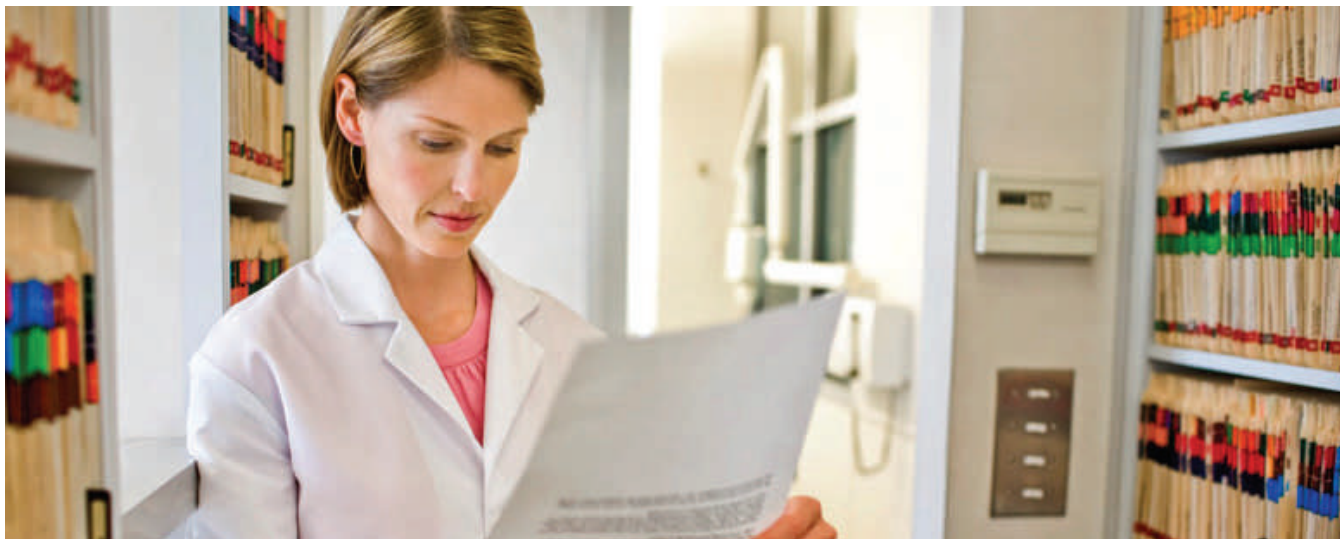


IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201013 MAY 11, 2010

Note: This bulletin is obsolete.
Please see BT201015 for the
updated version of this bulletin.



Medicaid Rehabilitation Option program has new benefit structure

Effective July 1, 2010, the Medicaid Rehabilitation Option (MRO) Program will undergo a transformation from its current process. The Office of Medicaid Policy and Planning (OMPP), in conjunction with the Division of Mental Health and Addiction (DMHA), has developed a benefit plan structure for Medicaid members receiving MRO services. Currently, there are no prior authorization (PA) requirements and no benefit limitations imposed for members receiving MRO services during the benefit period. While members can continue to access MRO providers based on a self-referral, members who have a qualifying MRO diagnosis will be assigned a service package based on their individual level of need (LON).

The MRO service package will ensure the delivery of the right services, to the right person, at the right time.

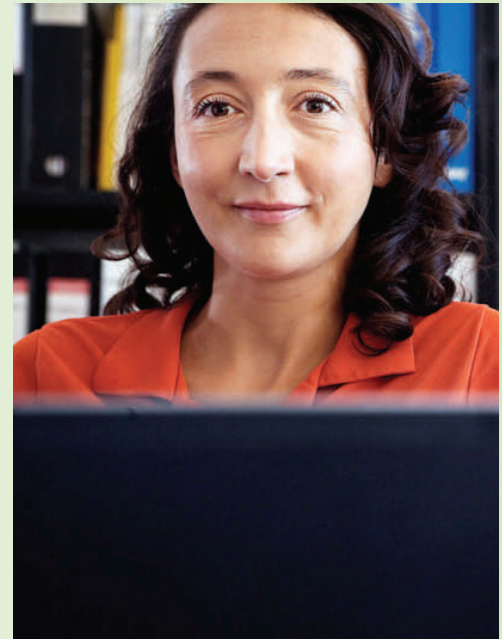
MRO provider qualifications

There will be three separate categories of provider types available to render MRO services. Each MRO service will have specific provider qualifications that must be met in order for providers to be reimbursed for service delivery.

