service add up to eight or more minutes, the provider may round up to one 15-minute unit. If staff delivers a service for seven minutes or less, or the total daily minutes for the service add up to seven minutes or less, the provider rounds down to zero units and therefore may not bill for the service. The same rounding rules apply to portions of time remaining once one or more full 15-minute units have been converted.

Figure 24.2 – Examples of 15-Minute Billing

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**Examples: 15-Minute Unit Billing**

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**Example B-1:**

The member (from the preceding Example A-1) received 18 total minutes of Home and Community-Based Habilitation and Support Services from three different staff members in a 24-hour period, as reflected in the member’s clinical record. Home and Community-Based Habilitation and Support Services are billed in 15-minute units, so for billing purposes, only one unit of Home and Community-Based Habilitation and Support Services may be billed.

18 minutes of Home and Community-Based Habilitation and Support Services = One 15 minute unit of Home and Community-Based Habilitation and Support Services. (one full 15-minute unit plus three additional minutes, which must be rounded down)

**Example B-2:**

The member (from the preceding Example A-2) received 40 minutes of Therapy and Behavioral Support Services, individual, from two different providers on the same day, as reflected in the member’s clinical record. Therapy and Behavioral Support Services are billed in 15-minute units, so for billing purposes, three units of Therapy and Behavioral Support Services may be billed.

40 Minutes of Therapy and Behavioral Support Services = Three 15 minute units of Therapy and Behavioral Support Services (two full 15-minute units plus 10 additional minutes, which may be rounded up)
One-Hour (60-Minute) Unit

AMHH Addiction Counseling Services are billed in one-hour (60-minute) units. If staff delivers Addiction Counseling Services for 45 or more minutes, or the total minutes of Addiction Counseling Services provided for the day adds up to 45 or more minutes, the provider may bill for the appropriate number of units of Addiction Counseling Services. If staff delivers Addiction Counseling Services for 44 minutes or less, or the total minutes of Addiction Counseling Services provided for the day adds up to 44 minutes or less, the provider rounds down to zero units and therefore may not bill for this service. The same rounding rules apply to portions of time remaining, once one or more full one-hour (60-minute) units have been converted.

Figure 24.3 – Example of One-Hour Unit Billing

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**Example: One-Hour Unit Billing**

A member receives 48 minutes of Addiction Counseling Services, individual. For billing purposes, 48 minutes of service is greater than (>) the 44-minute threshold, and the provider may round up to one one-hour unit.

\[ 48 \text{ minutes} > 44 \text{-minute threshold} = \text{provider may bill for one 1-hour unit of Addiction Counseling Services}. \]

A member receives 25 minutes of Addiction Counseling Services. For billing purposes, 25 minutes of service is less than (<) the 44-minute threshold. The provider must round down to zero (0) and **may not bill** for this service.

\[ 25 \text{ minutes} < 44 \text{ minutes} = \text{provider may not bill for Addiction Counseling Services rendered}, \]

A member receives 20 minutes of Addiction Counseling Services from one staff member and 25 minutes of Addiction Counseling Services from a second staff member on the same day. The provider totals the actual time delivering the service to 45 minutes. For billing purposes, 45 minutes of service is greater than the 44-minute threshold, and the provider rounds up to one one-hour unit.

\[ 20 \text{ minutes} + 25 \text{ minutes} = 45 \text{ minutes} > 44 \text{-minute threshold} = \text{provider may bill for one 1-hour unit of Addiction Counseling Services} \]

A member receives 80 minutes of Addiction Counseling Services, group. For billing purposes, 80 minutes is greater than the 44-minute threshold for one 1-hour unit of service but does not qualify for a second one-hour unit of service.

\[ 80 \text{ minutes} = 60 \text{ minutes (one one-hour unit of service)} + 20 \text{ minutes}; \]

\[ 20 \text{ minutes} < 44 \text{-minute threshold} = \text{provider may bill for one one-hour unit of Addiction Counseling Services, group and may not bill the additional 20 minutes of services rendered.} \]
Half-Day Units

AMHH Adult Day Services is the only AMHH service that is billed in half-day units, which consist of a minimum of three and maximum of five consecutive hours of the service. Up to 20 minutes in break time may occur within the minimum three-hour block of service time. If more than three consecutive hours are provided, up to a 60-minute break is allowed in addition to the 20-minute break. The 60-minute break may not be billed as a component of the service, however.

