INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Medicaid Rehabilitation Option Services

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Section 1: Introduction

This document provides instructions specifically for Indiana Health Coverage Programs (IHCP) providers enrolled in the Community Mental Health Rehabilitation Services Program, generally known as the Medicaid Rehabilitation Option (MRO) services. The Indiana Family and Social Services Administration (FSSA) administers the MRO services, with policy and operational oversight provided through the FSSA's Office of Medicaid Policy and Planning (OMPP) and Division of Mental Health and Addiction (DMHA).

Specific rules for MRO services can be found in *Indiana Administrative Code 405 IAC 5-21.5*. Details provided in the applicable IAC are not repeated in this document except to clarify or expand on procedural issues.

As stated in *405 IAC 5-21.5*, the IHCP reimburses for community mental health services for members with mental illness when the provider for those services is an enrolled mental health center that meets applicable federal, state, and local laws concerning the operation of community mental health centers (CMHCs). MRO services include outpatient mental healthcare for the seriously mentally ill or seriously emotionally disturbed, partial hospitalization services, and case management services. Outpatient mental health services may include clinical attention in the member's home, workplace, mental health facility, emergency department, or wherever needed. A qualified mental health professional, as outlined in *405 IAC 5-21.5-1(c)* must render these services.

The *Mental Health and Addiction Services* module has detailed information about how CMHCs and other providers bill clinic services.

Unique MRO requirements are outlined by exception in this document. Exception discussion centers on the following topics:

- Common service standards
- Treatment plan requirements
- Supervising physician responsibilities
- Medicare and third-party liability (TPL) requirements
- Prior authorization (PA) status
- Claim format requirements
- Procedure code and narrative requirements

Section 2: Medicaid Rehabilitation Option Services

Medicaid Rehabilitation Option (MRO) services are designed to assist in the rehabilitation of the member's optimum functional ability in daily living activities by:

- Assessing the member's needs and strengths
- Developing an Individualized Integrated Care Plan (IICP) that outlines objectives of care, including how MRO services assist in reaching the member's rehabilitative and recovery goals
- Delivering appropriate MRO services to the member

MRO Provider Agency Requirements

Community mental health centers (CMHCs) are the exclusive providers for the following Medicaid services and programs:

- MRO services
- Behavioral and Primary Healthcare Coordination (BPHC)
- Adult Mental Health Habilitation (AMHH), as authorized by the Centers for Medicare & Medicaid Services (CMS) under a *1915(b)(4)* waiver

All MRO service provider agencies must be certified by the Family and Social Service Administration (FSSA) Division of Mental Health and Addiction (DMHA) as a CMHC and be an enrolled Medicaid provider.

The CMHC's designated staff explains the process for making an informed choice of providers and answers questions. The applicant or member is also advised of his or her right to choose among providers and provider agencies. Providers within an agency and provider agencies themselves may be changed as necessary or requested.

MRO Provider Staff Qualifications

Provider staff delivering service must meet appropriate federal, state, and local regulations for their respective disciplines. Specific provider qualifications, program standards, and exclusions are included in each service definition in this section.

Three predominant categories of providers may provide MRO services:

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

Each MRO service includes specific provider qualifications including but not limited to licensed professionals, QBHPs, and OBHPs. Provider qualifications are noted in the corresponding service definition.

Licensed Professional

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

- Psychiatrist
- Physician
- Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *Indiana Code IC 25-23.6-10.5*

Qualified Behavioral Health Professional

A QBHP is defined by 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 defined previously; such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
  - Psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse (RN) in Indiana
  - Pastoral counseling from an accredited university
  - Rehabilitation counseling from an accredited university
- An individual who is under the supervision of a licensed professional, as defined previously, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
  - Social work from a university accredited by the Council on Social Work Education
  - Psychology from an accredited university
  - Mental health counseling from an accredited university
  - Marital and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional, as defined previously
- An authorized health care professional (AHCP):
  - 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 (NP) or a clinical nurse specialist (CNS), 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*

Other Behavioral Health Professional

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

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

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

MRO Service Requirements

As stated in *405 IAC 5-21.5*, Indiana Health Coverage Programs (IHCP) reimbursement is available for members who meet specific diagnosis and level of need (LON) criteria under the approved DMHA assessment tool or who submit prior authorization (PA) for MRO services. MRO services are clinical behavioral health services provided to members and families of members living in the community who need aid intermittently for emotional disturbances, mental illness, and addiction. Services may be provided in individual or group settings and in the community. For the purposes of MRO, a "day" is a calendar day, unless otherwise specified. The IHCP provides reimbursement for the following MRO outpatient mental health services:

- Adult Intensive Rehabilitation Services (AIRS) Addiction Counseling
- Behavioral Health Counseling and Therapy
- Behavioral Health Level of Need Redetermination
- Case Management
- Child and Adolescent Intensive Resiliency Services (CAIRS)
- Crisis Intervention
- Intensive Outpatient Treatment (IOT)
- Medication Training and Support
- Peer Recovery
- Psychiatric Assessment and Intervention
- Skills Training and Development

AIRS

AIRS is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured rehabilitative services to serve and support the member on an outpatient basis. AIRS is curriculum-based and designed to alleviate emotional or behavioral problems with the goal of reintegrating the member into the community, increasing social connectedness beyond a clinical and/or employment setting. AIRS is limited to 270 hours for service packages 4 and 5. Authorization for AIRS is limited to 90 consecutive days. PA is required for members requiring AIRS past 90 days. See *Appendix A* for information regarding units and service packages.

Healthcare Common Procedure Coding System (HCPCS)

Table 1 – HCPCS Codes for AIRS

Code and Modifiers	Code Description
H2012 HW HB U1	Behavioral health day treatment, per hour; funded by state mental health agency; adult program; group setting

Target Population

AIRS may be provided for members at least 18 years of age with serious mental illness who:

- Need structured therapeutic and rehabilitative services.
- Have significant impairment in day-to-day personal, social, and/or vocational functioning.
- Do not require acute stabilization, including inpatient or detoxification services.
- Are not at imminent risk of harm to self or others.

AIRS may be provided to members between the ages of 16 and 18 with an approved PA.

Provider Qualifications

The following providers may provide AIRS:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

- AIRS must be authorized by a physician or HSPP.
- Direct services must be supervised by a licensed professional.
- Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
- Member goals must be designed to facilitate community integration, employment, and use of natural supports.
- Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
- A weekly review and update of progress occurs and must be documented in the member's clinical record.
- AIRS programs must be offered a minimum of two hours and up to six hours per day, three to five days per week, excluding time associated with formal educational or vocational services.
- AIRS must be provided in an age-appropriate setting for a member age 18 and under.
- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when provided in a group setting.
- Services must demonstrate movement toward or achievement of member treatment goals identified in the IICP.
- Service goals must be rehabilitative in nature.

Exclusions

- AIRS is not reimbursed for members who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW U1) on the same day.

- Services that are purely recreational or diversionary in nature, or that do not have therapeutic or programmatic content, are not reimbursable.
- Formal educational or vocational services are not reimbursed.
- A member may not receive CAIRS and AIRS on the same day.
- AIRS that are provided in a residential setting are not reimbursable.

AIRS Exclusion Example

A member participates in a time-limited, curriculum-based series of groups at his group home. These groups occur from 9 a.m. to noon and 1 p.m. to 3 p.m., Monday through Friday, and are a combination of clinical therapies, psycho-educational groups, and rehabilitative activities.

Not billable to AIRS due to being held in a residential setting.

Addiction Counseling (Individual Setting)

Addiction Counseling is a planned and organized service with the member and/or family members, or nonprofessional caregivers, where addiction professionals and clinicians provide counseling intervention that works toward the goals identified in the IICP. Addiction Counseling is designed to be a less intensive alternative to IOT.

Addiction Counseling is limited to the following:

- 32 hours for service packages 3, 4, and 5
- 50 hours for service package 5A

PA is required for members requiring additional units of this service. These maximum limits also include any units billed under H2035 HW, H2035 HW HR, H2035 HW HS, H0005 HW, H0005 HW HR, and H0005 HW HS. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 2 – HCPCS Codes for Addiction Counseling (Individual Setting)

Code and Modifiers	Code Description
H2035 HW	Alcohol and/or other drug treatment program, per hour; funded by state mental health agency
H2035 HW HR	Alcohol and/or other drug treatment program, per hour; funded by state mental health agency; family/couple with client present
H2035 HW HS	Alcohol and/or other drug treatment program, per hour; funded by state mental health agency; family/couple without client present

Target Population

Addiction Counseling may be provided for members of all ages with a substance-related disorder and 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 level of care

Provider Qualifications

The following providers may provide Addiction Counseling:

- Licensed professionals, including LCACs
- QBHPs

Program Standards

- The member is the focus of Addiction Counseling.
- Documentation must support how Addiction Counseling benefits the member, including when the member is not present.
- Addiction Counseling requires face-to-face contact with the member and/or family members or nonprofessional caregivers.
- Addiction Counseling consists of regularly scheduled sessions.
- Addiction Counseling is intended to be a less intensive alternative to IOT.
- Addiction Counseling may include the following:
  - Education on addiction disorders
  - Skills training in communication, anger management, stress management, and relapse prevention
- Addiction Counseling must demonstrate progress toward and achievement of member treatment goals identified in the IICP.
- Addiction Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Addiction Counseling must be provided in an age-appropriate setting for a member younger than 18 years of age receiving services.
- Addiction Counseling must be individualized.
- Referral to available community-based support services is expected.

Exclusions

- Members with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Members at imminent risk of harm to self or others are not eligible for this service.
- Addiction Counseling may not be provided for professional caregivers.
- Addiction Counseling sessions that consist of education services only are not reimbursed.

Addiction Counseling Family/Couple (Individual Setting) Example

A member and his girlfriend met with a QBHP for a one-hour session to discuss the impact of the member's use of substances on their relationship.

This may be billed as Addiction Counseling, Family/Couple (H2035 HW HR).

Addiction Counseling (Group Setting)

Group Addiction Counseling is a planned and organized service with the member and/or family members, or nonprofessional caregivers, where addiction professionals and clinicians provide counseling intervention that works toward the goals identified in the IICP. Addiction Counseling is designed to be a less intensive alternative to IOT. Addiction Counseling is limited to the following:

- 32 hours for service packages 3, 4, and 5
- 50 hours for service package 5A

PA is required for members requiring additional units of service. These maximum limits also include any units billed under H2035 HW, H2035 HW HR, H2035 HW HS, H0005 HW, H0005 HW HR, and H0005 HW HS. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 3 – HCPCS Codes for Addiction Counseling (Group Setting)

Code and Modifiers	Code Description
H0005 HW	Alcohol and/or drug services; group counseling by clinician; funded by state mental health agency
H0005 HW HR	Alcohol and/or drug services; group counseling by clinician; funded by state mental health agency; family/couple with client present
H0005 HW HS	Alcohol and/or drug services; group counseling by clinician; funded by state mental health agency; family/couple without client present

Target Population

Addiction Counseling may be provided for members of all ages with a substance-related disorder and 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 level of care

Provider Qualifications

The following providers may provide Addiction Counseling:

- Licensed professionals, including LCACs
- QBHPs

Program Standards

- The member is the focus of Addiction Counseling.
- Documentation must support how Addiction Counseling benefits the member, including when services are provided in a group setting and/or the member is not present.
- Addiction Counseling requires face-to-face contact with the member and family members or nonprofessional caregivers.
- Addiction Counseling consists of regularly scheduled sessions.

- Addiction Counseling is intended to be a less intensive alternative to IOT.
- Addiction Counseling may include the following:
  - Education on addiction disorders
  - Skills training in communication, anger management, stress management, and relapse prevention
- Addiction Counseling must demonstrate progress toward and/or achievement of member treatment goals identified in the IICP.
- Addiction Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Addiction Counseling must be provided in an age-appropriate setting for a member younger than 18 years of age receiving services.
- Addiction Counseling must be individualized.
- Referral to available community-based support services is expected.

Exclusions

- Members with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services are not eligible for this service.
- Members at imminent risk of harm to self or others are not eligible for this service.
- Addiction Counseling may not be provided for professional caregivers.
- Addiction Counseling sessions that consist of education services only are not reimbursed.
- Family/Couple Group Addiction Counseling is not reimbursed for members who receive IOT (H0015 HW U1) on the same day.

Addiction Counseling (Group Setting) Example

A member just completed eight weeks of IOT and is ready to be stepped down to a Relapse Prevention program. This member participates in group from 5 p.m. to 6 p.m. on Monday and Tuesday each week. It is anticipated the member will reach recovery-focused goals within four to six weeks.

This service is billable as Addiction Counseling (H0005 HW).

Behavioral Health Counseling and Therapy (Individual Setting)

Behavioral Health Counseling and Therapy is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the IICP. The face-to-face interaction may be with the member and/or family members or nonprofessional caregivers. Behavioral Health Counseling and Therapy must be provided at the member's home or at other locations outside the clinic setting. When Behavioral Health Counseling and Therapy services are school-based, they must be billed under the Clinic Option. Behavioral Health Counseling and Therapy is limited to the following:

- 32 units for service package 3
- 48 units for service packages 4, 5, and 5A

PA is required for members requiring additional units of this service. These maximum limits also include any units billed under H0004 HW, H0004 HW HR, and H0004 HW HS. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 4 – HCPCS Codes for Behavioral Health Counseling and Therapy (Individual Setting)

Code and Modifiers	Code Description
H0004 HW	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency
H0004 HW HR	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple with client present
H0004 HW HS	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple without client present

Target Population

Behavioral Health Counseling and Therapy may be provided for members of all ages.

Provider Qualifications

The following providers may provide Behavioral Health Counseling and Therapy:

- Licensed professionals, except for LCACs, as defined under *IC 25-23.6-10.5*
- QBHPs

Program Standards

- Behavioral Health Counseling and Therapy requires face-to-face contact.
- The member is the focus of the service.
- Documentation must support how Behavioral Health Counseling and Therapy benefits the member, including when the member is not present.
- Behavioral Health Counseling and Therapy must demonstrate movement toward and/or achievement of member treatment goals identified in the IICP.
- Behavioral Health Counseling and Therapy goals must be rehabilitative in nature.

Exclusions

- Behavioral Health Counseling and Therapy services provided in a clinic setting and/or as a part of school-based services are not billable under MRO services and must be billed to the Clinic Option.
- LCACs, as defined under *IC 25-23.6-10.5*, may not provide Behavioral Health Counseling and Therapy.
- If medication management is a component of the Behavioral Health Counseling and Therapy session, Medication Training and Support may not be billed separately for the same visit by the same provider.
- Family/Couple Behavioral Health Counseling and Therapy may not be provided for professional caregivers.

Behavioral Health Counseling and Therapy (Individual Setting) Examples

A 12-year old male has been having difficulties at home and school and frequently hits others when he does not get his way. His parents are invited to meet with his therapist at their home to discuss his behavior and its impact on his family. His parents report being angry with him most of the time. They report that they want to be constructive in their interaction with him. The therapist focuses the session on where the boy fits into the family and works with the parents to gain an understanding of triggers and ways to diffuse outbursts when he is at home. He is not present for this service.

This service may be billed as Family/Couple Behavioral Health Counseling and Therapy (Individual Setting) without the Member Present (H0004 HW HS).

Behavioral Health Counseling and Therapy (Individual Setting) Exclusion Example

A 12-year old male has been having difficulties at home and school and frequently hits others when he does not get his way. His parents are invited to meet with the therapist in the therapist's office to discuss his behavior and its impact on his family. His parents report being angry with him most of the time. They report that they want to be constructive in their interaction with him. The therapist focuses the session on where the boy fits into the family and works with the parents to gain an understanding of triggers and ways to diffuse outbursts when he is at home. He is not present for this service.

This service example is not billable to MRO due to the office and clinic setting but may be billed under the Clinic Option if Clinic Option requirements are met.

Behavioral Health Counseling and Therapy (Group Setting)

Group Behavioral Health Counseling and Therapy is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the IICP. The face-to-face interaction may be with the member and/or family members or nonprofessional caregivers. Behavioral Health Counseling and Therapy must be provided at the member's home or at other locations outside the clinic setting. When Behavioral Health Counseling and Therapy services are school-based, they must be billed under the Clinic Option.

Behavioral Health Counseling and Therapy is limited to the following:

- 48 units for service package 3
- 60 units for service packages 4, 5, and 5A

PA is required for members requiring additional units of this service. These maximum limits also include any units billed under H0004 HW U1, H0004 HW HR U1, and H0004 HW HS U1. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 5 – HCPCS Codes for Behavioral Health Counseling and Therapy (Group Setting)

Code and Modifiers	Code Description
H0004 HW U1	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; group setting
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple with client present; group setting
H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes; funded by state mental health agency; family/couple without client present; group setting

Target Population

Behavioral Health Counseling and Therapy may be provided for members of all ages.