- Licensed professional
 - Licensed psychiatrist
 - Licensed physician
 - Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
 - Licensed clinical social worker (LCSW)
 - Licensed mental health counselor (LMHC)

[Continue](#)

- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor, as defined under *IC 25-23.6-10.5*
- Qualified behavioral health professional (QBHP)
 - An individual who has had at least two years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
 - Psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana
 - Pastoral counseling from an accredited university
 - Rehabilitation counseling from an accredited university
 - An individual who is under the supervision of a licensed professional, as defined above; is eligible for and working toward licensure; and has completed a master's or doctoral degree, or both, in any of the following disciplines:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology from an accredited university
 - Mental health counseling from an accredited university
 - Marital and family therapy from an accredited university
 - A licensed independent practice school psychologist under the supervision of a licensed professional, as defined above.
 - An authorized health care professional:
 - A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician, and subject to the requirements of *IC 25-27.5-5*.
 - A nurse practitioner or clinical nurse specialist with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to *IC 25-23-1*.
- Other behavioral health professional (OBHP)
 - An individual with an associate or bachelor degree, and/or equivalent behavioral health experience, meeting minimum competency standards set forth by the community mental health center and supervised by a licensed professional, as defined above, or QBHP, as defined above.
 - A licensed addiction counselor, as defined under *IC 25-23.6-10.5*, supervised by a licensed professional, as defined above, or QBHP, as defined above.



Services must be billed using the appropriate modifiers to note the midlevel scope of practice. Providers should use the rendering NPI of the supervising practitioner (physician or HSPP) to bill psychiatric and clinical nurse specialist

services. Providers must use these modifiers with the appropriate procedure code, which are as follows:

- AH – Clinical psychologist
- AJ – Clinical social worker
- SA – Nurse practitioner

Providers are not required to include other modifiers that denote the level of practitioner rendering the service. Providers must continue to use the HW modifier to denote MRO services. Place the modifiers in field 24D of the CMS-1500 claim form. Additional information about billing for MRO services will be available in the updated *MRO Provider Manual* located at <http://www.indianamedicaid.com>. A banner page will be released once the *MRO Provider Manual* is available to view online.

Information about billing for MRO services will be available in the updated *MRO Provider Manual* located at <http://www.indianamedicaid.com>. A banner page will be released once the *MRO Provider Manual* is available to view online.

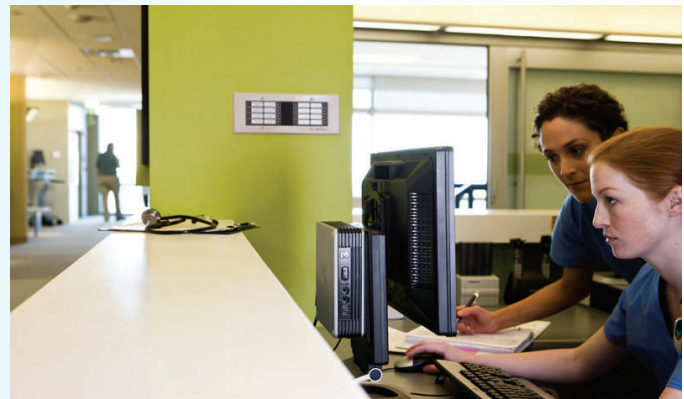
MRO service package process

MRO services will be accessible to Medicaid members who have a qualifying MRO diagnosis and a LON based on the Child & Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA). Members who do not have a qualifying MRO diagnosis and/or LON may submit PA for MRO services.

