INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Mental Health and Addiction Services

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Revision History

Version	Date	Reason for Revisions	Completed By
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	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 18, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of May 1, 2017 Published: January 23, 2018	Scheduled update: • Reorganized and edited text for clarity • Updated the *Managed Care Considerations for Behavioral Health Services* section, removing specific provider types and clarifying the role of the BHO • Added the *Self-Referral* subheading and added information about in-network requirements for behavioral health services other than psychiatric services • Added the *Carved-Out and Excluded Services* subheading and clarified text, including that PRTF services are excluded rather than carved out • Removed the *Mental Health Coverage for the Children's Health Insurance Program* subsection • Clarified office visit limitations in the introductory text of *Section 2: Outpatient Mental Health Services* • Renamed the *Outpatient Mental Health Professional Services* section and updated the text • Added the *Physician or HSPP Supervision* subheading and added physician as a supervising provider type	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		• Added the *Billing and Reimbursement* subheading and removed HW from the list of mid-level practitioner modifiers • Added code descriptions and PA reference to the *Psychiatric Diagnostic Interview Examinations* section • Added the *Annual Depression Screening* section • Added descriptions for U modifiers and added information regarding X modifiers to the *Applied Behavioral Analysis Therapy* section • Added billing information to the *Additional Service Limitations* section • Updated the *Outpatient Mental Health Hospital Services* section, including replacing reimbursement amounts with a reference to the Fee Schedule • Updated the introductory text in *Section 3: Inpatient Mental Health Services* • Renamed and updated text in the *Psychiatric Hospital Requirements* section, clarified age restrictions, and added information about IMDs • Added the *Reimbursement Methodology for Inpatient Mental Health Services* heading and its subheadings and updated the text as follows: – Defined “distinct parts” – Added a reference to the *Inpatient Hospital Services* module – Specified criteria for hospitalization and therapeutic leave in the *Reserving Beds* subsection • Clarified and reorganized information in the *Prior Authorization for Inpatient Mental Health Services* section, including adding information about the plan of care and updating Tables 1 and 2	

Version	Date	Reason for Revisions	Completed By
		• Removed *Care Select* information from the *Managed Care Considerations for PRTF Services* section • Added a note about opioid treatment programs to the introductory text in *Section 7: Substance Abuse and Addiction Treatment Services* • Added the *Inpatient Chemical Dependency Services* heading and introductory text and updated information in that section • Updated and added information in the *Tobacco Dependence Treatment* section and its subsections, and replaced smoking cessation terminology	

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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 behavioral health services, including mental health and substance abuse treatment 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

Most behavioral health services are carved into the Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise managed care programs. Other than services that are specifically carved out the managed care program, behavioral health services – such as mental health, psychiatric, substance abuse, and chemical dependency services – rendered to IHCP managed care members should be billed to the managed care entity (MCE) with which the member is enrolled, or to the behavioral health organization (BHO) subcontracted by that MCE, if applicable.

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

Self-Referral

Members enrolled with an MCE in the HIP, Hoosier Care Connect, or Hoosier Healthwise programs can access behavioral health services – including mental health, psychiatric, substance abuse, and chemical dependency services – on a self-referral basis. A referral from the member's primary medical provider (PMP) is not required.

For psychiatric services, managed care members can self-refer to any IHCP-enrolled provider licensed to provide psychiatric services within their scope of practice. However, for behavioral health services from any of the following provider types, self-referrals must be in-network (that is, to providers enrolled within the MCE network):

- Outpatient mental health clinics
- Community mental health centers (CMHCs)
- Psychologists
- Certified psychologists
- Health service providers in psychology (HSPPs)
- Certified social workers

- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses (APNs), under *Indiana Code IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy, or mental health counseling, under *405 IAC 5-20-8*

Carved-Out and Excluded Services

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

- Medicaid Rehabilitation Option (MRO) services rendered to individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness
  - 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*
    - *Division of Mental Health and Addiction Child Mental Health Wraparound Services*

Claims for MRO and 1915(i) HCBS services are processed by DXC, with the exception of claims for mental health medications billed by a pharmacy, which are processed by the State's fee-for-service pharmacy benefit manager, OptumRx.