Provider Qualifications

The following providers may provide Behavioral Health Counseling and Therapy:

- Licensed professionals, except for LCACs, as defined under *IC 25-23.6-10.5*
- QBHPs

Program Standards

- Behavioral Health Counseling and Therapy requires face-to-face contact.
- The member is the focus of the service.
- Documentation must support how Behavioral Health Counseling and Therapy benefits the member, including when services are provided in a group setting and/or the member is not present.
- Behavioral Health Counseling and Therapy must demonstrate movement toward and/or achievement of member treatment goals identified in the IICP.
- Behavioral Health Counseling and Therapy goals must be rehabilitative in nature.
- Group Behavioral Health Counseling and Therapy must be provided in an age-appropriate setting for members less than 18 years of age.

Exclusions

- Behavioral Health Counseling and Therapy services provided in a clinic setting and/or as a part of school-based services are not billable under MRO services and must be billed to the Clinic Option.
- LCACs, as defined under *IC 25-23.6-10.5*, may not provide Behavioral Health Counseling and Therapy.
- If medication management is a component of the Behavioral Health Counseling and Therapy session, then Medication Training and Support may not be billed separately for the same visit by the same provider.
- Family/Couple Behavioral Health Counseling and Therapy may not be provided for professional caregivers.

Behavioral Health Level of Need Redetermination

Behavioral Health Level of Need Redetermination are services associated with the DMHA-approved assessment tool – Child and Adolescent Needs and Strength (CANS) or Adult Needs and Strengths Assessment (ANSA) – required to determine LON, assign an MRO service package, and make changes to the IICP. The redetermination requires face-to-face contact with the member and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which results in a completed redetermination. Reimbursement for one needs and strengths redetermination assessment is allowed per member, per service package. PA for this service is not available for additional units or for members who do not have an MRO service package. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 6 – HCPCS Code for Behavioral Health Level of Need Redetermination

Code and Modifier	Code Description
H0031 HW	Mental health assessment, by nonphysician; funded by state mental health agency

Target Population

Behavioral Health Level of Need Redetermination may be provided for members of all ages.

Provider Qualifications

Providers must meet DMHA training competency standards for the performance of the DMHA-approved assessment tool (CANS or ANSA).

Program Standards

- The DMHA-approved assessment tool, **CANS** must be completed within **30 days** prior to the end date of an existing service package to determine the continued need for MRO services.
- The DMHA-approved assessment tool, **ANSA** must be completed within **60 days** prior to the end date of an existing service package to determine the continued need for MRO services**.**
- Reassessment may occur when there is a significant event or change in member status.
- Reimbursement is available only for one assessment per service package.

Exclusions

- MRO redetermination should not be duplicative of assessments available under the Clinic Option.
- Behavioral Health Level of Need Redetermination may not be billed as part of the initial biopsychosocial assessment when a member is entering treatment.

Behavioral Health Level of Need Redetermination Example

A member was seen in her home December 12, 2014, from 10 a.m. to 10:55 a.m. by an OBHP. Together, they contacted the member's mother over the telephone to obtain information and completed the member's ANSA reassessment. Time spent was 55 minutes. The member's initial ANSA assessment took place July 3, 2014. The ANSA reassessment and LON results were placed in the assessment section of the medical record.

This service is billable as Behavioral Health Level of Need Redetermination (H0031 HW).

Behavioral Health Level of Need Redetermination Exclusion Example

A member was seen today for her initial biopsychosocial assessment and initial ANSA. Please refer to the ANSA assessment and LON results located in the assessment section of this medical record.

This service is not billable as Behavioral Health Level of Need Redetermination due to its being her initial ANSA assessment. If the ANSA was conducted as part of the initial biopsychosocial assessment, the service may be billed under Clinic Option.

Case Management

Case Management consists of services that help members gain access to needed medical, social, educational, and other services. This includes direct assistance in gaining access to services, coordination of care, oversight of the entire case, and linkage to appropriate services. Case Management does not include direct delivery of medical, clinical, or other direct services. Case Management is on behalf of the member, not to the member, and is management of the case, not the member.

Case Management is limited to the following:

- 100 units for service package 2
- 200 units for service package 3
- 300 units for service package 4
- 400 units for service package 5
- 500 units for service package 5A

PA is required for members requiring additional units of this service. See *Appendix A* for information regarding units and service packages.

MRO and BPHC Service Authorization

The Behavioral and Primary Healthcare Coordination (BPHC) program became effective June 1, 2014. The following applies for members using MRO in conjunction with the BPHC service:

- For individuals who have an active MRO service package assignment at the time of BPHC application, the BPHC program eligibility end date will be aligned with the current MRO end date; therefore, the two application processes will be aligned. The number of BPHC units authorized will be prorated based on the time left until the MRO service package expiration as outlined in the following table.

Table 7 – BPHC Units Authorized with Active MRO Service Package

# Months Until MRO Expires	# Units of BPHC Authorized
6	48
5	40
4	32
3	24
2	16
1	8

- For example, if an individual is determined eligible for BPHC as of September 1, 2015, and the MRO service package expiration date is October 12, 2015, 16 BPHC units would be approved and the BPHC expiration date will be October 12, 2015.

> *Note: For initial applications submitted during the BPHC rollout, which had an original MRO expiration date between April 25, 2014, and June 1, 2014, the initial BPHC assignment effective date will not align with the MRO service package expiration. The dates will align upon BPHC renewal.*

- When BPHC and MRO service package authorizations are aligned following the initial application and authorization process described previously, the BPHC service will be approved for 48 units. The MRO Case Management Services (T1016HW) will be authorized at 48 fewer units of service than would be

authorized if the member was not using the BPHC service. The BPHC renewal process is posted on the in.gov/fssa website.

- For individuals who are not Medicaid eligible at the time of BPHC application and, therefore, do not have an active MRO service package assignment, the MRO effective date will be set retroactively to the BPHC effective date. Additional information regarding the effective date will be posted at in.gov/fssa/dmha in the near future. A total of 48 units of BPHC will be authorized and the MRO service package will be assigned based on the individual's LON as outlined in this document with the exception that the number of authorized MRO case management units (T1016 HW) will be reduced by 48 units as outlined in the following table.

Table 8 – MRO Case Management Units Authorized with Active BPHC

MRO Service Package	# Authorized MRO CM Units
3	152
4	252
5	352
5A	452

HCPCS

Table 9 – HCPCS Codes for Case Management

Code and Modifiers	Code Description
T1016 HW	Case management, each 15 minutes; funded by state mental health agency

Target Population

Case Management may be provided for members of all ages.

Provider Qualifications

The following providers may provide Case Management:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

- Case Management must provide direct assistance in gaining access to needed medical, social, educational, and other services.
- Case Management includes the development of an IICP, referrals to services, and activities or contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the mental health and/or addiction needs of the eligible member.

- Case Management may include:
  - *Needs Assessment*: Focusing on needs identification of the member to determine the need for any medical, educational, social, or other services. Specific assessment activities may include:
    - Taking member history
    - Identifying the needs of the member
    - Completing the related documentation
    - Gathering information from other sources, such as family members or medical providers
  - *IICP Development*: The development of a written IICP based on the information collected through the assessment phase. The IICP identifies the rehabilitative activities and assistance needed to accomplish the objectives.
  - *Referral/Linkage*: Activities that help link the member with medical, social, and educational providers, and/or other programs and services that are capable of providing needed rehabilitative services.
  - *Monitoring/Follow-up*: Activities and contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the member. The activities and contacts may be with the following:
    - Member
    - Family members
    - Nonprofessional caregivers
    - Providers
    - Other entities
- Monitoring and follow-up are necessary to help determine if services are being furnished in accordance with the member's IICP, the adequacy of the services in the IICP, and changes in the needs or status of the member. This function includes making necessary adjustments in the IICP and service arrangement with providers.
  - *Evaluation*: The case manager must periodically reevaluate the member's progress toward achieving the IICP's objectives. Based on the case manager's review, a determination would be made whether changes should be made. Time devoted to formal supervision of the case between case manager and licensed supervisor are included activities and should be documented accordingly. The supervision must be documented appropriately and billed under one provider only.

Exclusions

- Activities billed under Behavioral Health Level of Need Redetermination are excluded.
- A service and/or service activity 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, BPHC).

Note: Please note that this exclusion is effective as of June 1, 2014.

- The actual or direct provision of medical services or treatment is excluded. Examples include, but are not limited to:
  - Training in daily living skills
  - Training in work skills and social skills
  - Grooming and other personal services
  - Training in housekeeping, laundry, or cooking
  - Transportation service
  - Individual, group, or family therapy services

- Crisis intervention services
- Services that go beyond assisting the member in gaining access to needed services. Examples include, but are not limited to:
  - Paying bills and/or balancing the member's checkbook
  - Traveling to and from appointments with members
  - Court-ordered reports
  - Assistance completing Medicaid application or redetermination documentation

Case Management Example

To help a member gain access to safe housing, an OBHP explores available housing options to review with the member, conducts a housing needs assessment, develops IICP goals for locating and maintaining housing, and provides supportive housing information.

This service is billable as Case Management (T1016).

CAIRS

CAIRS is a time-limited, curriculum-based, nonresidential service provided to children and adolescents in a clinically supervised setting that provides an integrated system of individual, family, and group interventions based on an IICP. CAIRS is designed to alleviate emotional or behavioral problems with a goal of reintegration into age-appropriate community settings (for example, school and activities with pro-social peers). CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS is limited to 252 hours for service packages 4 and 5. Authorization for CAIRS is limited to 90 consecutive days. PA is required for members requiring additional units of this service. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 10 – HCPCS Codes for CAIRS

Code and Modifiers	Code Description
H2012 HW HA U1	Behavioral health day treatment, per hour; funded by state mental health agency; child/adolescent program; group setting

Target Population

CAIRS may be provided for members at least 5 years of age and less than 18 years of age with severe emotional disturbance who:

- Need structured therapeutic and rehabilitative services.
- Have significant impairment in day-to-day personal, social, and/or vocational functioning.
- Do not require acute stabilization, including inpatient or detoxification services.
- Are not at imminent risk of harm to self or others.

CAIRS may be provided to members age 18 and older, but less than 21 years of age, with an approved PA.

Provider Qualifications

The following providers may provide Case Management:

- Licensed professionals

- QBHPs
- OBHPs

Program Standards

- CAIRS must be authorized by a physician or HSPP.
- Direct services must be supervised by a licensed professional.
- CAIRS must be provided in close coordination with the educational program provided by the local school district.
- CAIRS may be provided in a facility provided by the school district.
- Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
- Member goals and a transitional plan must be designed to reintegrate the member into the school setting and less intensive level of care.
- Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
- A weekly review and update of progress occurs and must be documented in the member's clinical record.
- CAIRS must be provided in an age-appropriate setting for a member age 18 and under receiving services.
- CAIRS programs must be offered a minimum of two hours and a maximum of four hours per day, three to five days per week, excluding time associated with formal educational or vocational services.
- CAIRS must be provided in an age-appropriate setting for a member age 18 and under.
- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when provided in a group setting.
- CAIRS must demonstrate movement toward or achievement of member treatment goals identified in the IICP.
- CAIRS goals must be rehabilitative in nature.

Exclusions

- Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content are not reimbursable.
- Formal educational or vocational services are not reimbursable.
- CAIRS is not reimbursable for children less than 5 years of age.
- CAIRS is not reimbursable for members age 18 and older, but less than 21 years of age without an approved PA.
- CAIRS is not reimbursed for members who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW U1) on the same day.
- A member may not receive CAIRS and AIRS on the same day.

CAIRS Example

A member goes to school from 8 a.m. to 4 p.m. Monday through Friday. On Tuesday and Thursday, she is in formal education services all day. On Monday, Wednesday, and Friday, she receives behavioral health services from 8 a.m. to 9 a.m., formal education services and lunch from 9 a.m. to 3 p.m., and behavioral health services from 3 p.m. to 4 p.m.

CAIRS may be billed for two one-hour units of CAIRS service each day she participates (H2012 HW HA U1).

Crisis Intervention

Crisis Intervention is a short-term emergency behavioral health service, available 24 hours a day, seven days a week. Crisis Intervention includes, but is not limited to, crisis assessment, planning, and counseling specific to the crisis; intervention at the site of the crisis (when clinically appropriate); and prehospital assessment. The goal of Crisis Intervention is to resolve the crisis and transition the member to routine care through stabilization of the acute crisis and linkage to necessary services. Crisis Intervention may be provided in an emergency room, crisis clinic setting, or within the community.

HCPCS

Table 11 – HCPCS Codes for Crisis Intervention

Code and Modifiers	Code Description
H2011 HW	Crisis intervention service, per 15 minutes; funded by state mental health agency

Target Population

Crisis Intervention may be provided for adults and children (no age restrictions) who are:

- At imminent risk of harm to self or others
- Experiencing a new symptom that places the member at risk

Provider Qualifications

The following providers may provide Crisis Intervention:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

- Crisis Intervention does not require PA.
- The consulting physician, AHCP, or HSPP must be accessible 24 hours a day, seven days a week.
- The IICP must be updated to reflect the Crisis Intervention for members currently active with the behavioral health service provider.
- A brief crisis IICP must be developed and certified by a physician or HSPP for members new to the system, with a full IICP developed following resolution of the crisis.

- Crisis Intervention is a face-to-face service, and may include contacts with the family and other nonprofessional caretakers to coordinate community service systems. These collateral contacts are not required to be face-to-face but must be in addition to face-to-face contact with the member.
- To bill Crisis Intervention, a face-to-face service must be delivered to the member.
- Crisis Intervention is, by nature, delivered in an emergency and nonroutine fashion.
- Crisis Intervention should be limited to occasions when a member suffers an acute episode, despite the provision of other community behavioral health services.
- The intervention should be member-centered and delivered on an individual basis.
- Crisis Intervention is available to any Medicaid-eligible member in crisis.
- Documentation of action to facilitate a face-to-face visit must occur within one hour of initial contact with the community mental health center (CMHC) for a member at imminent risk of harm to self or others.
- Documentation of action to facilitate a face-to-face visit must occur within four hours of initial contact with the CMHC for a member experiencing a new symptom that places the member at risk.

Exclusions

- Interventions targeted to groups are not billable as Crisis Intervention.
- Time spent in an inpatient setting is not billable as Crisis Intervention.
- Interventions to address an established problem or need documented in the IICP may not be billed under Crisis Intervention, but may be billed to other MRO services as appropriate.
- Declared disaster crisis activities and services delivered by a disaster crisis team are not billable as Crisis Intervention.
- Routine intakes provided without an appointment or after traditional hours do not constitute Crisis Intervention.
- Non-face-to-face services provided without a face-to-face contact with the member to assess and provide crisis intervention services are not billable. Only when a face-to-face contact has occurred, may non-face-to-face activities be included in the billing for Crisis Intervention.

Crisis Intervention Examples

Example 1

A member has been seen by his behavioral health provider for the last two years for major depression, chronic, recurrent. The member has missed his last two appointments, which is atypical. His daughter telephones the behavioral health provider and reports that the member has refused to eat for the last three days, and has said the television is telling him not to eat, as there is poison in the food and he believes someone is trying to kill him. The member has never before presented symptoms of a thought disorder. The therapist arranges an emergency appointment to assess the member's mental status, the new symptoms, and potential need for hospitalization.

The member was seen in my office today from 10 a.m. to 10:43 a.m., for Crisis Intervention. He has been seen at the CMHC for the last two years for major depression, chronic, recurrent. He has missed his last two appointments, which is atypical. He says he is afraid to eat because his food is being poisoned. His thinking was disorganized, and he showed evidence of a thought disorder as described by his daughter. He does not appear to be at imminent risk for harm. The following plan has been put in place and added to his IICP. Arrangements were made for him to see the psychiatrist for medication assessment and to stay with his daughter for the next three days to ensure his safety. He will be seen again for an Individual Therapy appointment in three days. Time spent face-to-face: 43 minutes; time spent on telephone with daughter: 15 minutes; time spent making transportation arrangements: 20 minutes. Total time: 78 minutes.

This example presents an existing member who has new symptoms and needs that are not currently in his IICP. Crisis Intervention may be billed (H2011 HW). Please note there is documentation for the initial call and the face-to-face contact. Had there not been a face-to-face contact, the telephone contact could not be billed.

Example 2

A member calls the CMHC emergency telephone number published in the local telephone book. This member has never been to the CMHC and does not know what to do. He has not worked for three years, is on disability, and just found out his wife has left him. He has serious health problems and access to a lot of pain medicine. He reports he is thinking about taking all of his medicine because he cannot go on without his wife. The member has Medicaid. The on-call therapist arranges to meet the member at the local emergency room within the hour.