Adult Day Services allows for up to two half-day units of service to be billed in one day. The second half-day unit may be billed only if a previous half-day unit equaling five hours has been delivered and an additional three hours of the service is provided. The second unit of service may include an additional 20-minute break within the three-hour block of time.

Figure 24.4 – Example of Half-Day Unit Billing

<table>
<thead>
<tr>
<th>Example: Half-Day Unit Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>A member receives 53 minutes of Adult Day Services followed by a 10-minute break, an additional 50 minutes of Adult Day Services followed by a 10-minute break, and finally an additional 60 minutes of Adult Day Services. A total of 163 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 183 minutes of Adult Day Services was delivered (183 minutes is greater than (&gt; the 180 minute unit).</td>
</tr>
<tr>
<td>183 minutes &gt; 180 minutes = provider may bill for one half-day unit of Adult Day Services.</td>
</tr>
<tr>
<td>A member receives 30 minutes of Adult Day Services followed by a 10-minute break, then an additional 30 minutes of Adult Day Services followed by a 10-minute break, and finally an additional 30 minutes of Adult Day Services. A total of 90 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 110 minutes of Adult Day Services was delivered (110 minutes is less than (&lt;) the 180 minute unit).</td>
</tr>
<tr>
<td>110 minutes &lt; 180 minutes = provider may not bill for the Adult Day Services rendered.</td>
</tr>
</tbody>
</table>

Respite Care and Single-Day Units

AMHH Respite Care may be billed in two separate ways, depending on the length of time the service was provided during a 24-hour period. Respite Care is billed in 15-minute units when provided seven hours or less per day, and in single-day units when the service is provided for a minimum of eight hours up to a maximum of 24 hours in a one-day period.

Note: “Hourly” Respite Care and “Daily” Respite Care may not be billed on the same date of service.
Figure 24.5 – Examples of Respite Care Billing

<table>
<thead>
<tr>
<th>Examples: Respite Care Billing</th>
</tr>
</thead>
</table>

A member receives 204 minutes of Respite Care in a calendar day, which equates to three hours and 24 minutes. Because this is less than seven hours, the provider may bill for total of 14 15-minute units of “hourly rate” Respite Care.

3 hours x 4 units/hour = 12 units, plus 24 minutes = one 15-minute unit plus 9 additional minutes, rounded up to another whole unit, totaling 14 units.

A member receives 14 hours of Respite Care services in a calendar day. Since this is more than seven hours, the provider may bill for one single-day unit of Respite Care.

Modifiers for AMHH Services

The following modifiers are needed when submitting AMHH claims.

Table 24.2 – Service Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Group setting</td>
</tr>
<tr>
<td>HR</td>
<td>Family/couple with client present</td>
</tr>
<tr>
<td>HS</td>
<td>Family/couple without client present</td>
</tr>
<tr>
<td>UB</td>
<td>Face-to-face encounter</td>
</tr>
</tbody>
</table>

Midlevel Provider Modifiers

Midlevel provider modifiers should not be used when submitting AMHH services claims. The use of midlevel provider modifiers results in the denial of the AMHH services claim.

Third-Party Liability (TPL) Requirements

To ensure that the IHCP does not pay for services covered by other insurance sources, federal regulations (42 CFR 433.139) require that the IHCP be the payer of last resort. With some exceptions, providers are required to bill all liable third parties before submitting a claim to the IHCP. This activity is commonly referred to as cost avoidance. AMHH services are exempt from TPL cost avoidance editing and can be billed directly to the IHCP.
**Place of Service Codes**

AMHH services can be rendered in the following locations with the place of service code listed:

- 12 – Home
- 99 – Other unlisted facility (such as employment or a community place)
- 53 – Community mental health center (CMHC)

**Mailing Address for Claims**

AMHH claims are sent to the standard medical claim address:

**HP CMS-1500 Claims**
P.O. Box 7269
Indianapolis, IN 46207-7269

**Additional Addresses and Telephone Numbers**

Providers should direct questions about filing claims to Customer Assistance at 1-800-577-1278. The addresses and telephone numbers are also available on the [IHCP Quick Reference Guide](#) at indianahealthplan.com.
Appendix A: AMHH Acronyms and Definitions

The following acronyms and definitions apply to AMHH services and the policy and procedures outlined in the AMHH Provider Manual:

**Adult Mental Health Habilitation (AMHH)** refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his or her practice, for the habilitation of a mental disability and the restoration or maintenance of an individual’s best possible functional level. Services are clinical and supportive behavioral health services that are provided for individuals, families, or groups of adult persons who are living in the community and who need aid on a routine basis for a mental illness or co-occurring mental illness and addiction disorders.