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

- PRTF services rendered by a provider enrolled in the IHCP with a specialty of 034
  - Members in Hoosier Healthwise are disenrolled from managed care and moved to fee-for-service coverage 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 claim 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.
  - See the *Psychiatric Residential Treatment Facilities* section of this module for more information about PRTF services.

- Long-term care services in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disability (ICF/IID)
  - See the *Long-Term Care* module for information on short-term stays that are covered by MCEs.
- Inpatient services in a state psychiatric hospital that are not Medicaid services, but are provided under the State's 590 program
  - See the *590 Program* module for details about this program.
- Services provided through a Home and Community-Based Services (HCBS) waiver
  - For more information about these services, see the following modules:
    - *Division of Disability and Rehabilitative Services Home and Community-Based Services Waivers*
    - *Division of Aging Home and Community-Based Services Waivers*

Primary Care Services in Community Mental Health Centers

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

CMHC physician specialties and APN practitioners, as specified in current policy, can serve as 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, psychologists endorsed as a health service provider in psychology (HSPP), outpatient mental health facilities, psychiatric hospitals, and psychiatric wings of acute care hospitals.

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 retain this information for audit purposes.

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.

Outpatient Mental Health Professional Services

For professional services delivered in an outpatient setting, 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). Providers should bill one unit per encounter/session/date of service. The medical record documentation must identify the services and the length of time of each therapy session. Providers must make this information available for audit purposes.

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 employer or supervising psychiatrist bills for the services.

Physician or HSPP Supervision

The IHCP reimburses for services provided by mid-level practitioners in an outpatient mental health setting when a physician or an HSPP supervises the services.

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.

Billing and Reimbursement

Mid-level practitioners who render services must bill using the rendering National Provider Identifier (NPI) of the supervising practitioner (physician or HSPP) and the billing NPI of the outpatient mental health clinic or facility.

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)*
- 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 modifier SA, which is informational and does 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.

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.

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

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

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

All additional units of psychiatric diagnostic interviews require prior authorization; with the exception that two units are allowed per rolling 12-month period without PA 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).

Annual Depression Screening

Effective October 1, 2016, the IHCP covers HCPCS code G0444 – *Annual depression screening, 15 minutes*. This service is limited to one unit per member, per provider, per rolling 12-month period. PA is not required. Coverage is subject to limitations established for certain benefit plans.

Providers are expected to use validated, standardized tests for the screening. These tests include, but are not limited to, the Patient Health Questionnaire (PHQ), Beck Depression Inventory, Geriatric Depression Scale, and Edinburgh Postnatal Depression Scale (EPDS).

Applied Behavioral Analysis Therapy

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 three 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:

- U1 – *ABA therapy service provided by BCBA, BCBA-D, or HSPP*
- U2 – *ABA therapy service provided by BCaBA*
- U3 – *ABA therapy service provided by RBT*

When two or more distinct and separate ABA services are rendered to a member on the same date, providers should also include the appropriate modifier from the following list, after the U1, U2, or U3 modifier:

- XE – *Separate encounter; a service that is distinct because it occurred during a separate encounter*
- XP – *Separate practitioner; a service that is distinct because it was performed by a different practitioner*
- XU – *Unusual non-overlapping service; the use of a service that is distinct because it does not overlap usual components of the main service*

Medicaid Rehabilitation Option

Community mental health centers (CMHCs) must use the HW modifier to denote MRO services, in addition to modifiers that identify the qualifications of the mid-level practitioner rendering the service and any other modifiers needed to indicate the service rendered. For information regarding MRO services, see the *Medicaid Rehabilitation Option Services* module.

1915(i) Home and Community-Based Services

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

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

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

Additional Service Limitations

The following CPT 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

Additionally, the IHCP limits reimbursement for procedure codes 96150–96155 to eight units per date of service. This limit applies to all IHCP programs, subject to limitations established for certain benefit packages.

Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified healthcare professional. To report both services for reimbursement, the two services must be significant and separately identifiable. These services are reported using codes specific for psychotherapy performed with E/M services (90833, 90836, or 90838) as add-on codes to the E/M service.

For patients that require psychiatric services (90785–90899) as well as health and behavior assessment or intervention (96150 or 96155), providers report the predominant service preformed. CPT codes 96150–96155 should not be billed in conjunction with 90785–90899 on the same day.