This example presents someone new to a CMHC who has Medicaid; therefore, Crisis Intervention may be billed for this emergency service (H2011 HW), in addition to the individual face-to-face assessment, which actually occurred. Without a face-to-face contact, telephone and/or collateral contacts may not be billed.

Example 3 – Crisis Intervention Exclusion Example

A member reports experiencing an increase in paranoid thinking over the last two weeks. His IICP includes several goals and interventions related to assisting the member in learning appropriate coping skills to manage his paranoid thinking, along with the fear and anxiety it raises. The member became increasingly agitated in the group home this morning during breakfast. His therapist is called and agrees to schedule an emergency appointment later in the morning to see the member due to his increased distress.

This member is a known member with a history of paranoid thinking. His IICP includes goals and intervention to address this issue. Because symptom or issue is not new, the "emergency" session with his therapist would be billed as another service (for example, Behavioral Health Counseling and Therapy) under MRO or a Clinic Option service as appropriate. Crisis Intervention may not be billed.

IOT

IOT is a treatment program that operates at least three hours per day, at least three days per week, and is based on an IICP. IOT is planned and organized with addiction professionals and clinicians providing multiple treatment service components for rehabilitation of alcohol and other drug abuse or dependence in a group setting. IOT includes group therapy, interactive education groups, skills training, random drug

screenings, and counseling. IOT is limited to 40 three-hour sessions for service packages 4 and 5. PA is required for members requiring additional units of service. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 12 – HCPCS Codes for IOT

Code and Modifiers	Code Description
H0015 HW U1	Alcohol and/or drug services; intensive outpatient, including assessment, counseling; crisis intervention, and activity therapy or education; funded by state mental health agency; group setting

Target Population

IOT may be provided for members of all ages with a substance-related disorder and the following:

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

Provider Qualifications

The following providers may provide IOT:

- Licensed professionals, including LCACs
- QBHPs
- OBHPs

Program Standards

- Regularly scheduled sessions, within a structured program, must be at least three consecutive hours per day and at least three days per week.
- IOT includes the following components:
  - Referral to 12-step programs, peers, and other community supports
  - Education on addiction disorders
  - Skills training in communication, anger management, stress management, and relapse prevention
  - Individual, group, and family therapy (provided by a licensed professional or QBHP only)
- IOT must be offered as a distinct service.
- A licensed professional is responsible for the overall management of the clinical program.
- IOT must be provided in an age-appropriate setting for a member age 18 and under.
- At least one of the direct service providers must be an LAC or an LCAC.
- IOT must be individualized.
- Access to additional support services (for example, peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated treatment, referral to other community supports) must be provided as needed.

- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when the service is in a group setting.
- Services must demonstrate progress toward or achievement of member treatment goals identified in the IICP.
- Service goals must be rehabilitative in nature.
- Up to 20 minutes of break time is allowed during each session of three consecutive hours.

Exclusions

- Members with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Members at imminent risk of harm to self or others are not eligible for this service.
- IOT is not reimbursed for members receiving Group Addiction Counseling (H0005 HW, H0005 HW HS, and H0005 HW HR) on the same day.
- IOT sessions that consist of education services only are not reimbursable.
- Any service that is less than three hours may not be billed as IOT but may be billed as Group Addiction Counseling (if provider qualifications and program standards are met).

IOT Example

A member participated in three hours of IOT on March 18, 2014. The first hour of IOT focused on education related to the progressive course of addiction facilitated by an OBHP LAC. The member identified where he is in the progression and discussed the history of his use. The second hour of IOT was facilitated by an LCSW, on the impact of addiction on self-esteem. The member noted he really gets down on himself every time he uses and fails to follow through on what he is supposed to be doing. Per his IICP, The member will keep a journal of situations that lead to negative self-thoughts and develop strategies to recognize actions he can take to feel good about himself. The third hour of IOT was facilitated by a QBHP, and focused on the importance of taking a personal inventory. The member identified several things he had done while using that had a negative impact on others. Per his IICP, the member will complete a personal inventory to present to the group in one week.

IOT Exclusion Example

The member participated in two and one-half hours of IOT groups facilitated by an OBHP.

Not billable as IOT due to less than three-hour duration. May not be billed as Addiction Counseling Group because an OBHP does not meet provider qualifications to provide Addiction Counseling.

Medication Training and Support (Individual Setting)

Medication Training and Support involves face-to-face contact with the member and/or family or nonprofessional caregivers in an individual setting for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non-face-to-face activities.

Medication Training and Support is limited to the following:

- 60 units for service package 3
- 104 units for service packages 4, 5, and 5A

PA is required for members requiring additional units of this service. These maximum limits also include any units billed under H0034 HW, H0034 HW U1, H0034 HW HR, H0034 HW HS, H0034 HW HS U1, and H0034 HW HR U1. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 13 – HCPCS Codes for Medication Training and Support (Individual Setting)

Code and Modifiers	Code Description
H0034 HW	Medication training and support, per 15 minutes; funded by state mental health agency
H0034 HW HR	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple with client present
H0034 HW HS	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple without client present

Target Population

Medication Training and Support may be provided for members of all ages.

Provider Qualifications

The following providers may provide Medication Training and Support within the scope of practice as defined by federal and state law:

- Licensed physicians
- AHCPs
- RNs
- LPNs
- MAs who have graduated from a two-year clinical program

Program Standards

- Face-to-face contact is provided in an individual setting with the member and/or family or nonprofessional caregivers that includes monitoring self-administration of prescribed medications and monitoring side effects.
- When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- Medication Training and Support may also include the following services that are not required to be provided face-to-face with the member:
  - Transcribing physician or AHCP medication orders
  - Setting or filling medication boxes
  - Consulting with the attending physician or AHCP regarding medication-related issues
  - Ensuring linkage that lab and/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

- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when the member is not present.
- Medication Training and Support must demonstrate movement toward and/or achievement of member treatment goals identified in the IICP.
- Medication Training and Support goals are rehabilitative in nature.

Exclusions

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, Medication Training and Support 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 Medication Training and Support but may be billed as Skills Training and Development.
- Medication Training and Support may not be provided for professional caregivers.

Medication Training and Support (Individual Setting) Example

An RN meets with a member in his home to fill his pillbox and discuss the importance of taking medication regularly as prescribed. During the home visit, the nurse asks the member to identify the names of each of the medicines he takes and the reason why he takes them.

This service may be billed as Medication Training and Support (H0034 HW).

Medication Training and Support (Group Setting)

Medication Training and Support involves face-to-face contact with the member and/or family or nonprofessional caregivers in a group setting, for the purpose of providing education and training about medications and medication side effects. Medication Training and Support is limited to the following:

- 60 units for service package 3
- 104 units for services packages 4, 5, and 5A

PA is required for members requiring additional units of this service. These maximum limits also include any units billed under H0034 HW, H0034 HW U1, H0034 HW HR, H0034 HW HS, H0034 HW HR U1, and H0034 HW HS U1. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 14 – HCPCS Codes for Medication Training and Support (Group Setting)

Code and Modifiers	Code Description
H0034 HW U1	Medication training and support, per 15 minutes; funded by state mental health agency; group setting
H0034 HW HR U1	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple with client present; group setting
H0034 HW HS U1	Medication training and support, per 15 minutes; funded by state mental health agency; family/couple without client present; group setting

Target Population

Medication Training and Support may be provided for members of all ages.

Provider Qualifications

The following providers may provide Medication Training and Support within the scope of practice as defined by federal and state law:

- Licensed physicians
- AHCPs
- RNs
- LPNs
- MAs who have graduated from a two-year clinical program

Program Standards

- Face-to-face contact is provided in a group setting with the member and/or family or nonprofessional caregivers that includes education and training on the administration of prescribed medications and side effects, and/or conducting medication groups or classes.
- When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The member is the focus of the service.
- Documentation must support how the service benefits the member, including when the member is not present.
- Medication Training and Support must demonstrate movement toward and/or achievement of member treatment goals identified in the IICP.
- Medication Training and Support goals are rehabilitative in nature.
- Medication Training and Support must be provided in an age-appropriate setting for a member less than 18 years of age receiving services.

Exclusions

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding member self-administration of medications are not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.
- Medication Training and Support may not be provided for professional caregivers.
- The following non-face-to-face services are excluded:
  - Transcribing physician or AHCP medication orders
  - Setting or filling medication boxes
  - Consulting with the attending physician or AHCP regarding medication-related issues
  - Ensuring linkage that lab and/or other prescribed clinical orders are sent

  - Ensuring that the member follows through and receives lab work and other clinical orders
  - Follow-up reporting of lab and clinical test results to the member and physician

- Medication Training and Support may not be provided for members under the age of 12 years in a group setting.

Peer Recovery Services

Peer Recovery Services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer Recovery Services is included in adult service packages only and is limited to the following:

- 104 units for service package 3
- 156 units for service package 4
- 208 units for service package 5
- 260 units for service package 5A

PA is required for members requiring additional units of this service. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 15 – HCPCS Codes for Peer Recovery Services

Code and Modifiers	Code Description
H0038 HW	Self-help/peer recovery services, per 15 minutes; funded by state mental health agency

Target Population

Peer Recovery Services may be provided for member age 18 and older. Peer Recovery Services may be provided to a member age 16 or 17 with an approved PA.

Provider Qualifications

Peer Recovery Services must be provided by individuals meeting DMHA training and competency standards for a certified recovery specialist (CRS). Individuals providing Peer Recovery Services must be under the supervision of a licensed professional or QBHP.

Program Standards

- Peer Recovery Services must be identified in the IICP and correspond to specific treatment goals.
- The member is the focus of Peer Recovery Services.
- Peer Recovery Services must demonstrate progress toward and/or achievement of member treatment goals identified in the IICP.
- Peer Recovery Services are rehabilitative in nature.
- Peer Recovery Services must be age-appropriate for a member age 18 and under receiving services.
- Documentation must support how the service specifically benefits the member.

- Peer Recovery Services must be face-to-face and include the following components:
  - Assisting the member with developing self-care plans and other formal mentoring activities aimed at increasing active participation in person-centered planning and delivery of individualized services
  - Assisting the member in the development of psychiatric advanced directives
  - Supporting day-to-day problem solving related to normalization and reintegration into the community
- Education and promotion of recovery and anti-stigma activities must be associated with mental illness and addiction.

Exclusions

- Peer Recovery Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed.
- Interventions targeted to groups are not billable as Peer Recovery Services.
- Activities that may be billed under Skills Training and Development or Case Management services are not billable as Peer Recovery Services.
- Peer Recovery Services are not reimbursable for children under the age of 16.
- Peer Recovery Services that occur in a group setting are not reimbursable.

Peer Recovery Services Examples

A member met with her CRS to develop a self-care plan and talk about ways for her to get her own apartment. Together, they made a list of traits the member might like in a roommate.

The member was bored, so she called her CRS and asked for help finding something to do. The CRS met with the member to work on her IICP goal to become more active. They brainstormed ideas of what kinds of things she can do when she is bored. She decided she could take a walk around the block, go to the library, or write a letter to an old friend. On this date, the CRS took a walk with the member and developed a plan for her to take a walk each afternoon after lunch. They will meet again in one week to discuss how many walks the member took in one week.

These are examples of activities billable as Peer Recovery Services (H0038 HW).

Peer Recovery Services Exclusion Examples

A member was bored, so she called her CRS and asked her for help finding something to do. The CRS took the member bowling for the afternoon. They had a good time.

Not billable to Peer Recovery Services due to being purely recreational in nature.

A group of members met with their CRS to work on communication skills with their families. The group focused on practicing assertiveness skills and how to say “no” to a family member.

Not billable to Peer Recovery Services due to being a group. Peer Recovery Services are individual only. May be billed as Skills Training and Development group if the CRS also meets provider qualification criteria for an OBHP, QBHP, or licensed professional.

Psychiatric Assessment and Intervention

Psychiatric Assessment and Intervention services consist of face-to-face and non-face-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to members. Psychiatric Assessment and Intervention is included in adult service packages only and is limited to the following:

- 25 units for service package 5
- 100 units for services package 5A

These maximum limits include any units billed under H2019 HW and H2019 HW UA. PA is required for members requiring additional units of this service. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 16 – HCPCS Codes for Psychiatric Assessment and Intervention

Code and Modifiers	Code Description
H2019 HW	Therapeutic behavioral services, per 15 minutes; funded by state mental health agency
H2019 HW UA	Therapeutic behavioral services, per 15 minutes; funded by state mental health agency; non-face-to-face

Target Population

Psychiatric Assessment and Intervention may be provided for members age 18 and older with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community. For members under the age of 18, Psychiatric Assessment and Intervention may be prior authorized.

Provider Qualifications

The following providers may provide Psychiatric Assessment and Intervention:

- Physicians
- AHCPs

Program Standards

- The programmatic goals of Psychiatric Assessment and Intervention must be clearly documented by the provider.
- Psychiatric Assessment and Intervention is intensive and must be available 24 hours per day, seven days a week with emergency response.
- The member is the focus of Psychiatric Assessment and Intervention.
- Documentation must support how the service benefits the member, including when the service is not face-to-face.
- Psychiatric Assessment and Intervention must demonstrate movement toward or achievement of member treatment goals identified in the IICP.
- Psychiatric Assessment and Intervention goals must be rehabilitative in nature.

- Psychiatric Assessment and Intervention may include the following:
  - Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional, behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a member's treatment
  - Monitoring a member's medical and other health issues that are either directly related to the mental health- or substance-related disorder, or to the treatment of the disorder (for example, diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, and seizures)
- Non-face-to-face services may include consultation on assessment, service planning, and implementation with other members of the member's treatment team, the member's family, and nonprofessional caregivers.
  - This consultation may be provided either in or outside the team meeting.
  - To be a billable activity, consultation must be goal-oriented, focused on addressing barriers to fulfilling the member's IICP, and documented in the clinical record in a way that reflects the complexity of the interaction.

Exclusions

- Medication management activities provided in a clinic setting that may be reimbursed under the Clinic Option are excluded.
- Services that may be reimbursed under the Clinic Option are excluded.

Psychiatric Assessment and Intervention (Non-Face-to-Face) Examples

A staff person met with a member yesterday at the member's home. During the visit, the staff person noticed the member had not taken any medication for the last five days. He was agitated and insisted the staff person leave the house as he was expecting a visit from a well-known celebrity. The staff person returned to the clinic and located the team psychiatrist. The staff person reviewed the member's current status with the psychiatrist, who asked a number of questions regarding the member's mental status and the condition of his home. After reviewing the case, the psychiatrist recommended the staff person arrange for the member to come in for a medication check.

The psychiatrist may document the consultation and recommendation, and bill as Psychiatric Assessment and Intervention (non-face-to-face) (H2019 HW UA).

Psychiatric Assessment and Intervention (Non-Face-to-Face) Exclusion Example

A staff person met with a member yesterday at his home. During the visit, the staff person noticed the member had not taken any medication for the last five days. The member was agitated and insisted the staff person leave the house as he was expecting a visit from a well-known celebrity. The next morning during the team meeting, the staff person let the team psychiatrist know she had arranged a medication check for the member to see him the following week.

Not billable as Psychiatric Assessment and Intervention (non-face-to-face) because no service was provided by the physician during the meeting. The activity of assessing the member's needs and linking him to needed services may be billed as Case Management.

Psychiatric Assessment and Intervention (Face-to-Face) Example

The team psychiatrist visited a member in his home to assess his response to medication.

This may be billed as Psychiatric Assessment and Intervention (face-to-face) because the activity occurred in the member's home (H2019 HW).

Psychiatric Assessment and Intervention (Face-to-Face) Exclusion Example

The team psychiatrist saw a member in his office to assess the member's response to medication.

Not billable to Psychiatric Assessment and Intervention (face-to-face) due to the service location of the office. This may be billed as a Clinic Option service.

Skills Training and Development (Individual Setting)

Skills Training and Development involves face-to-face contact with the member and/or family or nonprofessional caregivers that result in the member's development of skills (for example, self-care, daily life management, or problem-solving skills), in an individual setting, directed toward eliminating psychosocial barriers. Development of skills is provided through structured interventions for attaining goals identified in the IICP and the monitoring of the member's progress in achieving those skills. Skills Training and Development is limited to the following:

- 600 units for service package 3
- 750 units for service package 4
- 900 units for service package 5
- 1,000 units for service package 5A

These maximum limits include any units billed under H2014 HW, H2014 HW U1, H2014 HW HR, H2014 HW HS, H2014 HW HS U1, and H2014 HW HR U1. PA is required for members requiring additional units of this service. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 17 – HCPCS Codes for Skills Training and Development (Individual Setting)

Code and Modifiers	Code Description
H2014 HW	Skills training and development, per 15 minutes; funded by state mental health agency
H2014 HW HR	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple with client present
H2014 HW HS	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple without client present

Target Population

Skills Training and Development may be provided for members of all ages.

