ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Behavioral Health Service Record Documentation Standards-IN MCD-AD-1073	11/01/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Behavioral Health Service Record Documentation Standards

B. Background

Medical record documentation is a fundamental element required to support medical necessity and is the foundation for coding and billing. Documentation relays important information, such as but not limited to assessments completed, services provided, coordination of services, timeliness of care, plan of care/treatment, rationale for orders, health risk factors, member's progress towards goals of the treatment plan, and response to treatment. Chronological documentation of member care contributes to high quality care and allows other healthcare professionals to plan treatment, monitor wellness and interventions over time, and ensures continuity of care.

Medical record documentation serves as a legal document that verifies care provided to individuals. Information in the record may be used to validate place(s) of service, medical necessity and appropriateness of diagnostics and/or therapeutic services provided, or that services provided have been accurately reported. According to the rules of the Mental Health Parity and Addictions Equity Act (MHPAEA), coverage for the diagnosis and treatment of behavioral health (BH) conditions will not be subject to any limitations that are less favorable than limitations that apply to medical or surgical conditions as covered under this policy.

Specific documentation requirements for applied behavior analysis for the treatment of autism, home and community-based services, and other therapy services can be located in specific provider modules on the State's website. The Indiana Family and Social Services Administration's (FSSA) Indiana Health Coverage Programs (IHCP) provides guidance on behavioral health (BH) services and record requirements, including program certification requirements, service definitions, and information on specialized programs on the State website (eg, Behavioral and Primary Healthcare Coordination Service). Provider manuals also document appropriate places of service for service provision and allowable performing provider, in addition to billing and reimbursement parameters, which this policy does not address. This policy is provided as a courtesy only. Any information located in IHCP Provider Manuals supersede information in this policy, including updates that may occur prior to policy reviews.

C. Definitions

- **Health Services Provider Psychology (HSPP)** – A BH professional licensed in psychology who may certify a mental health diagnosis within a plan of treatment.
- **Individual Plan of Care (POC)** – A written plan developed for each member (42 C.F.R. §§ 456.180-81) to improve conditions so that inpatient care not necessary.
- **Individually Identifiable Health Information** – A subset of health information, including demographic information collected from an individual, and
    - created or received by a health care provider, health plan, employer, or health care clearinghouse

  - related to past/present/future physical or BH condition of an individual, the provision of health care, or the past/present/future payment for health care
    - that identifies the individual
    - there is a reasonable basis to believe information can identify the individual
- **Medically Necessary Service** – A covered service required for the care or well-being of members provided in accordance with generally accepted standards of medical or professional practice.
- **Mental Health Diagnosis** – The evaluation of mental, emotional, behavioral, and addictive disorders by a licensed BH professional using the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* complying with 1) education, training, experience and licensure requirements in Ind. Code 25-23-6-11-4, and 2) the professional's scope of practice. This does not include physical diagnoses.
- **Mental Health Parity and Addictions Equity Act (MHPAEA)** – A 2008 federal law that generally prevents group health plans and health insurance issuers who provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations than on medical/surgical (M/S) coverage.
- **Protected Health Information (PHI)** – Individually identifiable health information that is transmitted or maintained by electronic media or in any other form or medium.
- **Provider Fraud** – Intentional deception or misrepresentation made by a person with knowledge that deception could result in some unauthorized benefit to self or another person, including any act that constitutes fraud under applicable federal or state law.
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** – A the agency within the US Dept of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

D. Policy
  I. General Guidelines
    A. CareSource supports the IHCP's efforts to prevent provider fraud, including
      1. altering medical records to generate medical payments
      2. billing for services or supplies not rendered or for more costly services than those rendered (upcoding)
      3. billing for group vs individual sessions
      4. misrepresenting services (eg, billing a covered code but providing a noncovered service)
      5. billing more than the charge to the public
      6. services provided by unlicensed or unqualified personnel
      7. soliciting, offering or receiving a kickback, bribe or rebate from medical providers for referrals or use of a product or service
    B. Records will fully disclose and document the extent of services provided to members and will be completed when services are rendered and prior to associated claim submission.
    C. All providers will maintain medical or other records as necessary to fully disclose and document the extent of services provided for a period of 7 years from the

date of service. A claim form copy submitted by the provider for reimbursement is not sufficient documentation, in and of itself, for compliance.

D. Medical or other records, or both, shall include, at the minimum, the following:
   1. identity of the member to whom service was rendered
   2. provider identity, including dated signature or initials
   3. identity and position of the provider employee rendering the service, if applicable, including dated signature or initials
   4. date of the service
   5. diagnosis of the condition of the member (relevant to physicians only)
   6. detailed statement describing services rendered, including duration of services rendered
   7. location at which services were rendered
   8. amount claimed for each specific service
   9. written evidence of physician involvement, including a legible signature or initials, and personal member evaluation to document acute medical needs
   10. when required under Medicaid rules, physician progress notes as to medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and redefine goals
   11. X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records, if applicable

E. IHCP does not cover the following BH services:
   1. biofeedback
   2. broken or missed appointments
   3. day care or partial day care
   4. hypnosis and hypnotherapy
   5. experimental drugs, treatments, procedures
   6. acupuncture
   7. hyperthermia
   8. cognitive rehabilitation, except for treatment of traumatic brain injury (see *IHCP Therapy Services Provider Manual*)