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

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.

Outpatient Mental Health Hospital Services

Hospitals bill for the facility use associated with outpatient mental health hospital services by reporting the appropriate clinic or treatment room revenue code using the institutional claim type (*UB-04* claim form, Portal institutional claim, or 837I electronic transaction).

The IHCP has designated specific individual, group, and family counseling procedure codes for use with revenue code 513 – *Clinic/Psychiatric*. For a list of these codes, see *Revenue Codes Linked to Specific Procedure Codes* on the *Code Sets* page at indianamedicaid.com. Providers must use these and only these procedure codes when billing revenue code 513 to avoid the following outcomes:

- 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*.

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.

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

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 rather to identify the level of service rendered.

For individual, family, and group therapy codes, the IHCP reimburses the lesser of the billed amount or a statewide flat fee per member, per session. See the Outpatient Fee Schedule at indianamedicaid.com for the rates associated with each service.

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

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

Indiana Health Coverage Programs (IHCP) members must meet medical necessity to be eligible for acute inpatient psychiatric or inpatient substance abuse services. Reimbursement is available for inpatient care provided in a freestanding psychiatric hospital or in the psychiatric unit of an acute care hospital only when the need for admission has been certified.

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

Psychiatric Hospital Requirements

The IHCP reimburses providers for inpatient psychiatric services provided to eligible individuals between 22 and 65 years old in a certified psychiatric hospital of 16 beds or less. Reimbursement for inpatient psychiatric services in institutions for mental diseases (IMDs) is not available for fee-for-service members under 65 years old and over 21 years of age (unless the member is under 22 years of age and had begun receiving inpatient psychiatric services immediately before his or her 21st birthday).

Note:	*Effective for dates of services on or after July 5, 2016, managed care entities (MCEs) may authorize coverage for short-term stays for members 21–64 years of age in IMDs in lieu of services or settings covered under Indiana's Medicaid State Plan. See the Long-Term Care module for details.*

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.

Reimbursement Methodology for Inpatient Mental Health Services

The IHCP reimburses for inpatient psychiatric services provided by facilities that are freestanding or distinct parts (psychiatric units of acute care hospitals) 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).
- 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 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.

For general information about reimbursement for inpatient stays, not specific to psychiatric or addiction treatment stays, see the *Inpatient Hospital Services* module.

Change in Coverage During Stay

In some cases, a member's coverage can change during an inpatient psychiatric stay from one plan to another; for example, from fee-for-service 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.

Reserving Beds

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

- Hospitalizations must be ordered by a physician for the treatment of an acute condition that cannot be treated in a psychiatric facility. The total length of time reimbursable per inpatient stay is 15 days. If a member requires more than 15 consecutive days, the member must be discharged from the psychiatric facility.
- Leaves of absence must be for therapeutic reasons and ordered by a physician, as indicated in the member's plan of care. The total length of time reimbursable for therapeutic leaves of absence is 60 days per calendar year per member.

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

Prior Authorization for Inpatient 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. Providers must submit inpatient psychiatric claims using the revenue code that has been authorized for the admission.

Specific PA criteria for inpatient psychiatric services are found in the *Medical Policy Manual*. Denial of PA request may be appealed as outlined in the *Prior Authorization Administrative Review and Appeal Procedures* section of the *Prior Authorization* module.

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

Telephone precertification provides a basis for reimbursement only if adequately supported by a written certification of need. All mental health, substance abuse, and chemical dependency inpatient admissions, regardless of the setting, require a written certification of need. The *Certification of the Need for Inpatient Psychiatric Hospital Services* (*State Form 44697 [R4/5-15]/OMPP 1261A)*, referred to as the *1261A* form, satisfies the requirements for the written certification of need. The *1261A* form is available for download from the *Forms* page at indianamedicaid.com. 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.

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

A written plan of care must also be submitted, along with the written certification of need. A copy of the plan of care must be also be kept as part of the member's record. For more information about requirements for the plan of care, see the *Medical Policy Manual* at indianamedicaid.com.

