OUTPATIENT MENTAL HEALTH ADDENDUM

MUST BE COMPLETED BY PROVIDER SPECIALTIES 110-OUTPATIENT MENTAL HEALTH CLINIC AND 111-COMMUNITY MENTAL HEALTH CENTER

The purpose of this addendum is to provide the Indiana Health Coverage Programs (IHCP) a complete list of individual practitioners who provide outpatient mental health services and their qualifications. The IHCP requires this addendum to be completed by all outpatient mental health facilities or clinics, or community mental health centers, during the provider enrollment process.

Pursuant *to IC 5-20-8*, Medicaid reimbursement is available 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). Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:

1. Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in *405 IAC 5-25*.
2. Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one of the following practitioners:
   - A licensed psychologist
   - A licensed independent practice school psychologist
   - A licensed clinical social worker
   - A licensed marital and family therapist
   - A licensed mental health counselor
   - A person holding a masters degree in social work, marital and family therapy, or mental health counseling
   - An advanced practice nurse who is a licensed, registered nurse holding a masters degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing
3. The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:
   - The physician, psychiatrist, or HSPP is responsible for seeing the recipient during the intake process or reviewing the medical information obtained by the practitioner listed in subdivision (2) within seven days of the intake process. This review by the physician, psychiatrist, or HSPP must be documented in writing.
   - The physician, psychiatrist, or HSPP must again see the patient or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed in subdivision (2) at intervals not to exceed ninety (90) days. This review must be documented in writing.
4. The supervising physician or HSPP must provide his or her IHCP provider number and a copy of his or her license.

Section I: Supervising Physician or HSPP

Supervising Physician or HSPP Name	IHCP Provider Number	Contractor or Employee

I, the undersigned, certify that I have read and understand the Outpatient Mental Health Addendum. I further certify that I am an employee or contractor of this clinic and supervise all plans of treatment as required by law and outlined in this addendum.

Signature of Supervising Practitioner **Date**

Section II: Employees or Contracting Practitioners

You must complete the following information. Please list below the practitioner's name, provider number (if available), practitioner type, and license type and number for all physician and/or other practitioners in your outpatient facility or clinic.

The supervising physician or HSPP must provide his or her IHCP provider number or a copy of his or her license. For any mid-level practitioners, you must denote the provider type (such as psychologist, social worker, and so forth). Please attach an additional page if more space is needed.

Practitioner's Name (mandatory) & IHCP Provider Number (if available)	Provider Type	Qualifications: License Type & Number

An authorized officer or owner of the billing provider, must complete the following section prior to submitting the addendum. This form must be submitted with your IHCP Provider Enrollment Application.

I, THE UNDERSIGNED ON BEHALF OF THE PROVIDER, HAVE READ AND UNDERSTAND THE OUTPATIENT MENTAL HEALTH ADDENDUM. I FURTHER CERTIFY THAT EACH PRACTITIONER LISTED ON THIS LIST IS AN EMPLOYEE OR CONTRACTOR OF OUR FACILITY, EACH OF THESE PRACTITIONERS HAS BEEN INFORMED OF THE IHCP POLICY FOR REIMBURSEMENT OF OUTPATIENT MENTAL HEALTH SERVICES, AND EACH PRACTITIONER, WHETHER EMPLOYED OR CONTRACTED, UNDERSTANDS THAT HE OR SHE WILL BE REIMBURSED FOR SERVICES BY OUR FACILITY. I FURTHER CERTIFY THAT ALL INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Printed name of person completing the addendum **Printed title**

Signature of person completing the addendum **Date**

Name of outpatient mental health clinic/community mental health center **Clinic provider number**