



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Mental Health and Addiction Services

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1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Semiannual update <ul style="list-style-type: none"> • Added information per 405 IAC 5-20-1 as an introductory statement • Updated the Managed Care Considerations for Behavioral Health Services section • Changed references to ADVANTAGE Health Services to Cooperative Managed Care Services (CMCS) • Removed reference to codes for Package C in the Mental Health Coverage for the Children's Health Insurance Program section • Added the Primary Care Services in Community Mental Health Centers section • Updated the Additional Service Limitations section • Added the Applied Behavioral Analysis Therapy section • Updated the Billing Procedures section • Updated the Outpatient Mental Health Hospital Services section • Removed the <i>Managed Care Considerations for Outpatient Mental Health Services</i> section • Updated the Reimbursement Requirements for Inpatient Mental Health Services section • Updated the Prior Authorization for Inpatient Mental Health Services section • Updated the Program Standards section • Updated the Exclusions section • Reorganized text for better flow and made general edits 	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
1.2	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: April 18, 2017	<ul style="list-style-type: none"> • Added Provider Healthcare Portal information to the billing and PA request instructions • Clarified that mid-level practitioners must bill using only the single most appropriate modifier from the list in the Billing Procedures section • Updated the Outpatient Mental Health Hospital Services section • Updated the Eligible Providers and Practitioners section directing smoking cessation providers to the <i>Provider Enrollment</i> module for enrollment information • Removed ICD-9 code 	FSSA and HPE

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Section 1: Introduction

Note: For policy information regarding coverage of mental health and addiction services, see the [Medical Policy Manual](#) at indianamedicaid.com.

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

IHCP reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, general hospitals, psychiatric residential treatment facilities (PRTFs) for children under 21 years of age, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology (HSPPs), subject to the limitations set out in *Indiana Administrative Code 405 IAC 5-20-1*.

Managed Care Considerations for Behavioral Health Services

Members enrolled with a managed care entity (MCE) in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise programs can access behavioral health services on a self-referral basis from any IHCP-enrolled provider qualified to render the service.

Most behavioral health services are carved into IHCP managed care programs. Other than services that are specifically carved out the managed care program, services rendered by providers enrolled in the IHCP with the following provider specialties are the responsibility of the member's MCE:

- 011 – *Freestanding Psychiatric Hospital*
- 110 – *Outpatient Mental Health Clinic*
- 111 – *Community Mental Health Center*
- 112 – *Psychologist*
- 113 – *Certified Psychologist*
- 114 – *Health Service Provider in Psychology*
- 116 – *Certified Social Worker*
- 117 – *Psychiatric Nurse*
- 339 – *Psychiatrist*

Behavioral health services (other than carved-out services) rendered by the mental health provider specialties in the preceding list should be billed directly to the applicable behavioral health organization (BHO) subcontracted by the MCE. Behavioral health services (other than carved-out services) rendered by non-mental-health provider specialties should be billed to the applicable MCE.

The following mental health services remain carved out of the managed care programs and are paid according to the fee-for-service methodology:

- **PRTF services** rendered by a provider enrolled in the IHCP with a specialty of 034
 - Members in Hoosier Healthwise are disenrolled from managed care and moved to fee-for-service while receiving services in the PRTF. Hoosier Care Connect members who are admitted to a PRTF have their managed care enrollment suspended and receive fee-for-service coverage during their PRTF stay. To facilitate appropriate claims payment, a level of care is established for members receiving PRTF services. PRTF providers need to contact Cooperative Managed Care

Services (CMCS) at 1-800-269-5720 when a managed care member is going to be admitted, so that CMCS can assign a level of care. After the level of care is assigned, the member will be disenrolled from the managed care program.

- When the member is discharged from the PRTF, he or she is reenrolled immediately into the most applicable IHCP program.
- **Medicaid Rehabilitation Option (MRO) services** rendered to individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness (See the [Medicaid Rehabilitation Option Services](#) module for more information about MRO services.)
- **1915(i) home and community-based services**, including Adult Mental Health and Habilitation (AMHH) services, Behavioral and Primary Healthcare Coordination (BPHC) services, and Child Mental Health Wraparound (CMHW) services (For more information about these services, see the following modules: [Division of Mental Health and Addiction Adult Mental Health Habilitation Services](#), [Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services](#), and [Division of Mental Health and Addiction Child Mental Health Wraparound Services](#).)

Claims for PRTF, MRO, and 1915(i) services are processed by Hewlett Packard Enterprise, with the exception of claims for mental health medications billed by a pharmacy, which are processed by the State's pharmacy benefit manager, OptumRx.

The following services remain excluded from managed care programs, and members are disenrolled from managed care when they qualify for such services:

- Services in a nursing facility or an intermediate care facility for individuals with intellectual disability (ICF/IID) (See the [Long-Term Care](#) module for information on short-term stays that are covered by MCEs.)
- Inpatient services in a state psychiatric hospital that are not Medicaid services, but are provided under the State's 590 program
- Services provided through a Home and Community-Based Services (HCBS) waiver

Note: Services requiring PA, when furnished to members enrolled in a managed care program, must be prior-authorized by the MCE in accordance with the MCE guidelines. For more information, see the [Healthy Indiana Plan](#), [Hoosier Care Connect](#), and [Hoosier Healthwise](#) pages at indianamedicaid.com.