AMHH behavioral health habilitation services include the following:

- Adult Day Services
- Home and Community-Based Habilitation and Support Services
- Respite Care
- Therapy and Behavioral Support Services
- Addiction Counseling Services
- Peer Support Services
- Supported Community Engagement Services
- Care Coordination
- Medication Training and Support

**Adult Needs and Strengths Assessment (ANSA)** is the approved Division of Mental Health and Addiction (FSSA/DMHA) behavioral health assessment tool, administered by a qualified individual who is trained and FSSA/DMHA-certified to administer the tool, in order to assist in determining the level of need and functional impairment of an applicant or member.

**Applicant** means an individual applying for AMHH services by inquiring about AMHH services or completing the AMHH application process.

**Assistance** means any kind of support given due to a behavioral health condition or disorder. This support includes but is not limited to the following:

- Mentoring
- Supervision
- Reminders
- Verbal cueing
- Hands-on assistance
Authorized healthcare professional (AHCP) means any of the following persons:

- A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5
- A nurse practitioner or clinical nurse specialist with prescriptive authority and performing duties within the scope of that person’s license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to IC 25-23-1

Community-based: AMHH services are approved by the Centers for Medicare & Medicaid Services (CMS) to be provided within the individual’s home (or place of residence), or at other locations based in the community (outside institutional settings). For more information regarding community-based settings, see Section 6: AMHH Member Home and Community-Based Residence Requirements.

Certified Recovery Specialist (CRS) means an individual meeting the FSSA/DMHA training and competency standards for a CRS.

Detoxification services means services or activities that are provided to a member during his or her withdrawal from alcohol and other addictive drugs, while under the direct supervision of a physician or clinical nurse specialist.

FSSA/DHMA refers to the Indiana Family and Social Services Administration’s Division of Mental Health and Addiction.

Group setting: A group setting means that the activity is meant to benefit more than one consumer, and may include family members and nonprofessional caregivers of multiple consumers, whether or not the consumers are present during the activity. The benefit to the consumer must be in accordance with each consumer’s individual treatment goals.

Example: The families of several consumers meet for an orientation session to an upcoming AMHH skills development group, which will be attended by several AMHH consumers. Because the group includes more than one consumer, the orientation is considered a group setting.

Habilitation services means activities that are designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.

Individualized Integrated Care Plan (IICP) means a treatment plan that:

- Integrates all components and aspects of care that are deemed medically necessary, are clinically indicated, and are provided in the most appropriate setting to achieve the individual’s goals; includes all indicated medical and support services needed by the individual to:
  - Remain in the community
  - Function at the highest level of independence possible
  - Achieve goals identified in the IICP
- Is developed for each individual
- Is developed with the individual
- Reflects the individual’s desires and choices

Indiana4IM: Indiana’s Medicaid Information Management System (MMIS) or claims payment system.
Individual setting:

An "individual setting" means that the activity is meant to benefit one consumer, even though the activity may include family members and nonprofessional caregivers, and the consumer may or may not be present during the activity. A "group setting" means the activity is meant to benefit more than one consumer, even though, again, the activity may include family members and professional caregivers of multiple consumers, and the consumers may or may not be present during the activity.

Example: An AMHH consumer, “John,” attends a family counseling session with his siblings and mother. Since the session is intended to benefit only John, it is considered an individual setting, even though multiple people are present.

Level of need means a recommended intensity of behavioral health services based on a pattern of an individual’s needs, as determined using a standardized assessment tool.

Licensed professional means any of the following persons:

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

Medicaid rehabilitation services means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a member to his or her best possible level of functioning.

Nonprofessional caregiver means any individual who does not receive compensation for providing care or services to a Medicaid member.

Office or FSSA/OMPP refers to the Indiana Family and Social Services Administration’s Office of Medicaid Policy and Planning.

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

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

Professional caregiver means an individual who receives payment for providing services and supports to a Medicaid member.
**Provider agency** means any FSSA/DMHA-approved agency that meets the qualifications and criteria to become an AMHH provider agency.

**Provider staff** means any individual working under a FSSA/DMHA-approved AMHH provider agency that meets the qualifications and requirements mandated by the AMHH service being provided.