Table 1 includes guidelines for inpatient psychiatric admissions to acute care hospital psychiatric units. Table 2 includes guidelines for inpatient psychiatric admissions to freestanding psychiatric hospitals. For additional PA requirements specific to inpatient substance abuse treatment, see the *Inpatient Chemical Dependency Services* section.

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

Category	Requirements
Telephone Precertification and Written Certification of Need (*1261A* Form)	Emergency and nonemergency admissions to psychiatric units of acute care hospitals require telephone precertification review. For each admission, the facility is responsible for initiating this review with the appropriate PA contractor based on the program assignment of the member. The precertification review must be followed by a written certification of need. *State Form 44697 (R4/5-15)/OMPP 1261A, Certification of the Need for Inpatient Psychiatric Hospital Services* (*1261A* form) fulfills the requirement for a written certification of need. The form is available for download from the *Forms* page at indianamedicaid.com.

Category	Requirements
Certification of Need Requirements	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 (or, for members 21 years old or younger, by the physician and an interdisciplinary team as described in *42 CFR 441.152(a) and 42 CFR 441.153*). The certification of need must be completed as follows: • **For nonemergency admission** – By telephone precertification review before admission, to be followed by a written certification of need within 10 business days of admission • **For emergency admissions** – By telephone precertification review within 48 hours of admission (not including Saturdays, Sundays, and legal holidays), to be followed by a written certification of need within 14 working days of admission *Note: If the provider fails to call within 48 hours of emergency admission (not including Saturdays, Sundays, and legal holidays), reimbursement is denied for the period from admission to the actual date of notification. Denial of the certification of need may be appealed as outlined in the Prior Authorization module.* • **For individuals applying for the IHCP while in the facility** – In writing within 10 business days of receiving notification of an eligibility determination and covering the entire period for which reimbursement is being sought • **For recertification** – In writing at least every 60 days after admission, or as requested by the Family and Social Services Administration (FSSA) or the appropriate PA contractor to recertify that the patient continues to require inpatient psychiatric hospital services
Plan of Care Requirements	In addition to the certification of need, an individually developed plan of care is also required for each member admitted: • For members 22 years old or older, the attending or staff physician must develop and submit a plan of care within 14 days of the admission date and must update the plan at least every 90 days. • For members 21 years old and younger, a physician and interdisciplinary team must develop and submit a plan of care within 14 days of the admission date and review the plan at least every 30 days. For specific plan of care requirements, see the *Medical Policy Manual*.
Basis for Reimbursement	Telephone precertification of medical necessity provides a basis for reimbursement only if adequately supported by the written certification of need submitted in accordance with the previously listed requirements. If the required written documentation is not submitted within the specified time frame, reimbursement is denied. The PA contractor reviews the written certification of need for each member and determines whether inpatient psychiatric care is warranted and what length of stay is justified given the member's medical needs. Reimbursement is denied for any days during the inpatient psychiatric hospitalization that are found to be not medically necessary.

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

Category	Requirements
Telephone Precertification and Written Certification of Need (*1261A* Form)	Emergency and nonemergency admissions to private freestanding psychiatric hospitals require telephone precertification review. For each admission, the facility must initiate the review with the appropriate PA contractor for based on the program assignment of the member. This precertification review must be followed by a written certification of need. *State Form 44697 (R4/5-15)/OMPP 1261A, Certification of the Need for Inpatient Psychiatric Hospital Services* (*1261A* form) fulfills the requirement for a written certification of need for both private and State-operated psychiatric hospitals. The form is available for download from the *Forms* page at indianamedicaid.com. *Note: Private freestanding psychiatric hospitals are required to submit the 1261A form to the appropriate PA contractor based on the program assignment of the member. State-operated facilities submit the 1261A form to the IHCP office.*
Certification of Need Requirements	Pursuant to *42 CFR 456.160*, reimbursement is available for services in a freestanding inpatient psychiatric facility only when each admission has been authorized. The certification of need must be completed by the attending physician or staff physician for members 22 years old and older (or, for members 21 years old or younger, by the physician and an interdisciplinary team as described in *42 CFR 441.152(a)* and *42 CFR 441.153*). The certification of need must be completed as follows: • **For nonemergency admissions** – By telephone precertification review before admission, to be followed by a written certification of need within 10 business days of admission • **For emergency admissions** – By telephone precertification review within 48 hours of admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within 14 working days of admission *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 module.* • **For individuals applying for the IHCP while in the facility** – In writing within 10 business days after receiving notification of an eligibility determination and covering the entire period for which reimbursement is being sought • **For recertification** – In writing at least every 60 days after admission, or as requested by the FSSA or the appropriate PA contractor to recertify that the member continues to require inpatient psychiatric hospital services