Provider Qualifications

The following providers may provide Skills Training and Development:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

- Skills Training and Development requires face-to-face contact with the member and/or family members or nonprofessional caregivers in an individual setting.
- Members are expected to show benefit from Skills Training and Development, with the understanding that improvement may be incremental.
- For children and adolescents, Skills Training and Development includes services to aid in the achievement of developmental milestones that would have been achieved if not for the presence of the behavioral health disorder.
- Skills Training and Development must result in demonstrated movement toward, or achievement of, the member's treatment goals identified in the IICP.
- Skills Training and Development includes monitoring the impact of training acquisition.
- Restore member's abilities essential to independent living, (for example, self-care and daily life management).
- As identified in the IICP, provide skills training specific to illness self-management.
- May include, but not limited to the following types of services:
  - Skills training in food planning and preparation, money management, and maintenance of living environment
  - Training in appropriate use of community services
  - Medication-related education and training by nonmedical staff
  - Training in skills needed to locate and maintain a home; renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, locating and interviewing prospective roommates, and understanding renter's rights and responsibilities
  - Social skills training necessary for functioning in a work environment

- The member is the focus of Skills Training and Development.
- Documentation must support how the service benefits the member, including when the member is not present.
- Skills Training and Development goals are rehabilitative in nature and time limited.

Exclusions

- Skills Training and Development that is habilitative in nature (except for the developmental milestones for members less than 18 years of age that would have occurred absent the presence of emotional disturbance) is not reimbursable.
- Skill-building activities not identified in the IICP are not reimbursable.
- Activities purely for recreation or diversion are not reimbursable.
- Job coaching is not reimbursable.
- Academic tutoring is not reimbursable.
- Individual Skills Training and Development services (H2014 HW) are not reimbursable if delivered on the same day as AIRS or CAIRS.
- Skills Training and Development may not be provided to professional caregivers.

Skills Training and Development (Group Setting)

Skills Training and Development involves face-to-face contact with the member and/or family or nonprofessional caregivers that result in the member's development of skills (for example, self-care, daily life management, or problem-solving skills), in a group setting, directed toward eliminating psychosocial barriers. Development of skills is provided through structured interventions for attaining goals identified in the IICP and monitoring the member's progress in achieving those skills. Skills Training and Development is limited to the following:

- 600 units for service package 3
- 750 units for service package 4
- 900 units for service package 5
- 1,000 units for service package 5A

These maximum limits include any units billed under H2014 HW, H2014 HW U1, H2014 HW HS, H2014 HW HR, H2014 HW HR U1, and H2014 HW HS U1. PA is required for members requiring additional units of this service. See *Appendix A* for information regarding units and service packages.

HCPCS

Table 18 – HCPCS Codes for Skills Training and Development (Group Setting)

Code and Modifiers	Code Description
H2014 HW U1	Skills training and development, per 15 minutes; funded by state mental health agency; group setting
H2014 HW HR U1	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple with client present; group setting
H2014 HW HS U1	Skills training and development, per 15 minutes; funded by state mental health agency; family/couple without client present; group setting

Target Population

Skills Training and Development may be provided for members of all ages.

Provider Qualifications

The following providers may provide Skills Training and Development:

- Licensed professionals
- QBHPs
- OBHPs

Program Standards

- Skills Training and Development requires face-to-face contact with the member and/or family members or nonprofessional caregivers on behalf of the member in a group setting.
- Members are expected to show benefit from Skills Training and Development, with the understanding that improvement may be incremental.
- For children and adolescents, Skills Training and Development includes services to aid in the achievement of developmental milestones that would have been achieved if not for the presence of the behavioral health disorder.
- Skills Training and Development must result in demonstrated movement toward, or achievement of, the member's treatment goals identified in the IICP.
- Skills Training and Development includes monitoring of impact of training acquisition.
- Restore member's abilities essential to independent living (for example, self-care and daily life management).
- As identified in the IICP, provide skills training specific to illness self-management.
- May include, but is not limited to the following types of services:
  - Skills training in food planning and preparation, money management, and maintenance of living environment
  - Training in appropriate use of community services
  - Medication-related education and training by nonmedical staff
  - Training in skills needed to locate and maintain a home; renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, locating and interviewing prospective roommates, and understanding renter's rights and responsibilities
  - Social skills training necessary for functioning in a work environment
- The member is the focus of Skills Training and Development.
- Documentation must support how the service benefits the member, including when the service is provided in a group setting and/or the member is not present.
- Skills Training and Development goals are rehabilitative in nature and time limited.
- When provided in a group setting, Skills Training and Development must be provided in an age-appropriate setting for a member age 18 and under.

Exclusions

- Skills Training and Development that is habilitative in nature (except for the developmental milestones for members less than 18 years of age that would have occurred absent the presence of emotional disturbance) is not reimbursable.
- Skill building activities not identified in the IICP are not reimbursable.
- Activities purely for recreation or diversion are not reimbursable.
- Job coaching is not reimbursable.
- Academic tutoring is not reimbursable.
- Group Skills Training and Development services (H2014 HW U1) are not reimbursable if delivered on the same day as AIRS or CAIRS.
- Skills Training and Development may not be provided to professional caregivers.

Skills Training and Development Example

A member identifies that he has never signed a lease or rented his own place. He says he is scared and does not know what to say to the landlord. Per his IICP, staff works with the member on assertiveness skills needed to negotiate with the landlord and ask questions about the property and lease expectations. Staff role-played as the landlord while the member practiced assertiveness skills. After three practice sessions, the member met with the prospective landlord.

Skills Training and Development Exclusion Example

The member hoards newspapers and mail, has not taken the trash to the dumpster in four weeks, and spoiled food and dirty dishes are covering the kitchen counters. Staff goes in and cleans the apartment for him and reminds him that he is to keep the apartment clean.

Doing tasks/activities for members is not billable under Skills Training and Development.

Home and Community-Based Waiver Service Programs

A member may be enrolled in a waiver program and other IHCP services, such as MRO services, at the same time. However, a federally approved waiver requires that waiver services not duplicate services that are already available. Service duplication would most likely occur in the following two areas:

- Skills Training and Development
- Case Management

Waiver case managers are responsible for monitoring services to prevent duplication. The behavioral health service provider must coordinate the provision of services with the waiver case manager.

1915(i) Home and Community-Based (HCBS) State Plan Amendment Programs

Indiana operates three 1915(i) HCBS State Plan Amendment programs that fall under the authority of CMS Home and Community-Based Services (HCBS) rules:

- **Child Mental Health Wraparound (CMHW)** program that provides services to youth ages 6-17 with serious emotional disturbances (SED) with intensive home and community-based wraparound services that will be provided within a System of Care (SOC) philosophy and consistent with Wraparound principles. Services are intended to augment the youth's existing or recommended behavioral health

treatment plan (for example, Medicaid Rehabilitation Option, Waiver, or Managed Care, and so on.). For additional information about this program, see the *CMHW Services* web page.

CMHW wraparound facilitators are responsible for monitoring services to prevent duplication. The behavioral health service provider must coordinate the provision of services with the wraparound facilitator.

- **Behavioral and Primary Healthcare Coordination (BPHC)** program provides services to adults with serious mental illness who demonstrate impairment in self-management of physical health needs due to their mental illness. See the *MRO and BPHC Service Authorization* section of this document and the *Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services* module for details. A member may be eligible and receive services from both BPHC and MRO at the same time

- **Adult Mental Health Habilitation (AMHH) program** – The AMHH program provides services to adults age 35 and older, with serious mental illness (SMI) who may most benefit a habilitative treatment approach, which promotes sustaining and learning skills to maintain a healthy safe lifestyle in community-based settings. See *405 IAC 5-21.6* and the *Division of Mental Health and Addiction Adult Mental Health Habilitation Services* module. **AMHH and MRO services are mutually exclusive.** A member may not be served in these programs at the same time.

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 are end-dated, the member can use MRO services if there is an authorized service package in place.

Transitioning Between MRO and AMHH Services

The AMHH program became effective November 1, 2014. Members may transition between MRO and AMHH services if needed and eligible. The following applies for members transitioning between MRO and AMHH services:

- When transitioning from MRO to AMHH, the member's AMHH eligibility start date is aligned with the MRO end date.

- When transitioning from AMHH to MRO, the member's AMHH eligibility end date is aligned with the MRO start date.

For additional information regarding AMHH, see *405 IAC 5-21.6* and the *Division of Mental Health and Addiction Adult Mental Health Habilitation Services* module.

Noncovered Services

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

- 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, Clinic Option, BPHC, and AMHH)

- 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/or limitations of the MRO service

- A service that is not documented as a covered or approved service on the member's IICP
- A service provided that exceeds the limits within the service definition, including service quantity/limit, duration and/or frequency
- Any service provided on the same day that the member is receiving inpatient or partial hospitalization
- 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, BPHC, 1915(c) waiver. (Any service provided simultaneously with another service, only one of the services provided is billable.)

Note:	*MRO and AMHH services are mutually exclusive. An individual may not be served in these services concurrently.*

IICP/Treatment Plan Requirements

The IICP is a treatment plan that integrates all components and aspects of care deemed medically necessary, are clinically indicated, and provided in the most appropriate setting to achieve recovery. An IICP must be developed for each member (*405 IAC 5-21.5-16*). The IICP must include all indicated medical and remedial services needed by the member to promote and facilitate independence and recovery. In addition, the IICP focuses on treating the disability and improving the member's level of functioning. The IICP is developed through a collaborative effort that includes the member, identified community supports (family/nonprofessional caregivers), and all individuals involved in assessing and/or providing care for the member. The IICP is developed after completing a holistic clinical and biopsychosocial assessment. The holistic assessment includes documentation in the member's medical record of the following:

- Review, discussion, and documentation of the member's recovery desires, needs, and goals (recovery-oriented goals)
- Review of psychiatric symptoms and how they affect the member's functioning and ability to attain recovery desires, needs, and goals
- Review of the member's skills and the support needed for the member to participate in a recovery process, including the ability to function in living, working, and learning environments
- Review of the member's strengths and needs, including medical, behavioral, social, housing, and employment

An IICP is developed with the member and must reflect the member's desires and choices. The member's signature demonstrating his or her participation in the development and ongoing IICP reviews is required. If a member refuses to sign, the provider must document that the IICP was discussed and the member chose not to sign. It also must include the following documentation:

- Outline of goals directed at recovery that promotes independence and integration into the community, treatment of behavioral health symptoms, and rehabilitating areas of functional deficits related to the behavioral health disorders
- Individuals or teams responsible for treatment; coordination of care, linkage, and referrals to internal or external resources; and care providers to meet identified needs
- A comprehensive listing of all specific treatments and services that will be provided to the member
- Frequency, duration, and time frame of each service
- Review or a face-to-face visit by the supervising physician or HSPP at intervals not to exceed 90 days

A licensed professional, QBHP, or OBHP may document the member's diagnoses and complete the IICP. The diagnoses and IICP *must be certified* by a supervising physician or HSPP. Certification should be consistent with the *Clinical Plan for Professional Services* or similar document defining services under policies and procedures for the facility. Certification standards include date signed, statement of agreement with diagnoses and IICP, printed name, signature, and credentials of the licensed professional, QBHP, or OBHP completing the IICP, and the signature (written or electronic) and credentials of the certifying physician or HSPP.

The supervising physician or HSPP is responsible for seeing the member during the intake process or reviewing information submitted by a licensed professional, QBHP, or OBHP, and approving the initial IICP within seven days of intake assessment. IICP updates must be conducted at a minimum of every 90 days by a supervising physician or HSPP. The supervising physician or HSPP must see the member or review the IICP at intervals not to exceed 90 days. These reviews must be documented in writing with acknowledgement that ongoing services, as documented in the IICP, are required. A simple signature notation or medication management progress note that does not directly reference the IICP does not constitute sufficient review.

MRO Clinical and Service Supervision Standards

The supervising physician or HSPP must be enrolled in the IHCP as a rendering provider, linked to the MRO provider, and have the following responsibilities:

- Review information submitted by the licensed professional, QBHP, or OBHP.
- Approve and certify the initial IICP and diagnosis within seven days of intake assessment.
- See the member or review the IICP at intervals not to exceed 90 days. Changes made in the IICP during the period between reviews do not require additional physician or HSPP review.
- Be available to see the member in emergency situations and when additional consultations are required.
- Keep all documentation in the member's medical record.

Some MRO services, such as CAIRS and AIRS, include additional supervision requirements related to certain provider qualifications or service standards (see the *MRO Service Requirements* section of this document). Where clinical supervision 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 MRO service standards. Operational supervision is at the discretion of the MRO provider to define and implement.

Section 3: Diagnosis and Level of Need

All Medicaid members who demonstrate a behavioral health need are eligible for Clinic Option services (*405 IAC 5-20-8*). However, only members with a qualifying diagnosis and level of need (LON) are also eligible for a Medicaid Rehabilitation Option (MRO) service package.

Qualifying Diagnosis

The behavioral health ICD diagnosis codes associated with MRO services are listed in the *Medicaid Rehabilitation Option Services Codes* on the *Code Sets* page at indianamedicaid.com. A "Y" indicates a qualifying MRO diagnosis. A member must have at least one qualifying diagnosis from the list to be eligible for an MRO service package. Note that adults and children or adolescents have separate qualifying diagnosis lists. The qualifying diagnosis for each member must be entered by the provider into the Division of Mental Health and Addiction (DMHA) Data Assessment Registry for Mental Health and Addiction (DARMHA) database for a service package to be assigned.

Level of Need

In addition to a qualifying diagnosis, a member with Medicaid must also have a qualifying LON, as demonstrated by the DMHA-approved assessment tool. Currently, DMHA has approved the use of the Child and Adolescent Needs and Strength (CANS) or Adult Needs and Strengths Assessment (ANSA). The CANS and ANSA are comprehensive, uniform assessment tools developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

The CANS or ANSA data for each member must be entered by the provider into the DMHA DARMHA system for an LON to be established and eligibility for an MRO service package to be determined.

Children with an LON of 2 and higher are eligible for an MRO service package. Adults with an LON of 3 and higher are also eligible for an MRO service package. Details regarding service packages may be found in *Section 4: Medicaid Rehabilitation Option Service Packages* of this document and *Appendix A*.

Members may present with the same diagnosis but have very different levels of needs. Service packages are designed to meet the member's behavioral health needs based on his or her functional assessment and resulting LON.

Level of Need Example

Two members have diagnoses of schizophrenia. One member hears and responds to voices, is not able to manage his own medicine or hold a job, and has moved six times in the last year. His ANSA LON is 5.

A second member has a job working at the local grocery store 20 hours per week. He has his own apartment, manages his own medications with some supervision, and performs all activities of daily living independently. He is involved with church and takes classes at the local community center. His ANSA LON is 3.

Service package 5 contains a broad array of services with a robust number of units of service available designed to meet the first member's intense LON. Service package 3 includes an assortment of services with some minimal/moderate number of units of services designed to meet the second member's lower intensity of needs.

Exceptions

A member who does not have a qualifying diagnosis or LON necessary to access an MRO service package may submit prior authorization (PA) for medically necessary MRO services. To do so, a provider must demonstrate that the member has a significant behavioral health need that would benefit from the provision of MRO services. This process is discussed in further detail in *Section 5: Prior Authorization*.

Section 4: Medicaid Rehabilitation Option Service Packages

A member with a qualifying diagnosis and level of need (LON) may be assigned a Medicaid Rehabilitation Option (MRO) service package. The MRO service package comprises units of MRO services that match the needs of the majority of MRO members. A member who does not have either a qualifying diagnosis or LON necessary to access an MRO service package may submit prior authorization (PA) for individual MRO services. If a member has an MRO service package and needs additional units of a service or a service that is not included in the service package, PA may be submitted. PA processes are discussed in further detail in *Section 5: Prior Authorization*.

Please note, although a process is in place to request PA for additional medically necessary service or units of service, treatment shall be individualized to meet each individual member's needs. Not all members need all services and/or units of services in assigned service packages.

Service package assignment is based on the member's LON. Typically MRO service packages are assigned for 180 days. Exceptions to this occur when MRO is established after another program with a service package assignment is pre-existing. See the *MRO and BPHC Service Authorization* section for details. Service packages are assigned by Indiana*AIM*, the State's Medicaid Management Information System (MMIS) or claims payment system. All assignments for service packages and PA approvals and denials are viewable on Web interChange. There are eight service packages, each with a set of services and units of service designed to meet the member's intensity of need. More information on the services and units of service in each service package may be found in *Appendix A* of this document.