For an MRO provider to receive reimbursement for the delivery of MRO services, a member must have an assigned MRO service package or prior authorized units of service. A member must have a qualifying diagnosis to be eligible for an MRO service package. Service packages are assigned by IndianaAIM, the state's Medicaid Management Information System (MMIS) or claims payment system, based on the member's LON. All assignments for service packages and prior authorization approvals and denials will be viewable on Web interChange – go to <https://www.indianamedicaid.com> and click **Web interChange**.

MRO providers have the following responsibilities to ensure timely service package assignment, administration of PA, and reimbursement.

- Enter member information into the Data Assessment Registry Mental Health and Addiction (DARMHA) system.
 - The following data fields will be transmitted from DARMHA to IndianaAIM for service package assignment. A service package will not be assigned, and consequently, claims will not be paid without the boldfaced fields.
 - Last name
 - First name
 - **Date of birth**
 - **Medicaid member identification number (RID)**
 - Social Security number (SSN)
 - **Diagnosis**



[Continue](#)

- **CANS or ANSA score**
- Assessment date
- Provider ID
- Assertive Community Treatment (ACT) indicator (for ACT consumers only)

Eligibility for an MRO service package is based on a qualifying diagnosis and LON. A member must have at least one qualifying diagnosis to be eligible.

- Perform required CANS/ANSA reassessments and enter data into DARMHA within the 30 days prior to the end of a member's service package in order to ensure continuity of care.
 - If a reassessment is performed after the member's initial service package end date, retroactive PA will not be available for providers to receive reimbursement.
- Check eligibility for Medicaid and MRO, and internally monitor service package utilization for each member.
 - MRO providers must check a member's Medicaid eligibility prior to each visit. In addition to this check, MRO providers must review the MRO service package assignment and available units of service prior to service delivery. Web interChange will provide service package detail, but it is the provider's responsibility to track utilization.
- Submit MRO claims for reimbursement on a timely basis.
 - Units of MRO services, as displayed in Web interChange, are decremented based on adjudicated claims. Timely submission of claims will ensure that the data accessible on Web interChange accurately reflects the remaining units of service for each member. Failure to submit claims in a timely manner places the provider at risk for non-payment.
 - Claims will be paid or denied based on the service package dates assigned and the number of remaining units of service at the time of claim adjudication.
 - Providers can access Web interChange at <https://interchange.indianamedicaid.com> and use the MRO Inquiry tab to track utilization of services using the member's RID.

Claims can be filed using the current claim filing process for MRO services documented in the *IHCP Provider Manual*, [Chapter 8, Section 4](#).

Service packages

Eligibility for an MRO service package is based on a qualifying diagnosis and LON. A member must have at least one qualifying diagnosis to be eligible. Complete listings of MRO-qualifying diagnosis codes will be available in the updated *MRO Provider Manual* located on the <http://www.indianamedicaid.com> site. A banner page will be released once the *MRO Provider Manual* is available to view online.

In addition to a qualifying diagnosis, a Medicaid consumer must also have a qualifying LON. LON refers to a recommended intensity of behavioral health services,

based on a pattern of a consumer's and family's needs as assessed using a standardized assessment instrument, currently the CANS and ANSA. The CANS and ANSA are comprehensive, uniform assessment tools developed to support care planning and level-of-care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

[Continue](#)

Service package assignment is based solely on the member's LON. There are eight service packages, each with a set of services and units of service designed to meet the consumer's intensity of need.

- Child/adolescent packages: 2, 3, 4, 5
- Adult packages: 3, 4, 5, 5A

Service packages will be assigned for 180 days. A complete listing of MRO services contained in each service package will be available in the updated *MRO Provider Manual* located at <http://www.indianamedicaid.com>. A banner page will be released once the *MRO Provider Manual* is available to view online.