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

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

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

Telephone Requests for PRTF Prior Authorization

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

PRTF Admission Criteria

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

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

- The illness must be of a subacute or chronic nature where there has been failure of acute or emergency treatment to sufficiently ameliorate the condition to allow the member to function in a lower level of care. The following are examples of lower levels of care:
  - Family or relative placement with outpatient therapy
  - Day or after-school treatment
  - Foster care with outpatient therapy
  - Therapeutic foster care
  - Group 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.

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 *Indiana Administrative Code 405 IAC 5-24* and *405 IAC 5-25*, respectively. The PRTF *per diem* rate includes the cost of all other IHCP-covered psychiatric services provided to members residing in a PRTF, as well as the cost for IHCP-covered services not related to the member's psychiatric condition, if such services are performed at the PRTF. The IHCP makes separate reimbursement available only in instances where IHCP-covered services, not related to the member's psychiatric condition, are unavailable at the PRTF and are performed at a location other than the PRTF.

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

- 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 follow sections address Indiana Health Coverage Programs (IHCP) coverage and procedures for specific substance abuse and addiction treatment services.

> *Note:* *Opioid treatment programs certified by the Indiana Family and Social Services Administration, Division of Mental Health and Addiction (FSSA/DMHA) are required to enroll as IHCP providers. See the Provider Enrollment module for details.*

Inpatient Chemical Dependency Services

The IHCP requires prior authorization (PA) for all inpatient stays for mental health, substance abuse, or chemical dependency treatment. The facility is responsible for initiating the PA review process, including the telephone precertification and written certification of need, as described in the *Prior Authorization for Inpatient Mental Health Services* section of this module.

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

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

For specific PA criteria, see the *Medical Policy Manual* at indianamedicaid.com.

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

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 is restricted to the following place-of-service codes:

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

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

Tobacco Dependence Treatment

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

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

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

Tobacco Dependence Drug Treatment

For dates of service on or after January 1, 2017, the IHCP covers tobacco dependence drug treatment (pharmacotherapy) for up to 180 days per member per calendar year. Treatment beyond 180 days within a calendar year will require the prescriber to document the medical necessity of continued treatment. For prior dates of service, reimbursement was limited to a 12-week course of tobacco dependence drug treatment per member per calendar year.

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

Providers must perform tobacco dependence counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within the course of treatment.

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

Tobacco Dependence Counseling

IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.

Billing Guidelines

Tobacco dependence counseling services must be billed using procedure code 99407 – *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*, with the modifier U6 – *Per 15 minutes*. A primary ICD-10 diagnosis code of F17.200–F17.299 is required.

One unit of 99407 U6 is 15 minutes of service. Providers should accumulate billable time equivalent to whole units prior to billing and should not round up to the nearest 15 minutes.

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

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

Eligible Providers and Practitioners

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

- Clinical social worker*
- Dentist
- Licensed clinical addiction counselor*
- Marital and family counselor*
- Mental health counselor*
- Nurse practitioner
- Optometrist*
- Pharmacist

- Physician
- Physician assistant
- Psychologist
- Registered nurse

> **Note:* *Provider types marked with an asterisk (*) are eligible to render tobacco dependence counseling for dates of service on or after January 1, 2017.*

Note that the following provider types *cannot* enroll as rendering providers in the IHCP and must bill under the IHCP-enrolled supervising practitioner's National Provider Identifier (NPI), using the appropriate mid-level-practitioner modifier:

- Clinical social worker
- Marital and family counselor
- Licensed clinical addiction counselor
- Physician assistants
- Psychologists who are not health service providers in psychology (HSPPs)
- Registered nurses

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.

All other practitioners eligible to provide tobacco dependence counseling services, but not currently enrolled as IHCP providers, should submit a provider enrollment application as described in the *Provider Enrollment* module to become eligible for IHCP reimbursement.