Service Package Assignment Process

A stepwise process has been created in Indiana*AIM* to assign service packages, pay claims, and track available service units. Child and Adolescent Needs and Strength (CANS) and Adult Needs and Strengths Assessment (ANSA) assessments that are completed and entered into the Data Assessment Registry for Mental Health and Addiction Medication (DARMHA) follow this process:

1. Data Transfer
   - Indiana*AIM* receives newly entered or updated member data from the DARMHA system through a daily file exchange.
     - DARMHA only transmits member data if the Medicaid member identification number (RID) has been entered in DARMHA by the provider.
     - If a RID is not entered for a member, the process for assigning an MRO service package is not initiated.
2. Member Data Match
   - DARMHA member data is matched to existing Medicaid member data using the Medicaid RID and date of birth (DOB).
     - Match – YES
       - Once matched, a member-specific MRO file is created and stored in Indiana*AIM* and displayed on Web interChange.
     - Match – NO
       - If a match is not made, a service package is not assigned. Matches are not made if there are errors in member data (Medicaid RID and DOB) submitted to DARMHA.
       - Indiana*AIM* generates an *Error Report* for each provider indicating members who were not matched to the Medicaid data. This file is available to providers daily. Providers

should use this report to review and correct member data entered into DARMHA. Once corrected, Indiana*AIM* accepts the member data and runs through the validation steps.

3. Criteria Validation
   - Indiana*AIM* performs a validation to determine whether the member meets the criteria necessary to assign an MRO service package. All rejection reasons are viewable on Web interChange.
   - The validation process is not initiated without all the following data fields:
     - Medicaid RID
     - DOB
     - CANS or ANSA score
     - Qualifying diagnosis

Provider Responsibility #1

Enter accurate member data into DARMHA in a timely manner. An MRO service package is not assigned, and consequently claims are not paid, without the boldfaced data fields:

- ✓ **First Name**
- ✓ **Last Name**
- ✓ **DOB**
- ✓ **Medicaid RID**
- ✓ SSN
- ✓ **Diagnosis**
- ✓ **CANS or ANSA score**
- ✓ Assessment Date
- ✓ Provider ID
- ✓ ACT indicator (for ACT members only)

(a) Qualifying Diagnosis (See the *Medicaid Rehabilitation Option Codes* on the *Code Sets* page at indianamedicaid.com for qualifying MRO diagnoses)
   - Does the member have a qualifying diagnosis?
     - YES – Move to next step.
     - NO – Service package not assigned.
       Rejection reason – Denied: Diagnosis code does not meet the MRO **services** criteria.

(b) Qualifying LON
   - Does the member's LON qualify (CANS 2-6, ANSA 3-5)?
     - YES – Move to next step.
     - NO – Service package not assigned.
       Rejection reason – Denied: LON does not meet MRO **services** criteria.

(c) Current Assessment
   - Is the CANS or ANSA current?
     - YES – Move to next step.
     - NO – Service package not assigned.
       Rejection reason – Denied: Assessment date does not meet MRO services criteria.

What is a "current" assessment?

- Current assessment policy for youth: A CANS assessment or reassessment is current if the assessment date is less than 30 days prior to the date of submission if a service package does not exist or 30 days prior to the end of a service package if a renewal package is being sought.
- Current assessment policy for adults: An ANSA assessment or reassessment is current if the assessment date is less than 60 days prior to the date of submission if a service package does not exist or 60 days prior to the end of a service package if a renewal package is being sought.
- Assessment date: The date upon which a provider completes the CANS or ANSA with the member.
- Date of submission: The date upon which the assessment data is received by Indiana*AIM* from DARMHA. DARMHA sends daily files of newly entered and updated data to *IndianaAIM*.

Note: A member's data is only transmitted from DARMHA to IndianaAIM if a Medicaid RID is provided, which can be matched to a Medicaid member file in IndianaAIM.

Provider Responsibility #2

Perform required CANS or ANSA reassessments and enter data into DARMHA within the required number of days prior to the end of a member's service package to ensure continuity of care **(30 days for CANS or 60 days for ANSA)**. If a reassessment is performed after the member's initial service package end date, retroactive PA is not available for providers to receive reimbursement.

(d) Active Service Package

- Does the member have an active service package with more than 60 days of authorization remaining?
  - YES – Service package not assigned.
  - NO – Move to next step.
    Rejection reason – Denied: Member has an active MRO service package.
- For a service package to be assigned, the system verifies whether or not the member has an active service package.
- If there is an open package with greater than 60 days of authorization remaining, the system does not create a new package (Member).
- If the package has less than 60 days of authorization remaining, the system assigns a new package to begin the day following the end date of the previous package (Member).

Active Service Package Policy

If the LON changes during the 180 days for which the package is authorized, Indiana*AIM* reacts as follows:

- If the LON goes *up*, the existing assigned service package remains the same for that 180-day period. If additional services or units are necessary to meet the needs of the member, the provider may use the new LON as evidence of medical necessity when requesting PA.
- If the LON goes *down*, the existing assigned service package remains the same for that 180-day period. Services assigned by the system are not prorated to adjust to the lower LON. However, audits are conducted to ensure that providers are only delivering medically necessary services. As such, the changed LON may be one source (along with other medical records) used to determine if services are being delivered appropriately.

(e) Assertive Community Treatment (ACT) Indicator

- Has the ACT indicator been selected?
  - YES – Indiana*AIM* performs the following additional checks:
    - If the LON is not 5, Indiana*AIM* ignores the indicator and moves to the next step.
    - If the LON is 5, Indiana*AIM* validates whether the provider submitting the member data has a certified ACT team.
  - YES (ACT certified) – Move to next step to assign package 5A.
  - NO (Not ACT certified) – Move to next step to assign package 5.
    Reason Code – Approved: LON and MRO service package assigned, but criteria for ACT service not met.
  - NO – Indiana*AIM* moves to the next step.

4. Service Package Assignment
   - If the member meets the criteria for MRO and passes the previous five-step criteria validation process, a service package is assigned for 180 days.
   - If a member has existing units of PA available prior to a service package assignment, the system end dates the PA for these individual services and assigns the service package.

Web interChange

Providers can access Web interChange to track utilization of services using the member's RID and other *Health Insurance Portability and Accountability Act* (HIPAA)-compliant data. Assigned service codes and available number of units are displayed on Web interChange for each member. Units of service are decremented from a member's service package when a claim is paid. While Web interChange provides service package detail, it is ultimately the responsibility of the provider to track utilization.

Provider Responsibility #3

Check eligibility for Indiana Health Coverage Programs (IHCP) and MRO and internally monitor service package utilization for each member.

- ✓ As is required for all IHCP service providers, MRO providers should check a member's IHCP eligibility prior to each visit.
- ✓ In addition to this check, MRO providers should review the MRO service package assignment and available units of service prior to service delivery.
- ✓ While Web interChange provides service package detail, it is ultimately the responsibility of the provider to track utilization.

MRO Inquiry Help

The *MRO Inquiry* window in Web interChange allows providers to search for an MRO member's associated MRO service packages and PAs.

Search by Member ID

1. To perform an MRO Inquiry, the user types the member's 12-digit RID into the box next to Member ID.

   Note: The down arrow to the right of the Member ID field provides the ability for the user to build and view a list of frequently used member IDs for future reference. The user list selection can be modified and updated at the discretion of the user.

2. Select **Search** and the results display the MRO service packages and PAs for the member. If the search results identify more than 50, the user is presented with a **Next** button to view the next 50 results. Via

the **Previous/Next** button, the user has access to all MRO service packages and/or PA line items for the MRO member.

3. If the search results do not find an MRO service package or PA for the Member ID entered, the following message displays: "No data was found that matched the search criteria."
4. Select **Reset** to clear the search criteria field of any Member ID entered.
5. Search results that appear on the screen indicate the MRO member ID entered by the user has an associated MRO service package or PA. The information is displayed in the following columns:
   - **Reference # –** Assigned when a service package is systematically generated or when a PA is generated by the PA vendor.

Note:	*The Reference # and the PA # are equivalent to each other on the MRO Inquiry windows.*

   - **Confirmation # –** Only assigned to a Web-based PA request. This field is blank if a Web PA was not requested.
   - **Service Package** – MRO service package is a numeric value based on the LON and valid MRO diagnosis. The MRO service package is valid for 180 days and appears in descending order based on the start date.
   - **LON** – LON is determined by the CANS or ANSA.
   - **Start Date** – The effective date of the MRO service package. Services submitted for reimbursement prior to this date are not considered. A blank in this field with a number in the Reference # column indicates this search result is a PA.
   - **End Date** – The end date of the MRO service package. Services submitted for reimbursement after this date are not considered. A blank in this field with a number in the Reference # column indicates this search result is a PA.
   - **Status** – Informs the user if the MRO service package is approved or the reason it was denied. A blank in this field with a number in the Reference # column indicates this search result is a PA. The status reasons are based on criteria approved by the Family and Social Services Administration (FSSA). The following list of reasons appears in this column based on the information submitted by the MRO provider:
     - **Approved**
       The MRO service package is approved.
     - **Denied: Diagnosis code does not meet the MRO services criteria.**
       The diagnosis code submitted must be an approved MRO Diagnosis Code and be valid for the CANS or ANSA.
     - **Denied: LON does not meet the MRO services criteria.**
       LON for a CANS must be greater than 1 and the LON for an ANSA must be greater than 2.
     - **Approved: LON and MRO service package assigned, but criteria for ACT service not met.**
       Providers requesting package 5A services for MRO members must be ACT certified. The PA vendor must have a copy of the certificate on file.
     - **Denied: Member has an active MRO service package.**
       An MRO service package is effective for 180 days. A new assessment (CANS or ANSA) may be submitted within the required time frame (30 days for CANS and 60 days for ANSA) prior to the end of a service package. If eligible, the start date is the day after the old service package expires.
     - **Denied: Assessment date does not meet MRO services criteria.**
       The CANS or ANSA assessment must be completed within 30 or 60 days of the date of submission.

6. To identify the difference between an MRO service package and a PA on the *MRO Inquiry* window, look for a Reference # that does not have information populated in the status, start date, and end date columns. A PA does not contain information in these columns.

MRO Inquiry Detail Help

1. To review the detail information associated with an MRO Service Package, the user selects the Reference # link. The Reference # and PA # are equivalent to each other on the *MRO Inquiry* windows.
2. The Provider/Request Information section in the upper left section is specific to the MRO provider that requested the MRO service package and/or PA.
3. The MRO Member Information section in the upper right section provides general demographic information about the MRO member. This information is obtained from Indiana*AIM*.
4. The Detail Information section provides specific information for the PA. The information displays in the following columns:
   - **Status** – An MRO provider may modify a service package or request additional PA for an MRO member. The status of that request displays in this column.
   - **Procedure** – The procedure code submitted by the MRO provider that is directly linked to the PA.
   - **Modifier(s)** – If the associated procedure code has modifiers, those are listed here. Up to four modifiers can be displayed for each procedure code.
   - **Description** – A brief description of the procedure code submitted by the MRO provider displays here.
   - **Start Date** – The effective date of the PA. Services submitted for reimbursement prior to this date are not considered.
   - **End Date** – The date the PA expires. Services submitted for reimbursement after this date are not considered.
   - **Units Auth** – The number of units that were authorized by the PA vendor for the PA.
   - **Units Used** – The number of units that have been used to date for the service package and/or PA.

Note: The information displayed from an MRO inquiry is based on paid claims only.

   - **Amount Auth** – This field is not populated for MRO services.
   - **Amount Used** – This field is not populated for MRO services.

Section 5: Prior Authorization

This section outlines the prior authorization (PA) guidelines for Medicaid Rehabilitation Option (MRO) services provided beyond the assigned MRO service package. For more information about general PA, please see *405 IAC 5* and the *Prior Authorization* module. Indiana Health Coverage Programs (IHCP) providers are responsible for reading and understanding portions of the *Indiana Administrative Code (IAC)* and the *IHCP Provider Reference Modules* that apply to their areas of service.

PA Vendor

On behalf of the Family and Social Services Administration (FSSA), the ADVANTAGE Health Solutions Prior Authorization Department reviews all MRO PA requests for IHCP members on a case-by-case basis. The decision to authorize, modify, or deny a PA request is based on medical necessity, all applicable IACs, PA guidelines, and IHCP bulletins and banner pages.

Submit the completed *Indiana Health Care Programs Prior Authorization Request Form* (universal PA form) to the following address as appropriate:

ADVANTAGE Health Solutions Prior Authorization Department
P.O. Box 40789
Indianapolis, IN 46240
1-800-269-5720 (telephone)
1-800-689-2759 (fax)

Allowable PA

For the majority of members receiving MRO services, the assigned MRO service packages provide a sufficient number of services and units of services to meet their needs. However, for members who require additional medically necessary services not included in the service package, or additional units of services assigned in the service package, a PA request is required. Under the four following scenarios, an MRO service provider is required to submit a PA request to the PA vendor to be reimbursed for additional medically necessary services or units of service.

Scenario 1: A member exhausts all units of a service included in his or her MRO service package and requires additional units of that medically necessary service.

Scenario 2: A member requires a medically necessary MRO service not assigned in his or her MRO service package.

Scenario 3: A member does not have a qualifying MRO diagnosis or level of need (LON), and has a significant behavioral health need that requires a medically necessary MRO service.

Scenario 4: A member is newly eligible to the Medicaid program or had a lapse in his or her Medicaid eligibility and was determined Medicaid-eligible for a retroactive period. In this case, a retroactive request for PA is appropriate for MRO services.

Retroactive PA Policy

Requests for retroactive PA are not authorized except where a member:

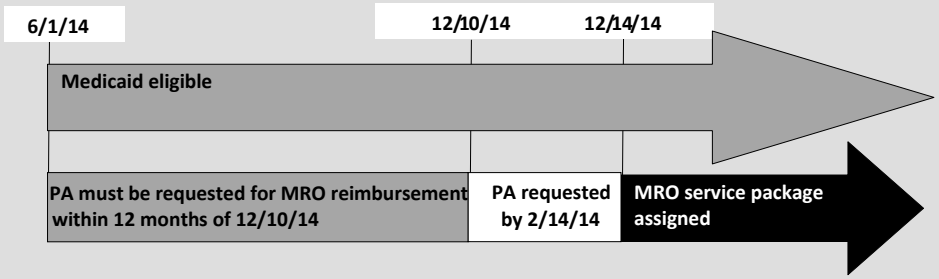
- Is newly eligible for Medicaid or other IHCP program that covers MRO services.
- Had a lapse in his or her Medicaid eligibility and was determined Medicaid eligible for a retroactive period.

Retroactive PA requests must be made within 12 months of a member's eligibility determination date or 60 days of the provider receiving notice of a member's eligibility. Clinical notes documenting dates of service, services, and duration of services must be submitted with retroactive PAs.

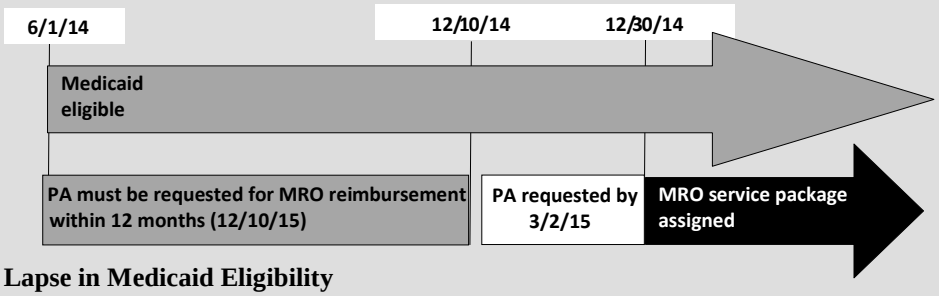
For all the scenarios presented previously, note that MRO service providers are required to submit documentation that supports medical necessity.

Scenario 4 (Retroactive PA) Examples

A member submits a Medicaid application on September 1, 2014. On December 20, 2014, she is notified that she is Medicaid-eligible retroactive to June 1, 2014. The member has an appointment with her behavioral health provider on December 14, 2014, and tells her that she is now eligible for Medicaid. Her provider completes an Adult Needs and Strengths Assessment (ANSA) and submits the ANSA score, a qualifying diagnosis, and member identification number (RID) to the Data Assessment Registry for Mental Health and Addiction Medication (DARMHA) on December 14, 2014. An MRO service package is assigned for 180 days. If the member's provider delivered MRO services between December 10, 2014, and December 14, 2014, PA must be submitted within 60 days of December 14, 2014, to receive reimbursement. If her provider delivered services between June 1, 2014, and December 10, 2014, PA must be made by December 10, 2015, to receive reimbursement.