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

- An individual who has had at least two years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master’s degree or doctoral degree, or both, in any of the following disciplines from an accredited university:
  - Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana
  - Pastoral counseling
  - Rehabilitation counseling

- An individual who is under the supervision of a licensed professional, is eligible for and working towards professional licensure, and has completed a master’s or doctoral degree, or both, in any of the following disciplines from an accredited university:
  - Social work from a university accredited by the Council on Social Work Education
  - Psychology
  - Mental health counseling
  - Marital and family therapy

- A licensed independent practice school psychologist under the supervision of a licensed professional.

- An authorized health care professional (AHCP) who is one of the following:
  - A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5
  - A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person’s license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to IC 25-23-1.

**Member** means an individual who has been deemed eligible for AMHH services by the FSSA/DMHA SET.

**Recreational** means activities people do to relax or have fun (for example, activities done for enjoyment).

**Self-help** means self-guided improvement in functioning through the use of supports and resources.

**Significant** means an assessed need for immediate or intensive action due to a serious or disablimg need.

**Skills training** means services or activities to further the reinforcement, management, adaptation, and retention of skills necessary for the individual to live successfully in the community.

**State Evaluation Team (SET)** means the FSSA/DMHA independent evaluation team that reviews and assesses all evaluation information and supporting clinical documentation collected for AMHH applications and members, and is responsible for making final determinations regarding the following:

- Eligibility of applicants for AMHH services
- Authorization for AMHH services for eligible members
- Continued eligibility determination for AMHH members
• Appropriate service delivery to AMHH members, as a result of conducting quality improvement reviews of AMHH service provider agencies

**Web interChange**: Electronic portal where AMHH authorization information may be viewed by AMHH providers. Link is [https://interchange.indianamedicaid.com/Administrative/logon.aspx](https://interchange.indianamedicaid.com/Administrative/logon.aspx).
Appendix B: AMHH-Eligible Primary Mental Health Diagnoses

AMHH-eligible members must have one or more of the AMHH-eligible primary mental health diagnoses, as outlined in Section 5: AMHH Program Member Eligibility. All diagnoses are Axis I diagnoses, and are effective July 1, 2014.

Table B.1 – AMHH-Eligible Primary Mental Health Diagnoses

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Code Type</th>
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<tr>
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<td>Acute Schizophrenic Episode, Sub-chronic with Acute Exacerbation</td>
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<td>Acute Schizophrenic Episode, Chronic with Acute Exacerbation</td>
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<td>295.83</td>
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<td>Schizophrenia NEC, Chronic with Acute Exacerbation</td>
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<tr>
<td>295.9</td>
<td>Schizophrenia NOS</td>
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<td>Schizophrenia NOS, Chronic with Acute Exacerbation</td>
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<td>295.93</td>
<td>Schizophrenia NOS, Sub-chronic with Acute Exacerbation</td>
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<td>296.04</td>
<td>Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features</td>
<td>DSM-IV-TR</td>
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<tr>
<td>Code</td>
<td>Name</td>
<td>Code Type</td>
</tr>
<tr>
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<tr>
<td>296.05</td>
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<td>296.14</td>
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<td>ICD-9</td>
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<td>296.3</td>
<td>Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features</td>
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<td>296.32</td>
<td>Major Depressive Disorder, Recurrent, Unspecified</td>
<td>DSM-IV-TR</td>
</tr>
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<td>296.33</td>
<td>Major Depressive Disorder, Recurrent, Moderate</td>
<td>DSM-IV-TR</td>
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<td>296.34</td>
<td>Major Depressive Disorder, Recurrent, Severe With Psychotic Features</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.4</td>
<td>Bipolar Affective, Manic</td>
<td>ICD-9</td>
</tr>
<tr>
<td>296.42</td>
<td>Bipolar I Disorder, Most Recent Episode Manic, Moderate</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.43</td>
<td>Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.44</td>
<td>Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features</td>
<td>DSM-IV-TR</td>
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<td>296.45</td>
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<td>296.52</td>
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<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.53</td>
<td>Bipolar I Disorder, Most Recent Episode Depressed, Moderate</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.54</td>
<td>Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.55</td>
<td>Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission</td>
<td>DSM-IV-TR</td>
</tr>
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<td>296.6</td>
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<td>Bipolar I Disorder, Most Recent Episode Mixed, Moderate</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.63</td>
<td>Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.64</td>
<td>Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.65</td>
<td>Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>296.7</td>
<td>Bipolar I Disorder, Most Recent Episode Unspecified</td>
<td>DSM-IV-TR</td>
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<td>Manic-Depressive NEC/NOS</td>
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<td>296.80</td>
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<td>Code Type</td>
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<td>-----------------</td>
</tr>
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<td>296.82</td>
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<td>Delusional Disorder</td>
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<td>298.9</td>
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<td>DSM-IV-TR</td>
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<td>300.3</td>
<td>Obsessive-Compulsive Disorder</td>
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</table>
Table C.1 shows the AMHH service codes and reimbursement rates as of FY2014.