[Continue](#)

MRO covered services

Common Title	Base Codes	Secondary Codes	Rate
Behavioral health level of need redetermination	H0031 HW		\$77.72 flat fee
Counseling and therapy	H0004 HW	H0004 HW HR H0004 HW HS	\$28.65 per 15 minutes
	H0004 HW HQ	H0004 HW HR HQ H0004 HW HS HQ	\$7.16 per 15 minutes
Medication training and support	H0034 HW	H0034 HW HR H0034 HW HS	\$18.62 per 15 minutes
		H0034 HW HQ H0034 HW HR HQ H0034 HW HS HQ	\$3.35 per 15 minutes
Skills training and development	H2014 HW	H2014 HW HR H2014 HW HS	\$26.14 per 15 minutes
		H2014 HW HQ H2014 HW HR HQ H2014 HW HS HQ	\$4.71 per 15 minutes
Case management	T1016 HW		\$14.53 per 15 minutes
Peer recovery services	H0038 HW		\$8.55 per 15 minutes
Addiction counseling (individual setting)	H2035 HW	H2035 HW HR H2035 HW HS	\$58.32 per hour
Addiction counseling (group setting)		H0005 HW H0005 HW HR H0005 HW HS	\$14.58 per hour



MRO covered services

Common Title	Base Codes	Secondary Codes	Rate
Crisis intervention	H2011 HW		\$33.72 per 15 minutes
Intensive Outpatient Treatment (IOT)	H0015 HW HQ		\$43.74 per 3 hours
Child and Adolescent Intensive Resiliency Services	H2012 HW HA HQ		\$14.62 per hour
Adult Intensive Rehabilitative Services (AIRS)	H2012 HW HB HQ		\$14.62 per hour
Psychiatric assessment and intervention	H2019 HW		\$30.62 per 15 minutes
		H2019 HW UA	\$18.37 per 15 minutes

Prior authorization

A provider may request PA for additional services or additional units of service for a member who has an assigned service package, or a member who does not have a qualifying diagnosis or LON to receive an assigned service package. The current PA process and request form will be used for MRO PA. ADVANTAGE Health SolutionsSM will authorize PA requests on behalf of the state. Prior authorization requests for MRO services will be directed to:

ADVANTAGE Health Solutions, Inc. – Fee-For-Service (FFS)
 Prior Authorization Department
 P.O. Box 40789
 Indianapolis, IN 46240
 Telephone: 1-800-269-5720
 Fax: 1-866-541-3977

Appropriate scenarios

Members with a qualifying MRO diagnosis are assigned an MRO service package based on LON. For the majority of members receiving MRO services, assigned MRO service packages will provide a sufficient number of services and units of services to meet members' needs. However, for members who require additional medically necessary services,



a prior authorization request is required. Please note that submitting a PA request for a full service package is not permitted. Under the following four scenarios, an MRO service provider is required to submit a PA request to the PA vendor in order to be reimbursed:

- **Scenario 1:** A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
- **Scenario 2:** A member requires a medically necessary MRO service not authorized in his or her MRO service package.
- **Scenario 3:** A member does not have one or more qualifying MRO diagnoses and/or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
- **Scenario 4:** A member is newly eligible to the Medicaid program, or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive request for prior authorization is appropriate for MRO services provided during the retroactive period.

Process and time frame

PA requests may be initiated with the PA vendor via telephone, Web interChange, mail, or fax. Please refer to the above information for the appropriate contact information for the PA vendor. For more information about how to submit a PA request to the PA vendor via Web interChange, please go to <https://interchange.indianamedicaid.com> and click **Web interChange**. Please note that when submitting PA requests via Web interChange, for “service type,” choose MH to request MRO PA. On paper PA forms, write MH on the top left of the form to request MRO PA. To ensure that service authorization

and reimbursement are not interrupted, MRO service providers are advised to submit new PA requests at least 30 days before the depletion of all units of a service. The only exception to this is Scenario 4. (See below for more information on [retroactive prior authorization](#).)