Mental Health Coverage for the Children's Health Insurance Program

The IHCP reimburses for mental health services, including PRTF and MRO services, under the Children's Health Insurance Program (CHIP) Package C. Providers can check the [Fee Schedule](#) at indianamedicaid.com to see whether PA is required.

The IHCP covers inpatient mental health and substance abuse services for Package C members when the services are medically necessary for the diagnosis or treatment of the member's condition, except when provided in a mental health institution with more than 16 beds.

The IHCP reimburses for 30 visits per member, per rolling calendar year for Package C members. The IHCP may cover an additional 20 visits with PA for a maximum of 50 visits per year.

Primary Care Services in Community Mental Health Centers

Effective January 1, 2016, the IHCP allows community mental health centers (CMHCs) to provide primary care services to IHCP members in accordance with *Indiana Code IC 12-15-11-8*. These services must be provided by IHCP-enrolled providers authorized to provide primary healthcare within their scope of practice and must be billed in accordance with IHCP guidelines.

CMHC physician specialties and advanced practice nurse (APN) practitioners, as specified in current policy, can serve as primary medical providers (PMPs) and maintain primary care panels for the MCE with which they are enrolled.

Primary care services and behavioral health services may be reimbursed for the same date of service when the services are rendered by the appropriate provider and the visits are for distinct purposes. The IHCP applies National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits, as required by the Centers for Medicare & Medicaid Services (CMS). PTP edits are applied to pairs of services delivered by the same provider to the same member on the same date of service, regardless of whether the services are billed on the same or separate claims.

Section 2: Outpatient Mental Health Services

As stated in *Indiana Administrative Code 405 IAC 5-20-8*, the Indiana Health Coverage Programs (IHCP) allows direct reimbursement for outpatient mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as a health service provider in psychology (HSPP).

The IHCP requires prior authorization (PA) for mental health services provided in an outpatient or office setting that exceed 20 units per member, per provider, per rolling 12-month period. Providers must attach a current plan of treatment and progress notes explaining the necessity and effectiveness of therapy to the PA form, and available for audit purposes, according to *405 IAC 5-20-13*.

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

For information about outpatient mental health services provided in a comprehensive outpatient rehabilitation facility (CORF), see the [Therapy Services](#) module.

Physician- or HSPP-Directed Outpatient Mental Health Services

Outpatient mental health services rendered by, or under supervision of, a physician or an HSPP are subject to the limitations in *405 IAC 5-25* and to the requirements outlined in this section.

Mid-Level Practitioner Requirements

Subject to PA by the Family and Social Services Administration (FSSA) or its designee, the IHCP reimburses physician- or HSPP-directed outpatient mental health services for group, family, and individual psychotherapy when services are provided by one of the following mid-level practitioners:

- A licensed psychologist
- A licensed independent practice school psychologist
- A licensed clinical social worker (LCSW)
- A licensed marriage and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A person holding a master's degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse (APN) who is a licensed, registered nurse holding a master's degree in nursing, with a major in psychiatric or mental health nursing, from an accredited school of nursing

These mid-level practitioners may not be separately enrolled as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or HSPP enrolled in the IHCP. The IHCP reimburses for covered services rendered. The employer or supervising psychiatrist bills for the services.

The IHCP reimburses for services provided by mid-level practitioners in an outpatient mental health facility when an HSPP supervises services. Mid-level practitioners who render services must bill using the rendering National Provider Identifier (NPI) of the supervising practitioner and the billing NPI of the outpatient mental health clinic or facility.

The physician or HSPP is responsible for certifying the diagnosis and supervising the plan of treatment, as stated in 405 IAC 5-20-8(3). The physician or HSPP must be available for emergencies and must see the patient or review the information obtained by the mid-level practitioner within seven days of the intake process. During the course of treatment, the physician or HSPP must see the patient again or review the documentation to certify the treatment plan and specific treatment modalities at intervals not to exceed 90 days. All reviews must be documented in writing; a cosignature is not sufficient.

The IHCP requires written evidence of physician or HSPP involvement and personal evaluation to document the member's acute medical needs. If practicing independently, a physician or an HSPP must order therapy in writing.

Neuropsychology and Psychological Testing

The IHCP requires PA for all units of neuropsychology and psychological testing.

In addition to requiring PA, neuropsychology and psychological testing corresponding to the following Current Procedural Terminology (CPT^{®1}) codes must be provided by a physician or HSPP:

- 96101 – *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report*
- 96110 – *Developmental screening, with interpretation and report, per standardized instrument form*
- 96111 – *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report*
- 96118 – *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report*

The IHCP provides reimbursement, with prior authorization, for the following psychological and neuropsychological testing CPT codes when rendered by a mid-level practitioner under the direct supervision of a physician or HSPP, as outlined in 405 IAC 5-20-8:

- 96102 – *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg MMPI, and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face*
- 96119 – *Neuropsychological testing (eg Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales, CNS Vital Signs and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face*

The IHCP does not reimburse CPT code 96101 when billed for the same test or services performed under psychological testing code 96102. Similarly, CPT code 96118 is not reimbursed when billed for the same test or services performed under neuropsychological testing code 96119.