A member submits a Medicaid application on September 1, 2014. On October 20, 2014, his provider completes an ANSA and submits the ANSA information to DARMHA with a qualifying diagnosis. On December 10, 2014, the member is notified that he is Medicaid-eligible retroactive to June 1, 2014. A service package is not assigned because the provider has not yet entered a RID into DARMHA to trigger the member's data be sent to Indiana*AIM*. The member has an appointment on December 30, 2014, and tells his provider that he is now eligible for Medicaid. The member's provider completes an ANSA and enters the ANSA information and the member's RID in DARMHA. An MRO service package is assigned. If the provider delivered services between December 10, 2014, and December 30, 2014, PA must be submitted within 60 days of December 30, 2014, to receive reimbursement. If the provider delivered services between June 1, 2014, and December 10, 2014, PA must be submitted by December 10, 2015, to receive reimbursement.



Lapse in Medicaid Eligibility

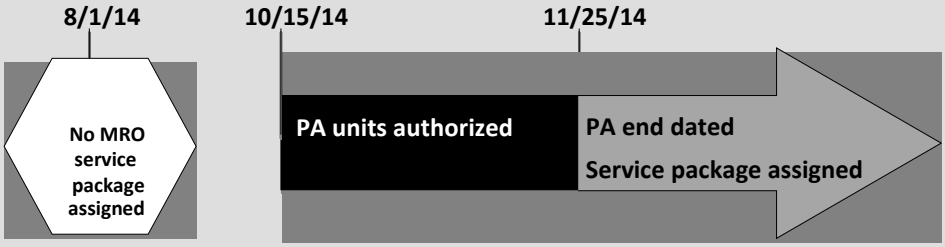
Retroactive PA is also available for members who experience a lapse in Medicaid eligibility. For example, a member is assigned service package 4 for 180 days. On day 40 of the service package, the member loses Medicaid eligibility and her eligibility is end dated in Indiana*AIM*. The MRO service package remains open for the 180-day period. On day 90, the member's eligibility is reinstated with a retroactive period back to day 40. Medicaid is reopened with retroactive period, resulting in no lapse in eligibility. The provider may submit claims without requesting retroactive PA.

Prior Authorization and Service Package Assignment

If at a later date within the PA period, the member is reassessed and the resulting LON qualifies him or her for an MRO service package, the existing PAs will be end dated and a service package assigned. This process is necessary to ensure Indiana*AIM* can properly adjudicate claims.

Prior Authorization and Service Package Assignment Example

On August 1, 2014, a provider completes an ANSA for a member, who is assessed as LON 2. No MRO service package is assigned. The provider submits a PA request for 50 units of Skills Training and Development on October 12, 2014, and the request is authorized by ADVANTAGE on October 15, 2014, for 50 units of Skills Training and Development for 90 days. On November 25, 2014, the provider completes another ANSA for this member, and she is assessed as LON 3. The provider enters this data into DARMHA and service package 3 is assigned for 180 days. The PA for the remaining units of Skills Training and Development is end dated.



PA Submission

PA requests may be initiated with the PA vendor via fax, mail, Web interChange, or telephone. For scenarios 1, 2, and 3 listed previously, the provider is responsible for submitting new PA requests at least 30 days before the current authorization period expires to ensure service authorization and reimbursement are not interrupted. For scenario 4, a request for PA may be made retroactively. To ensure that service authorization and reimbursement are not interrupted, MRO service providers are encouraged to submit new PA requests at least 30 days before a current authorization period expires, except for Scenario 4 (retroactive PA).

Providers should retain photocopies of the *Indiana Health Coverage Programs Prior Authorization Request Form* (universal PA form) for their records. The original of the form must be submitted to the ADVANTAGE Health Solutions PA department's address.

Provider Responsibility #4

- ✓ Request PA for additional services or additional units of service required for a member on a timely basis.
  - ADVANTAGE Health Solutions reviews PA requests on behalf of the State.
  - The current PA process and request form is used for MRO PA.

PA Policy Requirements

An Individualized Integrated Care Plan (IICP) and progress notes, including the necessity and effectiveness of therapy, must be attached to the PA form and a copy must be available for audit purposes. The PA form must be signed (handwritten or rubber stamp) by a physician or health service provider in psychology

(HSPP). Each PA submission is reviewed on a case-by-case basis. MRO services are subject to PA as found in *405 IAC 5-21*.

Providers that may submit PA for behavioral health services are:

- Doctor of medicine
- Doctor of osteopathy
- HSPP

PA Decision

A PA decision is represented by the following letters in the decision letter sent to the provider and member and in Web interChange:

- A (approved) − If the PA request is approved, the approval is backdated to the date of the admission or the date of the initial telephone or fax request.
- M (modified) − A modified PA request is an approved PA that has been changed in some way.
- S (suspended) − The PA request is suspended; additional information is required.
- P (pending) − The PA request is pending; the PA vendor is awaiting all required documentation.
- D (denied) − If the PA request is denied, the provider is not reimbursed by the IHCP for any dates of service applicable.

Exceptions

The IHCP does not reimburse providers for any IHCP service requiring PA, unless PA is obtained prior to services being rendered. The exception to this rule is when a PA request qualifies for retroactive eligibility provided the member's aid category covers MRO services. Any authorization of a service by ADVANTAGE Health Solutions is limited to authorization for payment of IHCP allowable charges. It is not an authorization of the provider's estimated fees. PA is not a guarantee of payment.

Providers may request PA on behalf of the IHCP member.

Note:	*If a member has other health insurance, and a service that is covered by Medicaid requires PA, the provider must obtain PA from both sources prior to rendering services.*

Member Eligibility

Granting PA confirms medical necessity but is valid only if a member is eligible for Medicaid on the date services are rendered. PA is not a guarantee of payment, and member eligibility should be verified by the provider before services are rendered. As the IHCP is the payer of last resort, claims must be submitted to the third-party carrier before they are submitted to the IHCP. Providers should also determine if the member has third-party liability (TPL) coverage and if PA from the third-party carrier is necessary.

All necessary PA forms for fee-for-service (FFS) can be found on the *Forms* page at indianamedicaid.com. Providers are responsible for using these forms to ensure accurate, timely PA review and claims processing. Unapproved forms are returned to the provider.

Section 6: Clinical Record Documentation Requirements

The documentation required to support billing for Medicaid Rehabilitation Option (MRO) services must:

- Focus on recovery.
- Emphasize member strengths.
- Reflect progress toward the goals reflected in the Individualized Integrated Care Plan (IICP).
- Be updated with every member encounter that billing is submitted for reimbursement.
- Note actual time used in delivering the service.
- Reflect start and end times of service.
- Be written and signed by the provider rendering services and cosigned as necessary.
- Include the date of service rendered (including month, day, and year) in the documentation.

See *Section 2: Medicaid Rehabilitation Option Services* of this document for complete service definitions, provider qualifications, program standards, target population, and exclusions (for example, activities that are not reimbursable or services that are not reimbursable on the same day).

Rehabilitation

The distinction of whether a service is “rehabilitative” versus “habilitative” is often more rooted in an individual’s level of functioning 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 best possible functional level.”

MRO Service Location Specifications

- Clinic setting is an outpatient, office-based environment and does not refer to a billing mechanism.
- Community setting is a nonclinical, office-based, noninstitutional (institutions include jail, psychiatric residential treatment facility [PRTF], state-operated facility [SOF] setting).
- Residential setting is any setting in which a member resides or sleeps.
- School setting is a formal education environment.
- Acute Care setting is inpatient or partial hospitalization.

General Documentation Requirements

For individuals participating in any MRO service, documentation must be provided for each encounter and must include:

- Type of service being provided

- Name and qualifications of the staff providing the service
- Location or setting where the service was provided
- Focus of the session or service delivered to or on behalf of the member
- Individual symptoms or issues addressed during the session
- Duration of the service (actual time spent with the member)
- Start and end time of the service
- Member's IICP goals being addressed during the session
- Progress made toward recovery goals
- Date of service rendered (including month, day, and year)

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

Group Setting Documentation Requirements

For individuals participating in services in a group setting (Behavioral Health Counseling and Therapy, Skills Training and Development, Addiction Counseling, Medication Training and Support, Intensive Outpatient Treatment [IOT]), documentation must be provided for each encounter and must include:

- All items under general requirements
- Focus of the group or session
- Member's level of activity in the group session
- How the service benefits the member and assists the member in reaching his/her recovery goals
- Progress toward the individual member's recovery goals as found in his or her IICP

Simply noting whether or not the member was present in the group does not constitute adequate documentation.

Services without the Member Present Documentation Requirements

For services provided without the member present (Behavioral Health Counseling and Therapy, Skills Training and Development, Addiction Counseling, Medication Training and Support), documentation must be provided for each encounter and must include:

- All items under general requirements
- Who attended the session and his or her relationship with the member
- How the service benefits the member and assists the member in reaching his or her recovery goals
- Progress toward the individual member's recovery goals as found in his or her IICP

Simply noting that the member was not present does not constitute adequate documentation.

Service-Specific Documentation Requirements

The following services have additional documentation requirements as described in this section.

Behavioral Health Level of Need Redetermination

Behavioral Health Level of Need Redetermination services are associated with the Division of Mental Health and Addiction (DMHA)-approved assessment tool – Child and Adolescent Needs and Strength (CANS) or Adult Needs and Strengths Assessment (ANSA) – required to determine level of need (LON), assign an MRO service package, and make changes to the member's IICP. For a complete definition of this service, see *Section 2: Medicaid Rehabilitation Option Services* of this document.

Documentation requirements include:

- Face-to-face contact with the member (required to bill this service)
- Face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, if applicable, and done in addition to the face-to-face contact with the member
- Type of reassessment being completed (CANS or ANSA)
- Name and qualifications of the staff providing the reassessment
- Location or setting where the reassessment was completed
- Duration of the reassessment (actual time spent)
- Start and end time of the reassessment

Behavioral Health Level of Need Redetermination Documentation Example

A member was seen in her home on December 12, 2014, from 10 a.m. to 10:55 a.m. by another behavioral health professional (OBHP). Together, they contacted the member's mother over the telephone to obtain information and completed her ANSA reassessment. Time spent was 55 minutes. The ANSA reassessment and LON results dated December 12, 2014, are located in the assessment section of this medical record.

This service is billable as Behavioral Health Level of Need Redetermination.

CAIRS

Child and Adolescent Intensive Resiliency Services (CAIRS) is a time-limited, nonresidential service provided in a clinically supervised setting that provides an integrated system of individual, family, and group interventions based on an IICP. CAIRS is designed to alleviate emotional or behavioral problems, with a goal of reintegrating the child into the community setting. CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS is curriculum-based, with goals that include reintegration into age-appropriate community settings (for example, school and activities with pro-social peers). For a complete definition of this service, see *Section 2: Medicaid Rehabilitation Option Services* of this document.

Documentation requirements include a weekly review with details of daily activities and update of progress providing details of services provided each day per the following:

- All items under general requirements
- All requirements noted in the *Group Setting Documentation Requirements* section
- Member's goals and a transitional plan to reintegrate the child into the school setting and a less restrictive level of care

Note:	*Providers may opt to use daily documentation versus a weekly review summary as long as there is consistency across the agency in which method is used. A daily review note requires all the same documentation elements as noted for weekly review.*

CAIRS Documentation Example

A member participated in CAIRS provided at her school on March 3, 4, and 5. Her IICP goals related to improving her self-esteem, appropriate expression of feelings, and appropriate classroom behavior were addressed this week. On March 3, the member participated for two hours (3-5 p.m.) in a group focused on building self-esteem with a qualified behavioral health professional (QBHP). The member identified three things she does well.

On March 4, the member participated in a one-hour group (8-9 a.m.) focused on communication skills and a two-hour group (3-5 p.m.) focused on constructive expression of feelings with an OBHP. The member was able to verbalize situations where assertiveness was appropriate, but was unable to maintain eye contact when verbalizing her wishes.

The member identified two situations this week where she threw tantrums, and she recognized the importance of using words to express her feelings. On March 5, the member participated in a three-hour psycho-educational group (3-6 p.m.) focused on appropriate classroom behavior with a licensed clinical social worker (LCSW). The member was able to sit quietly in class and speak when called on by the teacher three out of five days this week. The member will increase her time an hour a week in the regular classroom progressively over the next four weeks.

AIRS

AIRS is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured rehabilitative services to maintain the member on an outpatient basis. AIRS is curriculum-based and designed to alleviate emotional or behavior problems with the goal of transitioning to a less restrictive level of care, reintegrating the member into the community, increasing social connectedness beyond a clinical setting, and/or employment. For a complete definition of this service, see *Section 2: Medicaid Rehabilitation Option Services* of this document.

Documentation requirements include a weekly review with details of daily activities and update of progress providing details of services provided each day per the following:

- All items under general requirements
- All requirements noted in the *Group Setting Documentation Requirements* section
- 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 summary as long as there is consistency across the agency in which method is used. A daily review note requires all the same documentation elements as noted for weekly review.*

Crisis Intervention

Crisis Intervention is a short-term emergency behavioral health service, available 24 hours a day, seven days a week. Crisis Intervention includes, but is not limited to, crisis assessment, planning, and counseling specific to the crisis, intervention at the site of the crisis (when clinically appropriate), and prehospital assessment. The goal of Crisis Intervention is to resolve the crisis and transition the member to routine care through stabilization of the acute crisis and linkage to necessary services. Crisis Intervention may be

provided in an emergency room, crisis clinic setting, or within the community. A face-to-face contact with the member is required to bill this service. For a complete definition of this service, see *Section 2: Medicaid Rehabilitation Option Services* of this document.

The provider must document action to facilitate:

- A face-to-face visit within one hour of the initial contact with the behavioral health service provider for a member at imminent risk of harm to self or others
- A face-to-face visit within four hours of the initial contact with the behavioral health service provider for a member experiencing a new psychiatric symptom that places the member at risk

Documentation requirements for the clinical note include:

- Type of service being provided
- Name and qualifications of the staff providing the service
- Location or setting within which the service was provided
- Focus of the service delivered to or on behalf of the member
- Individual symptoms or issues addressed
- Subjective complaints voiced by the member and/or collaterals
- Mental status of the member during the crisis
- Observations and objective data regarding the crisis
- Face-to-face contact with the member
- IICP/treatment plan
- Time engaged in delivering the service
- Start and end time of the service

Documentation requirements for the crisis IICP include:

- Name and qualifications of the staff providing the service
- Focus of the service delivered to or on behalf of the member
- Individual symptoms or issues addressed
- Goals of the Crisis Intervention
- Treatment plan developed to address the intervention goals
- Time/units to be used delivering services

The content of the documentation must support the amount of time billed.

Crisis Intervention may be delivered on the same day as other Clinic Option or MRO services, but documentation must clearly indicate how the Crisis Intervention differed in the time of day that service was delivered, the provider delivering the service, and how the Crisis Intervention does not duplicate other services delivered in the same day.

Crisis Intervention Documentation Example

A member's daughter telephoned this office at 9 a.m. today, October 24, 2014, to report the member has refused to eat for the last three days. The member says the television is telling him not to eat, as there is poison in the food, and he believes someone is trying to kill him. He has never before presented symptoms of a thought disorder. An LCSW arranged an emergency appointment at 1 p.m. today to assess the member's mental status, the new symptoms, and potential need for hospitalization. Call ended at 9:15 a.m. Time spent: 15 minutes.

The member was seen in my office today from 10 a.m. to 10:43 a.m. for Crisis Intervention. He has been seen at the community mental health center (CMHC) for the last two years for major depression, chronic, recurrent. The member has missed his last two appointments, which is atypical. He says he's afraid to eat because his food is being poisoned. His thinking was disorganized, and he showed evidence of a thought disorder as described by his daughter. He does not appear to be at imminent risk for harm. The following plan has been put in place and added to his IICP. Arrangements were made for him to see the psychiatrist for medication assessment and to stay with his daughter for the next three days to ensure his safety. He will be seen again for an Individual Therapy appointment in three days. Time spent face-to-face: 43 minutes; time spent on telephone with daughter: 15 minutes, time spent making transportation arrangements: 20 minutes. Total time: 78 minutes.

This example illustrates an existing member who has new symptoms and needs that are not currently in the IICP. Crisis Intervention may be billed for five 15-minute units.

Peer Recovery

Peer Recovery services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

To be reimbursed for Peer Recovery services, the service must be provided by a certified recovery specialist (CRS) defined as individuals meeting DMHA training and competency standards for Peer Recovery services. Individuals providing Peer Recovery services must be under the supervision of a licensed professional or QBHP.

Documentation must be provided for each encounter and must reflect:

- All items under general requirements
- Nature of the services delivered to the member
- Issues addressed during the session
- Total number of minutes in the session
- Progress made toward recovery goals

Peer Recovery services must be identified in the IICP and correspond to specific treatment goals.