Required documentation

In order to **initiate** an MRO PA request via telephone or Web interChange, the following information is required:

- MRO service provider’s name
- MRO service provider’s National Provider Identifier (NPI)
- Member’s full name
- Member’s Medicaid recipient identification number (RID)
- Member’s MRO diagnosis
- Member’s LON
- Member’s current service package reference number, listed in Web interChange (if applicable)

- Requested Healthcare Common Procedure Coding System (HCPCS) **Base Codes** (see table above for base codes) and **modifiers**

Once a PA request has been initiated, a request will remain in a suspended status until the following required documentation is submitted to the PA vendor via mail or fax. Please note that MRO service providers have 30 calendar days from the date of an initial request to submit this information. Failure to submit the required documentation will result in a denial of a suspended request without retroactive coverage. If the information is submitted after the 30 days, it will be modified to the date received.

- **Indiana Prior Review and Authorization Request Form** –

This form is available online at [http://
provider.indianamedicaid.com/general-provider-services/
forms.aspx](http://provider.indianamedicaid.com/general-provider-services/forms.aspx).

- **DMHA Assessment Score** – The currently approved DMHA assessment tools are the CANS for children and the ANSA for adults. For the purposes of submitting a PA request, the score must come from an assessment that was completed within the 180 days prior to the date of the PA request. These assessments are available online at <http://dmha.fssa.in.gov/darmha/mainDocuments.aspx>.
- **Individualized Integrated Care Plan (IICP)** – In accordance with *405 IAC 5-21.5* (effective date of the rule is anticipated to be July 1, 2010).
- **Medical Necessity Documentation** – In accordance with *405 IAC 5-2-17*, a medically reasonable and necessary service is defined as a service that is “required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.” Therefore, in order to request additional services or units of services, one of the following must be documented and submitted to the PA vendor:
 - A list of specific symptoms or trigger events that have occurred and support an episode of decompensation or crisis that warrants the need for additional services or units of services in order to maintain goals, or
 - A list of specific symptoms or trigger events that may be prevented if services or additional units of services are authorized.

To ensure that an appropriate review and determination is made, additional documentation may be requested by the PA vendor, including but not limited to answers to the following questions:

- What is the member’s current service package?
- Is there a current active service package? If yes, what is the end date?



- At what level of acuity were the member's symptoms at the initiation of the service package?
- What is the current acuity level of the member's symptoms?
- Has progress been made toward the established IICP goals?
- Has the member's level of functioning and/or symptom stability improved with the requested services utilized to date?
- Has a **new** symptom occurred that requires medically necessary services?
- Has a new trigger event or situation occurred that led to increased or new symptoms and/or behavioral issues that require additional services? If yes, describe the trigger event/situation and significance to the consumer's behavioral health status and needs. What has changed?
- What are the member's **active** symptoms?
- How will the service requested improve the symptoms identified?
- How will the requested services promote achievement of the IICP goals?
- Has an attempt been made to increase the interval between services and/or transition to a less restrictive level of care?

Retroactive prior authorization

Requests for retroactive PA may not be authorized unless a member was granted Medicaid eligibility for a retroactive period as a result of the following:

- Being determined newly eligible for Medicaid, or
- Having a lapse in his or her Medicaid eligibility.

In accordance with *405 IAC 5-3-9*, to be authorized retroactively, PA requests must be submitted within the following time frames:

- 12 months from the date of the issuance of a member's Hoosier Health card (member's eligibility determination date)
- 60 days from the date that the provider received notice of a member's eligibility.

MRO service providers must submit the required PA documentation listed above via mail or fax, along with documentation demonstrating how a provider was notified of a member's Medicaid eligibility (that is, a copy of the member's Medicaid determination letter or Web interChange screen print from the date the provider checked the consumer's eligibility). Additionally, MRO service providers must indicate on the PA request form that it is a retroactive request.

Helpful tools

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

You can also e-mail questions about the MRO Benefit Service Plan to transformation@fssa.in.gov.

You will find helpful Web site resources about MRO, service packages, guidelines, and billing practices at: <http://www.indianamedicaid.com/> and at <https://myshare.in.gov/FSSA/ompp/MRO/default.aspx>.