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Note: When requesting PA, the provider must have a list of the tests or services to differentiate procedure code 96101 from 96102, and also procedure code 96118 from 96119.

Psychiatric Diagnostic Interview Examinations

According to 405 IAC 5-20-8 (14), reimbursement is available without prior authorization for one unit of psychiatric diagnostic interview examinations, CPT code 90791 or 90792, per member, per provider, per rolling 12-month period. All additional units of psychiatric diagnostic interviews require prior authorization; with the exception that two units are allowed every rolling 12-month period when the member is separately evaluated by **both** the physician or HSPP **and** a mid-level practitioner (one unit must be provided by the physician or HSPP and one unit must be provided by the mid-level practitioner).

Additional Service Limitations

The following Healthcare Common Procedure Coding System (HCPCS) codes *in combination* are subject to 20 units per member, per provider, per rolling 12-month period:

- 90832–90834
- 90836–90840
- 90845–90853
- 90899
- 96151–96155

Effective March 2, 2016, the IHCP added a unit restriction of eight units per date of service to procedure codes 96150 through 96155. This change applies to all IHCP programs, subject to limitations established for certain benefit packages.

The IHCP does not cover the following services:

- Biofeedback
- Broken or missed appointments
- Day care or partial day care
- Hypnosis
- Hypnotherapy
- Experimental drugs, treatments, and procedures, and all related services
- Acupuncture
- Hyperthermia
- Cognitive rehabilitation, except for treatment of traumatic brain injury (TBI)
- Partial hospitalization, except as set forth in 405 IAC 5-21.5 (See [Section 5: Acute Partial Hospitalization](#) for more information.)

CPT codes 90833, 90836, and 90838 for psychotherapy with medical evaluation and management are medical services. Therefore, the IHCP does not reimburse clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) for these codes.

Applied Behavioral Analysis Therapy

Effective February 6, 2016, the IHCP provides coverage for applied behavioral analysis (ABA) therapy for the treatment of autism spectrum disorder (ASD) for members 20 years of age and younger. ABA therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

ABA therapy is covered for eligible members when it is medically necessary for the treatment of ASD. ABA therapy services require PA, subject to the criteria outlined in *405 IAC 5-3*. PA requests must include, at a minimum, the following:

- Individual's treatment plan and supporting documentation
- Number of therapy hours being requested and supporting documentation
- Other documentation as requested to support medical necessity

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

PA for the initial course of therapy may be approved for up to six months. To continue providing ABA therapy beyond the initial authorized time frame, providers must submit a new PA request and receive approval. Generally, ABA therapy is limited to a period of 3 years and should not exceed 40 hours per week. Services beyond these limitations may be approved with PA when the services are medically necessary.

The IHCP provides reimbursement when the services are specified as direct ABA services and are provided by a qualified service provider. For purposes of the initial diagnosis and comprehensive diagnostic evaluation, a qualified provider includes any of the following:

- Licensed physician
- Licensed HSPP
- Licensed pediatrician
- Licensed psychiatrist
- Other behavioral health specialist with training and experience in the diagnosis and treatment of ASD

ABA therapy services must be delivered by an appropriate provider. For the purposes of ABA therapy, appropriate providers include:

- HSPP
- Licensed or board-certified behavior analyst, including bachelor-level (BCaBA), master-level (BCBA), and doctoral-level (BCBA-D) behavior analysts
- Credentialed registered behavior technician (RBT)

Services performed by a BCaBA or RBT must be under the direct supervision of a BCBA, BCBA-D, or an HSPP. Services performed by RBTs under the supervision of a BCBA, BCBA-D, or HSPP will be reimbursed at 75% of the rate on file. ABA services rendered by a BCBA-D, BCBA, BCaBA, or RBT must be billed under the NPI of an IHCP-enrolled physician or HSPP, because behavior analysts are not currently enrolled independently.

Providers must bill one of the procedure codes listed in the *Procedure Codes for Applied Behavioral Analysis Therapy* table in *Mental Health and Addiction Services Codes* on the [Code Sets](#) page at indianamedicaid.com. Providers must bill the procedure codes with a U1, U2, or U3 modifier to indicate that services are for ABA therapy, as well as to specify the educational level of the rendering provider.

Billing Procedures

For all outpatient services, providers must identify and itemize services rendered on the professional claim (CMS-1500 claim form, Provider Healthcare Portal (Portal) professional claim, or the 837P electronic transaction). The medical record documentation must identify the services and the length of time of each therapy session. Providers must make this information available for audit purposes.

Providers should use the rendering NPI of the supervising practitioner (physician or HSPP) to bill psychiatric and clinical nurse specialist services. However, when an APN provides services to a member who is on the APN's primary care panel, the APN must bill using his or her own NPI, not that of the supervising practitioner.

Mid-level practitioners must bill procedure codes using the most suitable modifier from the following list:

- AH – Services provided by a clinical psychologist
- AJ – Services provided by a clinical social worker
- HE in conjunction with SA – Services provided by a nurse practitioner or clinical nurse specialist
- HE – Services provided by any other mid-level practitioner as addressed in the *405 IAC 5-20-8 (10)*
- HW – Funded by State mental health agency (Medicaid Rehabilitation Option [MRO] services)
- SA – Nurse practitioner or clinical nurse specialist in a non-mental-health arena

For claims that providers bill for mid-level practitioner services and bill with the modifiers noted – except modifiers SA and HW, which are informational and do not affect reimbursement – the IHCP reimburses at 75% of the IHCP-allowed amount for the procedure code identified. No modifier is needed for HSPPs; the IHCP reimburses HSPPs at 100% of the resource-based relative value scale (RBRVS) fee.