Peer Recovery Documentation Example

A member is visited in his home by his CRS who documents the following: On January 12, 2014, this CRS conducted a home visit with the member for 60 minutes, from 3 to 4 p.m. During the visit, the member reported feeling lonely and depressed. He said he hadn't left his house for five days. We discussed his IICP recovery goal to become more involved in the community. We talked about how hard it is to make new friends and meet new people. I let him know he isn't alone and I feel that way sometimes, too. We talked about the kinds of things people do when they are lonely. He agreed to take a walk to the gas station with me and to say, "Hi," to at least one person he didn't know. He did a great job and said he was scared but proud he found the courage to go to the gas station. He said next time he would like to get a soda. This CRS will return in one week to check on his progress of getting out more.

Section 7: Billing Requirements for MRO Services

This section outlines Medicaid Rehabilitation Option (MRO) billing guidelines, claim format, and necessary billing-related information. Moreover, explanation of actual time spent conducting service versus time billed, modifiers, and other helpful billing-related items are included with examples. The Family and Social Services Administration (FSSA) sets the rate for each procedure code. For more information about general billing, see *405 IAC 1* and the *Claim Submission and Processing* module. Indiana Health Coverage Programs (IHCP) providers are responsible for reading and understanding portions of the *Indiana Administrative Code (IAC)* and the *IHCP Provider Reference Modules* that apply to their areas of services.

Billing Standards

- IHCP rendering provider numbers are assigned to physicians or health service providers in psychology (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 MRO 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 MRO 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 MRO provider to receive reimbursement for the delivery of MRO services, a member must have an assigned MRO service package or prior authorized service units.
- Service packages are assigned by IndianaAIM, the State's Medicaid Management Information System (MMIS) or claims payment system.
  - A stepwise process has been created in Indiana*AIM* to assign service packages, pay claims, and track available service units.
  - All assignments for service packages and prior authorization (PA) approvals and denials are viewable on Web interChange.
  - Indiana*AIM* and the service package assignment process is dependent upon reliable, accurate data submitted by the provider via the Data Assessment Registry for Mental Health and Addiction (DARMHA). Providers have the responsibility of ensuring that data and claims are submitted accurately and timely.

Provider Responsibility #4

- ✓ Submit MRO claims for reimbursement on a timely basis.
  - Units of MRO services, as displayed in Web interChange, are decremented based on adjudicated claims.
  - Timely submission of claims will ensure 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.

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 24J 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 an HSPP is not assigned an individual IHCP provider number.

CMHCs must use the HW modifier to denote MRO services, in addition to modifiers that identify the qualifications of the individual rendering the service and other specific modifiers needed for submission of MRO claims, as noted in this document. Place the modifiers in field 24D of the *CMS-1500* claim form.

For detailed, line-by-line billing instructions for the *CMS-1500* (02/12), see the *Claim Submission and Processing* module.

Claim Format

MRO claims can be billed using the *CMS-1500* paper claim format or the *Health Insurance Portability and Accountability Act* (HIPAA)-compliant electronic 837P claim format. Effective April 1, 2014, the IHCP will only accept version 02/12 of the *CMS-1500* paper claim form. Additional procedures for billing with the *CMS-1500* claim form are provided in the *Claim Submission and Processing* module.

The following instructions must be followed for billing claims to the IHCP for MRO 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.

MRO services may be billed with other IHCP-covered services on the same claim. Each IHCP provider number identifies all the programs for which a provider is qualified to deliver services and that were elected during the enrollment process. In addition, Indiana*AIM* adjudicates claims line by line, which allows a mixed-program claim as long as the claim is billed under the same provider number. However, mixing program billing on the same claim significantly complicates the RA claim reconciliation, and it is easier to reconcile RA claim transactions if MRO billing is separate from IHCP clinical billing, especially if different departments are responsible for those functions.

Each detail line identifies services billed using Healthcare Common Procedure Coding System (HCPCS) codes and service dates. Staff must bill each date of service as a separate detail line. The procedure code description defines the unit of service. When multiple staff members (regardless of the type of provider) deliver the same service on the same date of service, they must add time and bill those services on the same claim form and on one detail line. Billing separate detail lines for the same service and the same date of service causes the claim to be denied as exact duplicates.

Facility Fees

No facility fees are paid for MRO services.

Time Documentation

Staff must document actual time spent delivering services in a 24-hour period within the member's clinical record. 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. For billing purposes, a provider agency must total actual time delivering the same MRO 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, with the exception of Intensive Outpatient Treatment (IOT).

Time Documentation

A member receives five minutes of MRO Case Management from a case manager, four minutes of MRO Case Management from a second case manager, and nine minutes of MRO Case Management from a third case manager on the same day. The member's clinical record notes that three staff members provided Case Management on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time spent that may be billed is 18 minutes.

5 minutes + 4 minutes + 9 minutes = 18 minutes of Case Management

A member receives nine minutes of Skills Training and Development, Individual, from a licensed clinical social worker (LCSW) and 15 minutes of Skills Training and Support, Individual, from a master's level practitioner on the same day. The member's clinical record notes that two staff members provided Skills Training and Development, Individual, on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time that may be billed is 24 minutes. Even though the two staff members have different provider qualifications, they must add their time spent with the member together.

9 minutes + 15 minutes = 24 Minutes of Skills Training and Development, Individual

Rounding Minutes to Units

Providers may round the total actual time each day, as described previously, to the nearest whole unit when calculating reimbursement. Providers should refer to the HCPCS code for each service for information on the unit increment that is used for each service.

15-Minute Unit

If staff delivers a service 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. Providers must add actual time together (as described in the *Time Documentation* section) before rounding.

15-Minute Unit Example

A member receives five minutes of MRO Case Management from one case manager, four minutes of MRO Case Management from a second case manager, and nine minutes of MRO Case Management from a third case manager on the same day. The member's clinical record notes that three staff members provided MRO Case Management on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time spent that may be billed is 18 minutes.

5 minutes + 4 minutes + 9 minutes = 18 minutes of MRO Case Management
18 minutes of MRO Case Management = One 15 minute unit (T1016 HW HN)

A member receives nine minutes of Skills Training and Development, Individual, from an LCSW and 15 minutes of Skills Training and Support, Individual, from a master's level on the same day. The member's clinical record notes that two staff members provided Skills Training and Development, Individual, on the same day and the amount of time each staff person spent with the member. For billing purposes, the total actual time that may be billed is 24 minutes. Even though the two staff members have different provider qualifications, they must add their time spent with the member together.

9 minutes + 15 minutes = 24 Minutes of Skills Training and Development, Individual
24 Minutes of Skills Training and Development = Two 15 minute units (H2014 HW)

One-Hour (60 Minutes) Unit

If staff delivers a service for 45 or more minutes, or the total of minutes for the day for one service add up to 45 or more minutes, the provider rounds up to the one hour unit. If staff delivers a service for 44 minutes or less, or the total of minutes for the day for one service add up to 44 minutes or less, the provider rounds down to zero units and therefore may not bill for this service.

One-Hour Unit Examples

A member receives 48 minutes of AIRS from a staff person who has less than a bachelor's degree. 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 minutes > 44-minute threshold = provider may bill for one 1 hour unit of AIRS H2012 HW HB U1

A member receives 25 minutes of Addiction Counseling, Individual, from an LCSW. For billing purposes, 25 minutes of service is less than the 44-minute threshold. The provider must round down to zero and may not bill for this service.

25 minutes < 44 minutes = provider may not bill for Addiction Counseling, Individual, services rendered

A member receives 20 minutes of CAIRS from a staff person who has less than a bachelor's degree and 25 minutes of CAIRS from a second staff person with less than a bachelor's degree 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 must round up to one one-hour unit.

20 minutes + 25 minutes = 45 minutes > 44 minutes threshold = provider may bill for one 1 hour unit of CAIRS H2012 HW U1 HA

A member receives 80 minutes of Addiction Counseling, Group, from a licensed mental health counselor (LMHC). For billing purposes, 80 minutes is greater than the 44-minute threshold for one one-hour unit of service, but does not qualify for a second one-hour unit of service.

80 minutes = 60 minutes (One 1 hour unit of service) + 20 minutes; 20 minutes < 44-minute threshold = provider may bill for one 1 hour unit of Addiction Counseling, Group and may not bill the additional 20 minutes of services rendered H0005 HW

Three-Hour (180 Minutes) Unit

IOT is the only MRO service that may be billed in three-hour units. A provider must deliver three consecutive hours of IOT to be reimbursed for IOT. Up to 20 minutes in break time may occur within the three-hour block of time. Any amount of time less than three hours should be billed to Group Addiction Counseling, if all other requirements for Addiction Counseling are met.

Three-Hour Unit Examples

A member receives 53 minutes of IOT followed by a 10-minute break, an additional 50 minutes of IOT followed by a 10-minute break, and finally an additional 60 minutes of IOT from a master's level practitioner. A total of 163 minutes of IOT was delivered with the allowable 20 minutes of break time, for a total of 183 minutes of IOT.

183 minutes > 180 minutes = provider may bill for one three-hour unit of IOT (the additional three minutes may not be billed to Group Addiction Counseling because a member may not receive both IOT and Group Addiction Counseling on the same day) H0015 HW U1

A member receives 30 minutes of IOT followed by a 10-minute break, then an additional 30 minutes of IOT followed by a 10-minute break, and finally an additional 30 minutes of IOT from a doctoral-level practitioner. A total of 90 minutes of IOT was delivered with the allowable 20 minutes of break time, for a total of 110 minutes of IOT.

110 minutes < 180 minutes = provider may not bill for IOT services rendered
**The provider may bill for 120 minutes of Addiction Counseling or two one-hour units, if all other requirements for Addiction Counseling are met.*

Modifiers for MRO Services

The following modifiers are needed for the submission of MRO claims.

Table 19 – Service Modifiers

Modifier	Service Description
HW	Funded by State mental health agency
U1	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
UA	Non-face-to-face encounter
HA	Child/adolescent program
HB	Adult program

Midlevel Provider Modifiers

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

HCPCS Codes

Table 20 – HCPCS Codes

HCPCS Code	Common Title
H0004	Behavioral Health Counseling and Therapy
H0005	Addiction Counseling (Group Setting)
H0015	IOT
H0031	Behavioral Health Level of Need Redetermination
H0034	Medication Training and Support
H0038	Peer Recovery Services
H2011	Crisis Intervention
H2012	AIRS and CAIRS
H2014	Skills Training and Development
H2019	Psychiatric Assessment and Intervention
H2035	Addiction Counseling (Individual Setting)
T1016	Case Management

Third-Party Liability Requirements

To ensure that the IHCP does not pay for services covered by other insurance sources, federal regulations (*Code of 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.

Table 21 – Third-Party Liability (TPL) Requirements

HCPCS Code	HCPCS Title	TPL Requirement
H0004 HW HW HR HS U1	Behavioral health counseling and therapy, per 15 minutes Funded by state mental health agency Family/couple with client present Family/couple without client present Group setting	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H0005 HW HW HR HS	Alcohol and/or drug services; group counseling by clinician Funded by state mental health agency Family/couple with client present Family/couple without client present	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.

HCPCS Code	HCPCS Title	TPL Requirement
H0015 HW HW U1	Alcohol and/or drug services; intensive outpatient, including assessment, counseling; crisis intervention, and activity therapy or education Funded by state mental health agency Group setting	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H0031 HW HW	Mental health assessment, by nonphysician Funded by state mental health agency	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H0034 HW HW HR HS U1	Medication training and support, per 15 minutes Funded by state mental health agency Family/couple with client present Family/couple without client present Group setting	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H0038 HW HW	Self help/peer recovery services, per 15 minutes Funded by state mental health agency	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H2011 HW HW	Crisis intervention service, per 15 minutes Funded by state mental health agency	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H2012 HW HW HA HB	Behavioral health day treatment, per hour Funded by state mental health agency Child/adolescent program Adult program	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H2014 HW HW U1 HR HS	Skills training and development, per 15 minutes Funded by state mental health agency Group setting Family/couple with member present Family/couple without member present	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
H2019 HW HW UA	Therapeutic behavioral services, per 15 minutes Funded by state mental health agency Non-face-to-face	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.

HCPCS Code	HCPCS Title	TPL Requirement
H2035 HW HW HR HS	Alcohol and/or other drug treatment program, per hour Funded by state mental health agency Family/couple with member present Family/couple without member present	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.
T1016 HW HW	Case management, each 15 minutes Funded by state mental health agency	Code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.

Healthy Indiana Plan and Hoosier Care Connect Considerations

Healthy Indiana Plan (HIP) and Hoosier Care Connect programs require all enrolled members be linked with a managed care entity (MCE). MRO services by provider type and specialty are carved out of IHCP managed care programs. MRO providers are reimbursed for a carved-out service only if the rendering or supervising provider is enrolled with mental health provider specialty 011, 110-117, or 339 and is linked to a MRO provider billing number with the same specialty. Those claims for managed care members are submitted to Hewlett Packard Enterprise for processing. The *Mental Health and Addiction Services* module provides additional information about mental health services for managed care enrollees.

Healthy Indiana Plan

The IHCP implemented an expanded version of the HIP (HIP 2.0), effective February 1, 2015. HIP 2.0 expands coverage to all eligible Hoosiers ages 19-64 with incomes under approximately 138% of the federal poverty level (FPL).

HIP 2.0 includes four distinct plans: *HIP Plus*, *HIP Basic*, *HIP State Plan*, and *HIP Link.* The *HIP State Plan* includes a *Plus* and a *Basic* plan. All HIP members will be assigned to an MCE – Anthem, Managed Health Services (MHS), or MDwise. All benefits in the new HIP program, with the exception of MRO services, are provided through the MCEs. MRO services available to qualifying *HIP State Plan* members are "carved out" and reimbursed as fee-for-service claims. Reimbursement rates for MRO services provided to members covered under the *HIP State Plans* were increased by 30%, effective February 1, 2015. MRO services are not covered for members enrolled in *HIP Plus*, *HIP Basic*, or *HIP Link.*

Members in HIP 2.0 State Plan Basic/State Plan Plus and Copay Responsibilities

Most members enrolled in *HIP State Plan – Basic* are required to pay a $4 copayment for outpatient services and most MRO services. Certain services such as preventive care and services allowed without the member present are exempt from copayments.

Members enrolled in *HIP State Plan – Basic* will owe a separate $4 copayment for each distinct service rendered, even if they are rendered on the same date of service (DOS). If the same distinct service is rendered multiple times on a single DOS or if more than one unit of a distinct service is rendered on a single DOS, only one $4 copayment will be owed.

Service activities on behalf of the member that do not involve the member being present do not have the $4 copayment applied. For a list of the exempt procedure codes for MRO, see the *Medicaid Rehabilitation Option Services Codes* on the *Code Sets* page at indianamedicaid.com.

Hoosier Care Connect

Hoosier Care Connect is designed to improve the quality of care and clinical outcomes for members eligible for the IHCP on the basis of age, blindness, or disability. Hoosier Care Connect was implemented beginning April 1, 2015, for initial Hoosier Care Connect member enrollment. MCEs will not be responsible for claim processing for MRO services. Providers will continue to bill the IHCP for these carved-out services through the fee-for-service delivery system.

Place of Service Codes

MRO services can be rendered in the following locations with the place of service (POS) code listed:

- 11 – Office
- 12 – Home
- 23 – Emergency room – hospital
- 31 – Nursing facility
- 53 – CMHC (such as therapy)
- 99 – Other unlisted facility (such as employment or a community place)

Note:	*The MRO provider must ensure that the service provided is not already included in the nursing home or inpatient per diem rate.*

Mailing Address for Claims

MRO claims are sent to the standard medical claim address:

***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 toll-free at 1-800-577-1278. The addresses and telephone numbers are also available on the *IHCP Quick Reference Guide* at indianamedicaid.com.

Appendix A: MRO Service Packages

Table 22 identifies the services included in the service packages for each level of care. Level of need (LON) is determined by the Initial Assessment, which includes a biopsychosocial assessment, diagnosis by a physician or health service provider in psychology (HSPP) and functional assessment using the Child and Adolescent Needs and Strength (CANS) for children and adolescents or the Adult Needs and Strengths Assessment (ANSA) for adults. Individuals receiving a LON of 0, 1, or 2 are eligible for Clinic Services. Individuals receiving LON 3-6 are eligible for Clinic Option services and the Medicaid Rehabilitation Option (MRO) services identified in the service package for their LON. Crisis Intervention is available for all members who are Medicaid eligible. The Crisis Intervention service is not reflected in the service packages.

For most people receiving MRO services, the service packages, including the amount and duration of services, should match their assigned levels of care. For those few individuals with unusual circumstances, an exceptions process is established. The exceptions process may be used to request a different service or a different level of intensity of a service than what is in the LON service package to which a member is assigned.