<table>
<thead>
<tr>
<th>AMHH Service</th>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Unit/Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Services</td>
<td>S5101</td>
<td>UB</td>
<td>$28.80 per half day unit</td>
</tr>
<tr>
<td>Home and Community-Based Habilitation and Support Services with Member</td>
<td>H2014</td>
<td>UB</td>
<td>$26.14 per 15 minute unit.</td>
</tr>
<tr>
<td>(Individual Setting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home and Community-Based Habilitation and Support Services with Family and</td>
<td>H2014</td>
<td>UB HR</td>
<td>$26.14 per 15 minute unit.</td>
</tr>
<tr>
<td>Member (Individual Setting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home and Community-Based Habilitation and Support Services with Family</td>
<td>H2014</td>
<td>UB HS</td>
<td>$26.14 per 15 minute unit.</td>
</tr>
<tr>
<td>Without the Member Present (Individual Setting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home and Community-Based Habilitation and Support Services with Member</td>
<td>H2014</td>
<td>UB U1</td>
<td>$4.71 per 15 minute unit.</td>
</tr>
<tr>
<td>(Group Setting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home and Community-Based Habilitation and Support Services with Family and</td>
<td>H2014</td>
<td>UB U1 HR</td>
<td>$4.71 per 15 minute unit.</td>
</tr>
<tr>
<td>Member (Group Setting)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Home and Community-Based Habilitation and Support Services with Family</td>
<td>H2014</td>
<td>UB U1 HS</td>
<td>$4.71 per 15 minute unit.</td>
</tr>
<tr>
<td>Without the Member present (Group Setting)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Respite Care (Hourly)</td>
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<td>UB</td>
<td>$3.50 per 15 minute unit.</td>
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<tr>
<td>Respite Care (Daily)</td>
<td>S5151</td>
<td>UB</td>
<td>$100.00 per 1-day unit</td>
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<td>Therapy and Behavioral Support Services with Member (Individual Setting)</td>
<td>H0004</td>
<td>UB</td>
<td>$28.65 per 15 minute unit.</td>
</tr>
<tr>
<td>Therapy and Behavioral Support Services with Family and Member (Individual</td>
<td>H0004</td>
<td>UB HR</td>
<td>$28.65 per 15 minute unit.</td>
</tr>
<tr>
<td>Setting)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Therapy and Behavioral Support Services without the Member Present (Individual</td>
<td>H0004</td>
<td>UB HS</td>
<td>$28.65 per 15 minute unit.</td>
</tr>
<tr>
<td>Setting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy and Behavioral Support Services with Member (Group Setting)</td>
<td>H0004</td>
<td>UB U1</td>
<td>$7.16 per 15 minute unit.</td>
</tr>
<tr>
<td>Therapy and Behavioral Support Services with Family and Member (Group Setting)</td>
<td>H0004</td>
<td>UB U1 HR</td>
<td>$7.16 per 15 minute unit.</td>
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<tr>
<td>AMHH Service</td>
<td>HCPCS Code</td>
<td>Modifier</td>
<td>Unit/Rate</td>
</tr>
<tr>
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</tr>
<tr>
<td>Therapy and Behavioral Support Services Without the Member Present (Group Setting)</td>
<td>H0004</td>
<td>UB U1 HS</td>
<td>$7.16 per 15 minute unit</td>
</tr>
<tr>
<td>Addiction Counseling with Member (Individual Setting)</td>
<td>H2035</td>
<td>UB</td>
<td>$58.32 per 1 hour unit</td>
</tr>
<tr>
<td>Addiction Counseling with Family and Member (Individual Setting)</td>
<td>H2035</td>
<td>UB HR</td>
<td>$58.32 per 1 hour unit</td>
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<tr>
<td>Addiction Counseling with Family Without the Member Present (Individual Setting)</td>
<td>H2035</td>
<td>UB HS</td>
<td>$58.32 per 1 hour unit</td>
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<td>Addiction Counseling with Member (Group Setting)</td>
<td>H2035</td>
<td>UB U1</td>
<td>$14.58 per 1 hour unit</td>
</tr>
<tr>
<td>Addiction Counseling with Family and Member (Group Setting)</td>
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<td>UB U1 HR</td>
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</tr>
<tr>
<td>Addiction Counseling with Family Without the Member Present (Group Setting)</td>
<td>H2035</td>
<td>UB U1 HS</td>
<td>$14.58 per 1 hour unit</td>
</tr>
<tr>
<td>Peer Support Services</td>
<td>H0038</td>
<td>UB</td>
<td>$8.55 per 15 minute unit</td>
</tr>
<tr>
<td>Supported Community Engagement Services</td>
<td>97537</td>
<td>UB</td>
<td>$26.14 per 15 minute unit</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>T1016</td>
<td>UB</td>
<td>$14.53 per 15 minute unit</td>
</tr>
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<td>Medication Training and Support with Member (Individual Setting)</td>
<td>H0034</td>
<td>UB</td>
<td>$18.62 per 15 minute unit</td>
</tr>
<tr>
<td>Medication Training and Support with Family and Member (Individual Setting)</td>
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<td>UB HR</td>
<td>$18.62 per 15 minute unit</td>
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<tr>
<td>Medication Training and Support with Family Without the Member Present (Individual Setting)</td>
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<td>UB HS</td>
<td>$18.62 per 15 minute unit</td>
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<td>Medication Training and Support with Member (Group Setting)</td>
<td>H0034</td>
<td>UB U1</td>
<td>$3.35 per 15 minute unit</td>
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<tr>
<td>Medication Training and Support with Family and Member (Group Setting)</td>
<td>H0034</td>
<td>UB U1 HR</td>
<td>$3.35 per 15 minute unit</td>
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<tr>
<td>Medication Training and Support with Family Without the Member Present (Group Setting)</td>
<td>H0034</td>
<td>UB U1 HS</td>
<td>$3.35 per 15 minute unit</td>
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</tbody>
</table>
Appendix D: Sample AMHH Denial Notification