Community mental health centers (CMHCs) must continue to use the HW modifier to denote MRO services in addition to the modifiers listed previously that identify the qualifications of the individual rendering the service. Further, there are specific modifiers needed for submission of MRO claims. For information regarding MRO services, see the [Medicaid Rehabilitation Option Services](#) module.

When billing for home and community-based services provided through the Adult Mental Health and Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW) programs, providers must bill with UB, UC, and HA modifiers, respectively. For more information, see the following modules: [Division of Mental Health and Addiction Adult Mental Health Habilitation Services](#), [Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services](#), and [Division of Mental Health and Addiction Child Mental Health Wraparound Services](#).

Outpatient Mental Health Hospital Services

As required by the *House Enrolled Act (HEA) 1396*, the *Covered Services Rule*, *405 IAC 5-20*, providers cannot use revenue codes 500, 510, 90X, 91X, and 96X to bill covered outpatient mental health hospital services. Hospitals can bill for the facility use associated with these services by billing the appropriate clinic or treatment room revenue code using the institutional claim type (*UB-04* claim form, Portal institutional claim, or 837I electronic transaction).

Providers are required to use revenue code 513 – *Clinic/Psychiatric* when billing for individual, group, or family counseling procedure codes listed in the *Procedure Codes Linked to Revenue Code 513 – Clinic/Psychiatric* table of *Revenue Codes Linked to Specific Procedure Codes* on the [Code Sets](#) page at indianamedicaid.com:

- If a procedure code not listed on this table is billed with revenue code 513, the claim detail will be denied for explanation of benefits (EOB) 520 – *Invalid revenue code/procedure code combination*.
- If the claim detail is billed with revenue code 513 and no corresponding procedure code is present on the claim, the detail will be denied for EOB 389 – *The revenue code submitted requires a corresponding HCPCS code*.
- The IHCP reimburses providers for up to two individual sessions and one group session on the same date of service. The second individual session must be billed with an appropriate modifier to indicate that the service was separate and distinct from the first individual session. As a general reminder, modifiers should be used on outpatient claims as appropriate; however, for institutional claims, modifiers are used not to affect pricing, but to identify the level of service rendered.

For family and group therapy codes, the IHCP reimburses the lesser of the billed amount or a statewide flat fee of \$20.40, per member, per session. Individual therapy codes are reimbursed at the lesser of the billed amount or a statewide flat fee of \$40.80, per member, per session.

Note: For outpatient mental health services, providers should bill one unit per encounter/session/date of service.

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

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

Section 3: Inpatient Mental Health Services

The Indiana Health Coverage Programs (IHCP) reimburses providers for inpatient psychiatric services provided to eligible individuals between 22 and 65 years old only in a certified psychiatric hospital of 16 beds or less. If the member is 22 years old and began receiving inpatient psychiatric services immediately before his or her 22nd birthday, inpatient psychiatric services will continue to be covered.

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

Reimbursement Requirements for Inpatient Mental Health Services

According to *Indiana Administrative Code 405 IAC 5-20-3*, a psychiatric hospital must meet the following conditions to be reimbursed for inpatient mental health services:

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

The IHCP also reimburses providers for reserving beds in a psychiatric hospital (but not in a general acute care hospital) for hospitalization of Traditional Medicaid members, as well as for reserving beds for a therapeutic leave of absence. In both instances, the IHCP reimburses the facility at one-half the regular *per diem* rate. *405 IAC 5-20-2* provides specific criteria about the reservation of beds in an inpatient psychiatric facility.

The IHCP reimburses for inpatient psychiatric services provided by facilities that are freestanding or distinct parts at an all-inclusive, statewide *per diem* rate that includes routine, ancillary, and capital costs, with the following exceptions:

- The IHCP bases reimbursement for substance abuse and chemical dependency admissions on diagnosis-related group (DRG) payment methodology.
- Direct care services of physicians, including psychiatric evaluations, are excluded from the *per diem* rate and are billable separately by the rendering provider on the professional claim (*CMS-1500* claim form or electronic equivalent).
- For dates of service on or after October 1, 2015, evaluation and management (E/M) rounding performed by a nurse practitioner (NP) or clinical nurse specialist (CNS) in the inpatient mental health setting is also reimbursed separately from the *per diem* rate paid to the facility. (CRNAs are excluded from this reimbursement policy change.) E/M rounding includes initial, subsequent, and discharge-day management. Rounding services provided by an NP or CNS in the inpatient mental health setting on or after October 1, 2015, should be billed separately on the professional claim. These services can be

billed under the National Provider Identifier (NPI) of the NP or CNS (if available), or under the physician's NPI with the addition of the SA modifier. Services performed by an NP or CNS, regardless of billing method, are reimbursed at 100% of the billed charges or the IHCP allowed amount, whichever is less.