Table 22 – Authorized Services Adults

Authorized Services Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
0	No service needs	
1	Clinic Option and Access to Recovery services	
2	Clinic Option	
3	Clinic Option	
	Behavioral Health Level of Need Redetermination	1 Redetermination
	Individual Counseling and Therapy; Individual Family/Couple Counseling with the Member Present; Individual Family/Couple Counseling without the Member Present	32
	Group Counseling and Therapy; Group Family/Couple Counseling and Therapy with the Member Present; Group Family/Couple Counseling and Therapy without the Member Present	48

Authorized Services Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
	Medication Training and Support, Individual; Medication Training and Support, Group; Medication Training and Support, Family/Couple (Individual Setting) without the Member Present; Medication Training and Support, Family/Couple (Group Setting) without the Member Present; Medication Training and Support, Family/Couple (Individual Setting) with the Member Present; Medication Training and Support, Family/Couple (Group Setting) with the Member Present	60
	Skills Training and Development, Individual; Skills Training and Development, Group; Skills Training and Development, Family/Couple (Individual Setting) without the Member Present; Skills Training and Development, Family/Couple (Group Setting) without the Member Present; Skills Training and Development, Family/Couple (Individual Setting) with the Member Present; Skills Training and Development, Family/Couple (Group Setting) with the Member Present	600
	Case Management *Note: See the MRO and BPHC Service Authorization section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.*	200
	Peer Recovery Services	104
	Addiction Counseling, Individual Setting; Addiction Counseling, Group; Addiction Counseling, Family/Couple (Individual Setting) with Member Present; Addiction Counseling, Family/Couple (Individual Setting) without Member Present; Addiction Counseling, Family/Couple (Group Setting) with Member Present; Addiction Counseling, Family/Couple (Group Setting) without Member Present	32 Hours
4	Clinic Option	
	Behavioral Health Level of Need Redetermination	1 Redetermination
	Individual Counseling and Therapy; Individual Family/Couple Counseling with the Member Present; Individual Family/Couple Counseling without the Member Present	48

Authorized Services Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
	Group Counseling and Therapy; Group Family/Couple Counseling and Therapy with the Member Present; Group Family/Couple Counseling and Therapy without the Member Present	60
	Medication Training and Support, Individual; Medication Training and Support, Group; Medication Training and Support, Family/Couple (Individual Setting) without the Member Present; Medication Training and Support, Family/Couple (Group Setting) without the Member Present; Medication Training and Support, Family/Couple (Individual Setting) with the Member Present; Medication Training and Support, Family/Couple (Group Setting) with the Member Present	104
	Skills Training and Development, Individual; Skills Training and Development, Group; Skills Training and Development, Family/Couple (Individual Setting) without the Member Present; Skills Training and Development, Family/Couple (Group Setting) without the Member Present; Skills Training and Development, Family/Couple (Individual Setting) with the Member Present; Skills Training and Development, Family/Couple (Group Setting) with the Member Present	750
	Case Management *Note: See the MRO and BPHC Service Authorization section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.*	300
	Peer Recovery Services	156
	Addiction Counseling, Individual Setting; Addiction Counseling, Group; Addiction Counseling, Family/Couple (Individual Setting) with Member Present; Addiction Counseling, Family/Couple (Individual Setting) without Member Present; Addiction Counseling, Family/Couple (Group Setting) with Member Present; Addiction Counseling, Family/Couple (Group Setting) without Member Present	32 Hours
	Adult Intensive Rehabilitative Services (AIRS)	270 Hours – Limited to 90 Consecutive Days
	Intensive Outpatient Treatment (IOT)	40 3-Hour Sessions

Authorized Services Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
5	Clinic Option	
	Behavioral Health Level of Need Redetermination	1 Redetermination
	Individual Counseling and Therapy; Individual Family/Couple Counseling with the Member Present; Individual Family/Couple Counseling without the Member Present	48
	Group Counseling and Therapy; Group Family/Couple Counseling and Therapy with the Member Present; Group Family/Couple Counseling and Therapy without the Member Present	60
	Medication Training and Support, Individual; Medication Training and Support, Group; Medication Training and Support, Family/Couple (Individual Setting) without the Member Present; Medication Training and Support, Family/Couple (Group Setting) without the Member Present; Medication Training and Support, Family/Couple (Individual Setting) with the Member Present; Medication Training and Support, Family/Couple (Group Setting) with the Member Present	104
	Skills Training and Development, Individual; Skills Training and Development, Group; Skills Training and Development, Family/Couple (Individual Setting) without the Member Present; Skills Training and Development, Family/Couple (Group Setting) without the Member Present; Skills Training and Development, Family/Couple (Individual Setting) with the Member Present; Skills Training and Development, Family/Couple (Group Setting) with the Member Present	900
	Case Management *Note: See the MRO and BPHC Service Authorization section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.*	400
	Peer Recovery Services	208

Authorized Services Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
	Addiction Counseling, Individual Setting; Addiction Counseling, Group; Addiction Counseling, Family/Couple (Individual Setting) with the Member Present; Addiction Counseling, Family/Couple (Individual Setting) without the Member Present; Addiction Counseling, Family/Couple (Group Setting) with the Member Present; Addiction Counseling, Family/Couple (Group Setting) without the Member Present	32 Hours
	Adult Intensive Rehabilitative Services (AIRS)	270 Hours – Limited to 90 Consecutive Days
	Psychiatric Assessment and Intervention (Face-to-Face, Non-Face-to-Face, AHCP, physician)	25
	Intensive Outpatient Treatment (IOT)	40 3-Hour Sessions
5A	Clinic Option	
	Behavioral Health Level of Need Redetermination	1 Redetermination
	Individual Counseling and Therapy; Individual Family/Couple Counseling with the Member Present; Individual Family/Couple Counseling without the Member Present	48
	Group Counseling and Therapy; Group Family/Couple Counseling and Therapy with the Member Present; Group Family/Couple Counseling and Therapy without the Member Present	60
	Medication Training and Support, Individual; Medication Training and Support, Group; Medication Training and Support, Family/Couple (Individual Setting) without the Member Present; Medication Training and Support, Family/Couple (Group Setting) without the Member Present; Medication Training and Support, Family/Couple (Individual Setting) with the Member Present; Medication Training and Support, Family/Couple (Group Setting) with the Member Present	104
	Skills Training and Development, Individual; Skills Training and Development, Group; Skills Training and Development, Family/Couple (Individual Setting) without the Member Present; Skills Training and Development, Family/Couple (Group Setting) without the Member Present; Skills Training and Development, Family/Couple (Individual Setting) with the Member Present; Skills Training and Development, Family/Couple (Group Setting) with the Member Present	1,000

Authorized Services Adults – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
	Case Management *Note: See the MRO and BPHC Service Authorization section, which outlines special unit of service assignment rules when BPHC exists prior to MRO service package assignment.*	500
	Peer Recovery Services	260
	Addiction Counseling (Individual Setting); Addiction Counseling, Family/Couple (Individual Setting) with Member Present; Addiction Counseling, Family/Couple (Individual Setting) without Member Present; Addiction Counseling (Group Setting); Addiction Counseling, Family/Couple (Group Setting) with Member Present; Addiction Counseling, Family/Couple (Group Setting) without Member Present	50 Hours
	Psychiatric Assessment and Intervention (Face-to-Face, Non-Face-to-Face, authorized health care professional [AHCP], physician)	100

Table 23 – Authorized Services Children/Adolescents

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
0	No service needs	
1	Clinic Option	
2	Clinic Option	
	Case Management	100

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
3	Clinic Option	
	Behavioral Health Level of Need Redetermination	1 Redetermination
	Individual Counseling and Therapy; Individual Family/Couple Counseling with the Member Present; Individual Family/Couple Counseling without the Member Present	32
	Group Counseling and Therapy; Group Family/Couple Counseling and Therapy with the Member Present; Group Family/Couple Counseling and Therapy without the Member Present	48
	Medication Training and Support, Individual; Medication Training and Support, Group; Medication Training and Support, Family/Couple (Individual Setting) without the Member Present; Medication Training and Support, Family/Couple (Group Setting) without the Member Present; Medication Training and Support, Family/Couple (Individual Setting) with the Member Present; Medication Training and Support, Family/Couple (Group Setting) with the Member Present	60
	Skills Training and Development, Individual; Skills Training and Development, Group; Skills Training and Development, Family/Couple (Individual Setting) without the Member Present; Skills Training and Development, Family/Couple (Group Setting) without the Member Present; Skills Training and Development, Family/Couple (Individual Setting) with the Member Present; Skills Training and Development, Family/Couple (Group Setting) with the Member Present	600
	Case Management	200
	Addiction Counseling, Individual Setting; Addiction Counseling, Group; Addiction Counseling, Family/Couple (Individual Setting) with the Member Present; Addiction Counseling, Family/Couple (Individual Setting) without the Member Present; Addiction Counseling, Family/Couple (Group Setting) with the Member Present; Addiction Counseling, Family/Couple (Group Setting) without the Member Present	32 Hours

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
4	Clinic Option	
	Behavioral Health Level of Need Redetermination	1 Redetermination
	Individual Counseling and Therapy; Individual Family/Couple Counseling with the Member Present; Individual Family/Couple Counseling without the Member Present	48
	Group Counseling and Therapy; Group Family/Couple Counseling and Therapy with the Member Present; Group Family/Couple Counseling and Therapy without the Member Present	60
	Medication Training and Support, Individual; Medication Training and Support, Group; Medication Training and Support, Family/Couple (Individual Setting) without the Member Present; Medication Training and Support, Family/Couple (Group Setting) without the Member Present; Medication Training and Support, Family/Couple (Individual Setting) with the Member Present; Medication Training and Support, Family/Couple (Group Setting) with the Member Present	104
	Skills Training and Development, Individual; Skills Training and Development, Group; Skills Training and Development, Family/Couple (Individual Setting) without the Member Present; Skills Training and Development, Family/Couple (Group Setting) without the Member Present; Skills Training and Development, Family/Couple (Individual Setting) with the Member Present; Skills Training and Development, Family/Couple (Group Setting) with the Member Present	750
	Case Management	300
	Addiction Counseling, Individual Setting; Addiction Counseling, Group; Addiction Counseling, Family/Couple (Individual Setting) with the Member Present; Addiction Counseling, Family/Couple (Individual Setting) without the Member Present; Addiction Counseling, Family/Couple (Group Setting) with the Member Present; Addiction Counseling, Family/Couple (Group Setting) without the Member Present	32 Hours
	Child and Adolescent Intensive Rehabilitative Services (CAIRS) – Ages 5-18	252 Hours – Limited to 90 Consecutive Days
	Intensive Outpatient Treatment (IOT)	40 3-Hour Sessions

Authorized Services Children/Adolescents – Subject to modification based on fiscal review Per 180-day period Unit = 15-minute increment, unless otherwise noted		
Level of Need	**Service**	**Units**
5 and 6	Clinic Option	
	Behavioral Health Level of Need Redetermination	1 Redetermination
	Individual Counseling and Therapy; Individual Family/Couple Counseling with the Member Present; Individual Family/Couple Counseling without the Member Present	48
	Group Counseling and Therapy; Group Family/Couple Counseling and Therapy with the Member Present; Group Family/Couple Counseling and Therapy without the Member Present	60
	Medication Training and Support, Individual; Medication Training and Support, Group; Medication Training and Support, Family/Couple (Individual Setting) without the Member Present; Medication Training and Support, Family/Couple (Group Setting) without the Member Present; Medication Training and Support, Family/Couple (Individual Setting) with the Member Present; Medication Training and Support, Family/Couple (Group Setting) with the Member Present	104
	Skills Training and Development, Individual; Skills Training and Development, Group; Skills Training and Development, Family/Couple (Individual Setting) without the Member Present; Skills Training and Development, Family/Couple (Group Setting) without the Member Present; Skills Training and Development, Family/Couple (Individual Setting) with the Member Present; Skills Training and Development, Family/Couple (Group Setting) with the Member Present	900
	Case Management	400
	Addiction Counseling, Individual Setting; Addiction Counseling, Group; Addiction Counseling, Family/Couple (Individual Setting) with the Member Present; Addiction Counseling, Family/Couple (Individual Setting) without the Member Present; Addiction Counseling, Family/Couple (Group Setting) with the Member Present; Addiction Counseling, Family/Couple (Group Setting) without the Member Present	32 Hours
	Child and Adolescent Intensive Rehabilitative Services (CAIRS) – Ages 5-18	252 Hours – Limited to 90 Consecutive Days
	Intensive Outpatient Treatment (IOT)	40 3-Hour Sessions

Appendix B: MRO Acronyms

ACT – Assertive Community Treatment

AMHH – Adult Mental Health Habilitation

AHCP – authorized health care professional

AIM – Advanced Information System

AIRS – Adult Intensive Rehabilitation Services

ANSA – Adult Needs and Strengths Assessment

BA – Bachelor of Arts

BPHC – Behavioral and Primary Healthcare Coordination

BS – Bachelor of Science

CAIRS – Child and Adolescent Intensive Resiliency Services

CANS – Child and Adolescent Needs and Strength

CMHC – community mental health center

CMS – Centers for Medicare & Medicaid Services

CRS – certified recovery specialist

DARMHA – Data Assessment Registry for Mental Health and Addiction Medication

DMHA – Division of Mental Health and Addiction

DOB – date of birth

DOS – date of service

DSM – Diagnostic and Statistical Manual of Mental Disorders

FFS – fee-for-service

FSSA – Family and Social Services Administration

HAP – Hoosier Assurance Plan

HCPCS – Healthcare Common Procedure Coding System

HIP – Healthy Indiana Plan

HIPAA – Health Insurance Portability and Accountability Act

HSPP – health service provider in psychology

IAC – Indiana Administrative Code

IC – Indiana Code

ICD – International Classification of Diseases

IHCP – Indiana Health Coverage Programs

IICP – Individualized Integrated Care Plan

IOT – Intensive Outpatient Treatment

LAC – licensed addiction counselor

LCAC – licensed clinical addiction counselor

LCSW – licensed clinical social worker

LMFT – licensed marriage and family therapist

LMHC – licensed mental health counselor

LON – level of need

LPN – licensed practical nurse

MA – medical assistant

MMIS – Medicaid Management Information System

MRO – Medicaid Rehabilitation Option

NOS – not otherwise specified

NPI – National Provider Identifier

OBHP – other behavioral health professional

OMPP – Office of Medicaid Policy and Planning

PA – prior authorization

PRTF – psychiatric residential treatment facility

QBHP – qualified behavioral health professional

RA – Remittance Advice

RID – member identification number or recipient identification number

RN – registered nurse

SOF – state operated facility

SSN – Social Security number

TPL – third-party liability

Appendix C: MRO Definitions

Adult Mental Health Habilitation refers to services defined under *405 IAC 5-21.6*.

Approved DMHA assessment tool refers to a State-designated, member-appropriate instrument for provider assessment of member functional impairment. As of February 2010, the approved Division of Mental Health and Addiction (DMHA) assessment tool is the CANS for children and the ANSA for adults.

Behavioral and Primary Healthcare Coordination refers to services defined under *405 IAC 5-21.8*.

Clinic Option refers to services defined under *405 IAC 5-20-8*.

Detoxification services refer to services defined under *440 IAC 9-2-4*.

Level of need (LON) refers to a recommended intensity of behavioral health services, based on a pattern of a member's and family's needs, as assessed using a standardized assessment instrument. As of February 2010, the assessment instrument used to determine level of need is the Child and Adolescent Needs and Strength (CANS) for children and the Adult Needs and Strengths Assessment (ANSA) for adults.

Licensed professional means any of the following persons:

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

MRO refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his/her practice, for maximum reduction of physical or mental disability and restoration of a member's best possible functional level.

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

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

- An individual with an associate or bachelor degree, and/or equivalent behavioral health experience, meeting minimum competency standards set forth by the behavioral health service provider and supervised by a licensed professional, as defined previously, or qualified behavioral health professional (QBHP), as defined in the following paragraphs
- A licensed addiction counselor (LAC), as defined under *IC 25-23.6-10.5*, supervised by a licensed professional, as defined previously, or QBHP, as defined in the following paragraphs

Professional caregiver refers to an individual who receives payment for providing services to a Medicaid member

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

- 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 defined previously, such experience occurring after the completion of a master's degree or doctoral degree, in any of the following disciplines:
  - Psychiatric or mental health nursing from an accredited university, plus a license as an RN in Indiana
  - Pastoral counseling from an accredited university
  - Rehabilitation counseling from an accredited university
- An individual who is under the supervision of a licensed professional, as defined previously, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
  - Social work from a university accredited by the Council on Social Work Education
  - Psychology from an accredited university
  - Mental health counseling from an accredited university
  - Marital and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional, as defined previously
- An AHCP, defined as follows:
  - 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 a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to *IC 25-23-1*.

Rehabilitative refers to the federal definition of rehabilitative, as defined under *42 CFR 440.130(d).*