Figures D.1 shows a sample AMHH denial notification, Figure D.2 shows Appeal Form for AMHH Services and Figure D.3 outlines an AMHH applicant’s appeal rights.

Figure D.1 – Sample AMHH Denial Notification (page 1 of 2)

FSSA/Indiana Division of Mental Health and Addiction
Indiana Government Center South
402 W. Washington Street, W353
Indianapolis, Indiana 46204
Office: 317-232-7800
Secure Fax: 317-233-1986

Indiana Medicaid Adult Mental Health Habilitation (AMHH) Services DENIAL Notification

<table>
<thead>
<tr>
<th>Member Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name</td>
<td>Provider</td>
</tr>
<tr>
<td>Member Address</td>
<td>Provider Address</td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td>City, State, ZIP</td>
</tr>
<tr>
<td>RID:</td>
<td>Submitted by: (DMHA SET staff)</td>
</tr>
</tbody>
</table>

The Division of Mental Health and Addiction (DMHA) has received your application for the Adult Mental Health Habilitation (AMHH) Services Program. You are receiving this notice because your application has been denied. This notice explains why your application has been determined as not meeting the eligibility criteria for the AMHH program and what your appeal rights are if you do not agree with the determination. Please contact the provider who assisted in completing and submitting your application to discuss options and next steps.

DARMHA ID: Application Submit Date: ICP Number:

IMPORTANT NOTICE: This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals.

APPLICATION TYPE:
☐ Initial  ☐ Modification  ☐ Renewal

AMHH PROGRAM ELIGIBILITY:
☐ Yes  ☐ No

The AMHH Program Eligibility, 405 IAC 5-21.6-4, is denied due to the following reason(s):

- Does NOT meet one or more of the eligibility criteria:
  - Age 35 or over
  - AMHH eligible primary mental health diagnosis
  - Medicaid enrolled
  - Reside in a home or community-based setting

- Does NOT meet one or more of the needs-based criteria:
  - Demonstrated need for significant assistance in life domains related to their mental illness
  - Demonstrated significant need related to behavioral health
  - Demonstrated significant impairment in self-management of mental illness, or demonstrated significant need for assistance with mental health management
  - Demonstrated lack of sufficient natural supports to assist with mental illness management
  - Not a danger to self or others