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

In some cases, a member's coverage can change during an inpatient psychiatric stay from one plan to another; for example, from FFS coverage to a managed care plan, or from one MCE to another MCE. The reimbursement in such cases depends on whether the reimbursement for the stay is based on a DRG or level-of-care (LOC) methodology. If the reimbursement is based on a DRG methodology, the plan that was in effect on the day of admission is responsible for the entire stay. If the reimbursement is based on an LOC methodology, each plan is responsible for the days of the stay covered by that plan.

Prior Authorization for Inpatient Mental Health Services

The IHCP requires prior authorization (PA) for all psychiatric, rehabilitation, and substance abuse inpatient stays. The IHCP does not reimburse providers for days that are not approved for PA. The facility is responsible for initiating the PA review process. If the provider fails to complete a telephone PA precertification, reimbursement will be denied from the admission to the actual date of notification.

All mental health service admissions, including admissions for substance abuse and chemical dependency, regardless of the setting, require a *Certification of the Need for Inpatient Psychiatric Hospital Services (State Form 44697 [R4/5-15]/OMPP 1261A)*, referred to as the *1261A* form. For nonemergency admissions, the IHCP must receive the *1261A* form within 10 working days of the admission. For emergency admissions, the IHCP must receive the *1261A* form within 14 working days of the admission. The *1261A* form must include detailed information to document the admission. If the *1261A* form does not meet the requirements, any claim associated with the admission is denied. Providers must submit inpatient psychiatric claims using the revenue code that has been authorized for the admission.

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

PA for inpatient detoxification, rehabilitation, and aftercare for chemical dependency must include consideration of the following information:

- Review on a case-by-case basis by the appropriate PA department based on the program assignment of the member
- Treatment, evaluation, and detoxification based on the stated medical condition
- Need for safe withdrawal from alcohol or other drugs
- History of recent convulsions or poorly controlled convulsive disorder
- Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting

Admission to a general hospital floor is not indicated unless the medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.

Tables 1 and 2 include guidelines for inpatient psychiatric admissions to acute care hospital psychiatric units and to freestanding psychiatric hospitals. Specific PA criteria for inpatient psychiatric services are found in *405 IAC 5-20*.

Table 1 – Inpatient Psychiatric Admission PA Policy Parameters, Distinct Part Inpatient Psychiatric Services in Acute Care Hospitals

Category	Requirements
Telephone Precertification Reviews and 1261A Form	<p>Emergency and nonemergency admissions to psychiatric units of acute care hospitals require telephone precertification and concurrent review. The facility is responsible for initiating both with the appropriate PA department based on the program assignment of the member for each admission.</p> <p>The precertification review must be followed by a written certification of need (1261A form) within 10 days of a nonemergency admission and within 14 working days of an emergency admission.</p>
Certification of Need Requirements	<p>Reimbursement is available for inpatient care provided in the psychiatric units of acute care hospitals only when the need for admission has been certified. The certification of need must be completed by the attending physician or staff physician, as follows:</p> <ul style="list-style-type: none"> • By telephone precertification review before admission for an IHCP member admitted to the facility as a nonemergency admission, to be followed by a written certification of need within 10 business days of admission • By telephone precertification review within 48 hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within 14 working days of admission. If the provider fails to call within 48 hours of emergency admission, not including Saturdays, Sundays, and legal holidays, reimbursement is denied for the period from admission to the actual date of notification. (Denial of the certification of need may be appealed as outlined in <i>Prior Authorization Administrative Review and Appeal Procedures</i> section of the Prior Authorization module.) • In writing within 10 business days of receiving notification of an eligibility determination for individuals applying for the IHCP while in the facility and covering the entire period for which reimbursement is being sought • Concurrently – or as requested by the Family and Social Services Administration (FSSA) or the appropriate PA department based on the program assignment of the member – to recertify that the patient continues to require inpatient psychiatric hospital services
Basis for Reimbursement	<p>Reimbursement is denied for any days during the inpatient psychiatric hospitalization that are found to be not medically necessary. Telephone precertifications of medical necessity provide a basis for reimbursement only if adequately supported by the written certification of need submitted in accordance with the previously listed requirements. If the required written documentation is not submitted within the specified time frame, reimbursement is denied.</p>
Form Requests	<p>The <i>Certification of the Need for Inpatient Psychiatric Hospital Services (State Form 44697 [R4/5-15]/OMPP 1261A)</i> fulfills the requirements for written certification of need. The form is available for download from the Forms page at indianamedicaid.com.</p>

Table 2 – Inpatient Psychiatric Admission PA Policy Parameters, Inpatient Psychiatric Services in Freestanding Psychiatric Hospitals

Category	Requirements
State-Operated Facilities – 1261A Form	State-operated facilities submit the 1261A form to the IHCP office. The IHCP agency reviews the written certification of need for each member and determines whether inpatient psychiatric care is warranted, and what length of stay is justified given the patient’s medical needs. Reimbursement is denied for any days for which the facility cannot justify a member’s need for inpatient psychiatric care.
Private Facilities – Telephone Precertification Reviews and 1261A Form	Emergency and nonemergency admissions to private freestanding psychiatric hospitals require telephone precertification review. The facilities must initiate the review with CMCS for each admission. This precertification review must be followed by a written certification of need within 10 business days of a nonemergency admission and within 14 working days of an emergency admission. The 1261A form currently completed by freestanding psychiatric hospitals to certify the need for admission fulfills the requirements for written certification. Private freestanding psychiatric hospitals are required to submit the 1261A form to the PA contractor, rather than to the IHCP State office. The PA department reviews the written certification of need for each member and determines whether inpatient psychiatric care is warranted and what length of stay is justified given the member’s medical needs. Reimbursement is denied for any days for which the facility cannot justify the need for inpatient psychiatric care.
Certification of Need Requirements	<p>Pursuant to 42 CFR Sec. 456.171, reimbursement is available for services in a freestanding inpatient psychiatric facility only when CMCS has authorized each admission. The certification of need must be completed as follows:</p> <ul style="list-style-type: none"> • By the attending physician or staff physician for members between 22 and 65 years old in a psychiatric hospital of 16 beds or less, and for members 65 years old and older • In accordance with 42 CFR Sec. 441.152(a) and 441.153 for members 21 years old and younger • By telephone precertification review before admission for IHCP members admitted to the facility as a nonemergency admission, to be followed by a written certification of need within 10 business days of admission • By telephone precertification review within 48 hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within 14 working days of admission <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p><i>Note: If the provider fails to call within 48 hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, reimbursement is denied for the period from admission to the actual date of notification. (Denial of the certification of need may be appealed as outlined in the Prior Authorization Administrative Review and Appeal Procedures section of the Prior Authorization module.)</i></p> </div> <ul style="list-style-type: none"> • In writing within 10 business days after receiving notification of an eligibility determination for individuals applying for the IHCP while in the facility and covering the entire period for which reimbursement is being sought • In writing at least every 60 days after admission – or as requested by the FSSA or the appropriate PA department based on the program assignment of the member – to recertify that the member continues to require inpatient psychiatric hospital services

Category	Requirements
Basis for Reimbursement	Reimbursement is denied for any days during which the inpatient psychiatric hospitalization is deemed not medically necessary. Telephone precertification of medical necessity provides a basis for reimbursement only if adequately supported by the written certification of need submitted in accordance with the requirements listed previously. If the required written documentation is not submitted within the specified time frame, reimbursement is denied.
Form Requests	The <i>State Form 44697 (R4/5-15)/OMPP 1261A, Certification of the Need for Inpatient Psychiatric Hospital Services</i> fulfills the written certification of need requirements. The form is available for download from the Forms page at indianamedicaid.com.

Section 4: Bridge Appointments

Bridge appointments are follow-up appointments after inpatient hospitalization for behavioral health issues, when no outpatient appointment is available within seven days of discharge. The goal of the bridge appointment is to provide proper discharge planning while establishing a connection between the member and the outpatient treatment provider. During the bridge appointment, the provider should ensure, at minimum, that:

- The member understands the medication treatment regimen as prescribed.
- The member has ongoing outpatient care.
- The family understands the discharge instructions for the member.
- Barriers to continuing care are addressed.
- Any additional questions from the member or family are answered.

Reimbursement Requirements for Bridge Appointments

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

- Appointments must be conducted face-to-face in an outpatient setting on the day of discharge from an inpatient setting.
- Appointments must be a minimum of 15 minutes long.
- The member must have one or more identified barriers to continuing care, such as:
 - Special needs
 - Divorce or custody issues
 - Work conflicts
 - Childcare problems
 - Inability to schedule within seven days
 - History of noncompliance
 - Complex discharge plans
- The member must have one of the International Classification of Diseases (ICD) diagnosis codes listed on the *Diagnosis Codes for Bridge Appointments* tables in *Mental Health and Addiction Services Codes* on the [Code Sets](#) page at indianamedicaid.com. Bridge appointments may be appropriate for members with psychiatric diagnoses not listed; however, documentation must be maintained in the member's chart, indicating the reason the bridge appointment service was necessary.
- The bridge appointment must be conducted by a qualified mental health provider, defined as:
 - A licensed psychologist
 - A licensed independent practice school psychologist
 - A licensed clinical social worker (LCSW)
 - A licensed marriage and family therapist (LMFT)
 - A licensed mental health counselor (LMHC)
 - A person holding a master's degree in social work, marital and family therapy, or mental health counseling
 - An advanced practice nurse (APN) who is a licensed, registered nurse holding a master's degree in nursing, with a major in psychiatric or mental health nursing from an accredited school of nursing

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

Bridge Appointment Billing

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

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

Section 5: Acute Partial Hospitalization

Partial hospitalization programs are highly intensive, time-limited medical services intended to provide a transition from inpatient psychiatric hospitalization to community-based care or, in some cases, substitute for an inpatient admission. The program is highly individualized, with treatment goals that are measurable, functional, time framed, medically necessary, and directly related to the reason for admission.

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

To qualify for partial hospitalization services, Indiana Health Coverage Programs (IHCP) members must have a diagnosed or suspected mental health illness and one of the following:

- Short-term deficit in daily functioning
- High probability of serious deterioration of the patient's general medical or mental health

Services for partial hospitalization on and after September 1, 2013, must be billed using H0035 – *Mental health, partial hospitalization, treatment, less than 24 hours*.

Target Population for Partial Hospitalization

The target population for partial hospitalization is members with psychiatric disturbances that meet the criteria for acute inpatient admission, but who can maintain safety in a reliable, independent housing situation. Partial hospitalization is not covered for persons currently residing in group homes or other residential care settings.