No recommendation for intensive community-based care (Adult Needs and Strengths Assessment [ANSA] Level of Need is less than 4 and/or ANSA was completed more than 60 days prior to application submission
Figure D.1 – Sample AMHH Denial Notification (page 2 of 2)

You are receiving this letter because of a **DENIAL** for one or more of the services in your proposed IICP under 1915(i) Adult Mental Health Habilitation program. The following service(s) have been **DENIED**:

<table>
<thead>
<tr>
<th>Denial Date</th>
<th>Procedure Code</th>
<th>AMHH Service Denied</th>
<th>Reason(s) for Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>Service Procedure Code</td>
<td>Service Title</td>
<td>Reasons for denial</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>Service Procedure Code</td>
<td>Service Title</td>
<td>Reasons for denial</td>
</tr>
</tbody>
</table>

(repeated as needed for each requested service that is denied)

The applicant and Selected Provider will review the Denial Form along with the letter explaining the action. If the service is still requested, the IICP must be reconfigured to provide supporting documentation and re-submitted for review.
Figure D.2 – Appeal Form for AMHH Services

### Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services

Indiana Medicaid Adult Mental Health Habilitation Services Denial Notification

<table>
<thead>
<tr>
<th>Member Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name</strong></td>
<td>Provider</td>
</tr>
<tr>
<td><strong>Member Address</strong></td>
<td>Provider Address</td>
</tr>
<tr>
<td><strong>City, State, ZIP</strong></td>
<td>City, State, ZIP</td>
</tr>
<tr>
<td><strong>RID:</strong></td>
<td>Submitted by: (DMHA SET staff)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denial Date</th>
<th>Procedure Code</th>
<th>AMHH Service Denied</th>
<th>Reason(s) for Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>Service Procedure Code</td>
<td>Service Title</td>
<td>Reasons for denial</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>Service Procedure Code</td>
<td>Service Title</td>
<td>Reasons for denial</td>
</tr>
</tbody>
</table>

(repeated as needed for each requested service that is denied)

If you wish to appeal this decision, please read the enclosed Appeal Rights as an Applicant for Adult Mental Health Habilitation Benefits. Sign and date below and return this completed form to begin the appeal process:

Mail to: Indiana Family and Social Services Administration
Office of Hearings and Appeals, MS 04
402 W Washington St, Room E034
Indianapolis, IN 46204
Fax: 317/232-4412 (Attn: Office of Hearings and Appeals)

I wish to appeal the above decision, for the following reasons:

Signature of Applicant/Guardian: ___________________________ Date: ___________
Relationship to Applicant: ________________________________
Figure D.3 – Appeal Rights as an Applicant for AMHH

**Appeal Rights as an Applicant for Adult Mental Health Habilitation (AMHH)**

If you have questions or disagree with the indicated decision, you should discuss this matter with your selected provider.

**Right to Appeal and Have a Fair Hearing:**

The Notice of Action provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a fair hearing. If you are currently receiving AMHH Services and your renewal application has been denied, your AMHH Services will continue if your appeal is received within the required time frame described below under "How to Request an Appeal" unless you request to end services.

**Can I continue to get benefits when my appeal is pending?**

New services cannot be started but you may keep your current benefits until an Administrative Law Judge (ALJ) issues a decision after an evidentiary hearing. In order to maintain your current benefits, you must file your appeal:

- a) Within 10 calendar days of the date of the Notice; or
- b) Before the date that the agency’s decision goes into effect, whichever is later.

Any benefits you receive while your appeal is being decided may have to be paid back if the ALJ determines that the original decision is correct. However, you will only be responsible for paying back benefits provided to you on appeal after the authorization period.

**How to Request an Appeal:**

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
   - a) 33 calendar days following the effective date of the action being appealed; or
   - b) 33 calendar days from the date of the notice of agency action, whichever is later.

2) To file an appeal, please sign, date and return the enclosed *Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services*:

   Mail to: Indiana Family and Social Services Administration
   Office of Hearings and Appeals, MS 04
   402 W Washington St, Room E034
   Indianapolis, IN 46204

   Fax: 317/232-4412 (Attn: Office of Hearings and Appeals)

3) If you send a letter rather than this Notice of Action, be sure that the letter contains your full name, address and telephone number where you can be reached. Please attach a copy of this decision to the letter and state the name of the action you are appealing. If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal. A telephone request for an appeal cannot be accepted.

4) You will be notified in writing by the Indiana Family and Social Services Administration, Office of Hearings and Appeals of the date, time and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Selected Provider.

5) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing, you will have full opportunity to:
   - a) Call witnesses;
   - b) Establish all pertinent facts and circumstances;
   - c) Advance any arguments without interference and question; or
   - d) Refute any testimony or evidence presented.
## Appendix E: Example Crisis Plan Format

Figure E.1 – Example Crisis Plan

<table>
<thead>
<tr>
<th>Example Crisis Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and current medications:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Brief history of crisis encounters and outcomes:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Known triggers:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Anticipated potential crisis situations:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Action Steps and Person(s) Responsible:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Appendix F: CMHC Provider Application and Attestation to Provide AMHH Services

Figure F.1 – CMHC Provider Application and Attestation to Provide AMHH Services

CMHC PROVIDER APPLICATION AND ATTESTATION TO PROVIDE
ADULT MENTAL HEALTH HABILITATION SERVICES

I, ________________________, CEO of _____________________________ CMHC, attest to the following:

_________________________ CMHC is:

- a FSSA/DMHA-certified Community Mental Health Center (CMHC) in good standing
- an enrolled Medicaid provider
- willing and able to provide AMHH services as described in the CMS approved 1915(i) State Plan Amendment (SPA) (TN12-003), AMHH rule (405 IAC 5-21.6) and the AMHH Provider Manual (see attachment A) to meet the identified habilitation needs of each eligible recipient
- committed to ensuring that recipients have access to the services and supports needed to meet his/her individual needs.

The signature below attests that ________________________________ CMHC requests to become a FSSA/DMHA approved AMHH service provider in the state of Indiana. The above requirements and referenced documents have been read, are understood, and will be implemented per FSSA program standards.

_____________________________________

Date: ____________________

Community Mental Health Center CEO
Appendix G: AMHH Application Status Codes

Table G.1 explains the status codes that are viewable in the “Application Status” pull-down menu of the AMHH application in DARMHA. The status code is updated whenever a new action is taken on an AMHH application. Providers can use this code to track where an application is in the process.

Table G.1 – AMHH Application Status Codes

<table>
<thead>
<tr>
<th>Status Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discarded</td>
<td>The application was discarded by the provider or was in draft mode for more than 60 days and was discarded by the FSSA/DMHA State Evaluation Team. Applications discarded for either reason have not been submitted for review by the FSSA/DMHA State Evaluation Team.</td>
</tr>
<tr>
<td>Draft</td>
<td>A draft was saved by the provider. The application has not yet been submitted for review by the FSSA/DMHA State Evaluation Team.</td>
</tr>
<tr>
<td>Submitted</td>
<td>The application was submitted by the provider and is undergoing FSSA/DMHA State Evaluation Team review.</td>
</tr>
<tr>
<td>DMHA Pending</td>
<td>The application was pended by FSSA/DMHA State Evaluation Team for review and potential updates to be made by the provider (that is, the supporting documentation is inconsistent or insufficient for the FSSA/DMHA State Evaluation Team to make a program and/or services eligibility determination). If not resubmitted within seven calendar days, the application will be denied based on the original submission.</td>
</tr>
<tr>
<td>DMHA Approved</td>
<td>The applicant has been approved for AMHH eligibility by the FSSA/DMHA State Evaluation Team and all requested services were approved. The application will be forwarded to HP for service package assignment.</td>
</tr>
<tr>
<td>DMHA Approved with Partial Services</td>
<td>The applicant has been approved for AMHH eligibility by the FSSA/DMHA State Evaluation Team, but one or more of the requested services were not approved. The application and approved requested services will be forwarded to HP for service package assignment.</td>
</tr>
<tr>
<td>DMHA Denied</td>
<td>The application has been denied by the FSSA/DMHA State Evaluation Team. Therefore, the individual is not eligible for AMHH.</td>
</tr>
<tr>
<td>HP Data Sent</td>
<td>The applicant was approved by the FSSA/DMHA State Evaluation Team and the information has been sent to HP for AMHH service package assignment.</td>
</tr>
<tr>
<td>HP Error</td>
<td>An error would occur if the information sent from DARMHA does not match what HP has in its system for that RID (last name, DOB, gender, and so on), or if the format of the file was incorrect.</td>
</tr>
<tr>
<td>HP Processed</td>
<td>An AMHH service package assignment has been generated by HP. AMHH start and end dates and assigned units are viewable in Web interChange.</td>
</tr>
</tbody>
</table>