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

Program Standards

Partial hospitalization has the following program standards:

- Services must be ordered and authorized by a psychiatrist.
- Services require prior authorization, pursuant to *Indiana Administrative Code 405 IAC 5-3-13(a)*.
- A face-to-face evaluation and assignment of mental illness diagnosis must take place within 24 hours following admission to the program.
- A psychiatrist must actively participate in the case review and monitoring of care.
- Documentation of active oversight and monitoring of progress by the physician, psychiatrist, or HSPP must appear in the patient's clinical record.
- At least one individual psychotherapy service or group psychotherapy service must be delivered daily.
- For members under 18 years old, documentation of active psychotherapy must appear in the patient's clinical record.
- For members under 18 years of age, a minimum of one family encounter per five business days of episode of care is required.

- Partial hospitalization programs must include *four to six hours* of active treatment per day and must be provided at least *four days a week*.
 - If less than four to six hours (or four days per week) of active treatment is to be provided, the individual services provided (for example, therapy) must be billed instead of partial hospitalization.
- The program must not mix patients in partial hospitalization with consumers receiving outpatient behavioral health services.
- Some overlap with activities and services with psychiatric inpatients may be acceptable if the services are provided in the least restrictive setting and not in a locked unit.
- The treatment team must include licensed mental health providers with direct supervisory oversight by a physician, psychiatrist, or health service provider in psychology (HSPP).

Note: Partial hospitalization is not a Medicaid Rehabilitation Option (MRO) service.

Treatment Plan

The individual treatment plan must identify the following:

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

The treatment plan must receive regular review by the physician, psychiatrist, or HSPP.

Exclusions

The following are excluded from partial hospitalization service:

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

Authorization Process for Partial Hospitalization

Providers must contact the member's health plan at the time of partial hospitalization admission to request authorization for services.

Services are authorized for up to five days, depending on the patient's condition. If less than four days per week of active treatment is provided, individual services (for example, therapy) provided must be billed instead of partial hospitalization.

Reauthorization criteria is applied to stays that exceed five days.

Prior Authorization Criteria

Partial hospitalization is offered as an alternative to inpatient admission. All partial hospitalization services require prior authorization and review by the health plan for medical necessity. Contact the member's health plan to request specific details or to request authorization of services.

Reauthorization Criteria

Continued stay in partial hospitalization requires at least one of the following criteria be met:

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

Limitations and Restrictions

IHCP partial hospitalization coverage carries the following limits and restrictions:

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

Acute Partial Hospitalization and Third-Party Liability

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

Section 6: Psychiatric Residential Treatment Facilities

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

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

Prior Authorization for PRTF Admission

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

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

Required Documentation

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

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

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

Emergency PA for PRTF Services

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

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

Telephone Requests for PRTF Prior Authorization

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

PRTF Admission Criteria

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

- The member's mental disorder (as classified in the current edition of the *Diagnostic and Statistical Manual* is rated severe, or the presence of two or more diagnoses on Axes I and II indicates that the member's disturbance is severe or complex.
- The member's behavior has disrupted his or her placement in the family or in a group residence two or more times in the past year, or the member has a persistent pattern of behavior that has severely disrupted life at home and school over the nine months preceding inpatient care. For children younger than 12 years old, these time frames are six months for a family or group residence, and six months for home and school.
- Family functioning or social relatedness is seriously impaired as evidenced by one or more of the following circumstances:
 - History of severe physical, sexual, or emotional maltreatment
 - History of a disrupted adoption or multiple, two or more, foster family placements
 - A physical assault against a parent or adult caregiver
 - A history of sexual assault by the member
 - A history of fire setting resulting in damage to a residence
 - Runaways from two or more community placements by a child younger than 14 years old
 - Other impairment of family functioning or social relatedness of similar severity

- The illness must be of a subacute or chronic nature where there has been failure of acute or emergency treatment to sufficiently ameliorate the condition to allow the member to function in a lower level of care. The following are examples of lower levels of care:
 - Family or relative placement with outpatient therapy
 - Day or after-school treatment
 - Foster care with outpatient therapy
 - Therapeutic foster care
 - Group child care supported by outpatient therapy
 - Therapeutic group child care
 - Partial hospitalization
 - Other
- The following symptom complexes must show a need for extended treatment in a residential setting due to a threat to self or others:
 - Self-care deficit, not age-related. Basic impairment of needs for nutrition, sleep, hygiene, rest, or stimulation included in the following:
 - Self-care deficit severe and long-standing enough to prohibit participation in an alternative setting in the community, including refusal to comply with treatment (for example, refusing medications)
 - Self-care deficit places child in life-threatening physiological imbalance without skilled intervention and supervision – for example, dehydration, starvation states, or exhaustion due to extreme hyperactivity
 - Sleep deprivation or significant weight loss
- Impaired safety such as threat to harm others. Verbalization or gestures of intent to harm others caused by the member's mental disorder, such as the following indicators:
 - Threats accompanied by one of the following behaviors:
 - Depressed mood (irritable mood in children, weight gain, weight loss)
 - Recent loss
 - Recent suicide attempt or gesture, or past history of multiple attempts or gestures
 - Concomitant substance abuse
 - Recent suicide or history of multiple suicides in family or peer group
 - Aggression toward others
 - Verbalization escalating in intensity, or verbalization of intent accompanied by gesture or plan
 - Impaired thought processes (reality testing). Inability to perceive and validate reality to the extent that the child cannot negotiate his or her basic environment, nor participate in family or school (paranoia, hallucinations, delusions). The following indicators are examples of this behavior:
 - Disruption of safety of self, family, or peer or community group
 - Impaired reality testing sufficient to prohibit participation in any community educational alternative
 - Nonresponsive to outpatient trial of medication or supportive care
 - Severely dysfunctional patterns of behavior that prohibit any participation in a lower level of care – for example, habitual runaway, prostitution, or repeated substance abuse
- Member must show need for long-term treatment modalities. Modalities can include behavior modification treatment with some form of aversive therapy and operant conditioning procedures. Special, strictly educational programs do not qualify as behavior therapy. Modalities include multiple therapies such as group counseling, individual counseling, recreational therapy, expressive therapies, and so forth.

Managed Care Considerations for PRTF Services

When entering a PRTF, Hoosier Care Connect and Hoosier Healthwise members are disenrolled or suspended from managed care, respectively. However, the managed care entities (MCEs) must provide care coordination services and associated services related to PRTF services before and after admission. These services are subject to the PA and reimbursement policies of the member's managed care plan. Providers should verify the member's eligibility at initial admission on the 1st and 15th of the month to determine the member's current managed care eligibility.

The *Care Select* program ended July 31, 2015. *Care Select* claims for PRTF services prior to August 1, 2015, do not require certification from the primary medical provider (PMP). PA for PRTF placement of *Care Select* members was provided by the appropriate care management organization (CMO), and providers bill claims to the IHCP.

Leave Days

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

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

Medical Leave Days

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

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

Therapeutic Leave Days

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

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

Billing for PRTF Services

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

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

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

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

Section 7: Substance Abuse and Addiction Treatment Services

The following sections address Indiana Health Coverage Programs (IHCP) policies and procedures for specific substance abuse and addiction treatment services.

Screening and Brief Intervention Services

The IHCP reimburses providers for screening and brief intervention (SBI) services. SBI identifies and intervenes with individuals at risk for substance abuse-related problems or injuries. SBI services use established systems, such as trauma centers, emergency rooms, community clinics, and school clinics, to screen patients who are at risk for substance abuse and, if necessary, provide the patients with brief interventions or referrals to appropriate treatment.

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

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

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

SBI services currently do not require prior authorization.

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

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

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

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

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

Smoking Cessation Treatment

The IHCP makes reimbursement for smoking cessation available for one 12-week course of treatment per member per calendar year. Treatment may include prescription of any combination of smoking cessation products and counseling. Providers can prescribe one or more modalities of treatment. Providers *must* include counseling in any combination of treatment.

Note: For information about reimbursement of smoking cessation products, see the [Pharmacy Services](#) module.

Providers must order smoking cessation treatment services for the IHCP to reimburse for the services. Practitioners ordering smoking cessation services should maintain documentation about the order in the same manner used for other covered services.

The IHCP does not require prior authorization for reimbursement for smoking cessation products or counseling. Providers of smoking cessation treatment services must obtain primary medical provider (PMP) certification for Hoosier Healthwise enrollees.

Eligible Providers and Practitioners

Practitioners eligible to provide smoking cessation treatment services, but not currently enrolled as IHCP providers, should submit a provider enrollment application as described in the [Provider Enrollment](#) module. Eligible practitioners, such as pharmacists who work for or own IHCP-enrolled pharmacies, bill for treatment services rendered through the enrolled entity where services are provided. Physician assistants, registered nurses, and psychologists who are not health service providers in psychology (HSPPs) bill for counseling services rendered through the enrolled entity through which services are provided.

Treatment services must be prescribed by a licensed practitioner within the scope of license under Indiana law. The IHCP reimburses for smoking cessation treatment services rendered by the following licensed practitioners participating in the IHCP:

- Nurse practitioner
- Pharmacist
- Physician
- Physician assistant
- Psychologist
- Registered nurse
- Dentist

Note that physician assistants, psychologists, and registered nurses *cannot* obtain an IHCP rendering National Provider Identifier (NPI) and must bill under the supervising practitioner's NPI.

Smoking Cessation Counseling

Providers or practitioners of smoking cessation counseling services must bill using procedure code 99407 U6 – *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes; per 15 minutes* with a primary ICD-10 diagnosis code of F17.200–F17.299. Providers must bill the modifier U6 to denote “per 15 minutes.”

Note: Providers and practitioners must bill the usual and customary charge for the units of service rendered, and the IHCP calculates the final reimbursement amount.

One unit of 99407 U6 is 15 minutes of service. For smoking cessation services, providers should accumulate billable time equivalent to whole units prior to billing and should not round up to the nearest fifteen minutes

Providers must perform smoking cessation counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within the 12 week course of treatment. Providers must bill counseling in 15-minute increments.

When providers and practitioners furnish a service to the general public at no charge, including smoking cessation counseling services, they cannot receive IHCP reimbursement for that service. The IHCP Program Integrity Department closely monitors adherence to this program limitation.

Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself; this requirement is consistent with existing IHCP policies and regulations.