F. Release(s) of Information (ROI)
   ROIs must be valid (not expired), filled out completely with respect to requested elements, and consistent with requested information. Plain language must be used, and the covered entity must provide the individual with a copy of the signed authorization if seeking disclosure of PHI. Core elements of ROIs include
   1. a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion
   2. name or other specific identification of the person(s) or group authorized to make the requested use or disclosure
   3. name or other specific identification of the person(s) or group to whom the covered entity may make the requested use or disclosure
   4. a description of each purpose of the requested use or disclosure (“At the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)

5. an expiration date or event that relates to the individual or the purpose of the use or disclosure (“End of the research study,” “none,” or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.)
6. a legible signature of the individual and date (If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.)
7. required statements that place a member on notice of the following:
   a. member right to revoke authorization in writing, exceptions to revocation, and how the member may revoke authorization
   b. the ability or inability to condition treatment, payment, enrollment, or eligibility for benefit on the authorization
   c. the potential for information disclosed to be subject to redisclosure by the recipient and no longer protected by the ROI

G. Physical Examination Prior to a Mental Health Diagnosis
If a BH professional licensed under Ind. Code § 25-23.6 performs an evaluation to determine a mental health diagnosis of a member and determines that the member either 1) has not seen a physician, advance practice registered nurse (APRN) or a physician assistant (PA) within the previous 12 months, or 2) may have a physical condition that requires medical attention, the BH professional will document all actions in the member record and will
   1. advise the member to schedule, and assist with the scheduling of, a physical examination at the earliest opportunity
   2. provide the member with a list of practitioners to contact to schedule a physical examination, including the name, address and telephone numbers
   3. coordinate member care as appropriate with the practitioner, unless the member declined consent to the coordination of care

H. Outpatient treatment plan supervision may be conducted by the following licensed professionals with a master’s degree and within the scope of practice, education, and training:
   1. clinical social workers
   2. mental health counselors
   3. clinical addiction counselors
   4. marriage and family therapists

I. Mental health safety plans must be individualized, collaboratively developed with the member, and in a standard format that includes the following information:
   1. member name, address, and contact information
   2. early warning signs that a crisis may be developing
   3. internal coping strategies
   4. contact information for individuals and social settings that may provide distraction for the member
   5. contact information for persons from whom the member can ask help
   6. contact information for professionals or agencies the member can contact at the onset of or during a crisis

7. a plan for making the environment safe for the member
8. 1 thing that matters most to the member making life worth living
9. other information, including issues concerning physical health, if necessary

J. Interactive complexity (IC) is an add-on code specific for BH services referring to communication difficulties during service delivery and reported in conjunction with other codes only. Difficulties may include services with members who have other individuals legally responsible for care, those who request others to be involved during the visit, or those who require the involvement of other 3rd parties (eg, parole officers, school officials, child welfare agency personnel). IC may be reported when 1 of the following is present:
   1. the need to manage maladaptive communication among participants complicates delivery of care
   2. caregiver emotions or behaviors interfering with implementation of the treatment plan
   3. evidence or disclosure of a sentinel event and mandated report to a 3rd party (eg, abuse or neglect with report to state agency) with initiation of discussion of the event and/or report with the member and other visit participants
   4. use of play equipment, physical devices, interpreter, or translator to overcome significant language barriers

II. Outpatient Behavioral Health (BH) Services

The IHCP's *Behavioral Health Services Provider Manual* provides details on billing and reimbursement, particularly claim details, revenue code detail, and modifier information, including both professional and/or facility services. Medical record documentation must identify services and length of time of each session with the information available for audit purposes. A physician or other health professional (see the IHCP's *Behavioral Health Services Provider Manual* for a full list and details) must certify the diagnosis. The physician, psychiatrist, or HSPP is responsible for supervising the plan of treatment as follows

1. document a visit with the member during the intake process or review the medical information obtained by the practitioner within 7 days of intake
2. document seeing the member or reviewing medical information to certify the service as medically necessary on the basis of information provided by the practitioner at intervals not to exceed 90 days

All reviews must be documented in writing. A cosignature is not sufficient.

Some services (eg, medicaid rehabilitation option services, urine drug testing, 1915i wavier services) are extensively covered in other IHCP provider manuals. This section serves to provide clarification on documentation requirements from the *Behavioral Health Services Provider Module* for some services.

A. Annual Depression Screening

   This service is limited to 1 unit per member per provider per rolling 12-month period with no PA requirement. Validated, standardized tests must be documented (eg, Patient Health Questionnaire, Beck Depression Inventory).

B. Applied Behavior Analysis (ABA)
IHCP publishes coverage criteria, practitioner requirements, and PA requisites for the provision of ABA, which also requires documented supervision of practitioners. Records must be available for audit, if requested. Documentation requirements include the following:
1. diagnosis of Autism Spectrum Disorder by a qualified healthcare provider
2. completion of a comprehensive, diagnostic evaluation using the most recent *DSM* and including a recommended treatment referral
3. completion of an individualized treatment plan, including
    a. identification of behavioral, psychological, family and medical concerns
    b. measurable short-term, intermediate, and long-term goals that
        01. are appropriate for age and level of impairment
        02. are based on standardized assessments relative to age-expected norms
        03. address behaviors and impairments for which the intervention is to be applied
        04. include baseline measurements and progress to date in the following:
            (1). social skills
            (2). communication skills
            (3). language skills
            (4). adaptive functioning
            (5). restricted, repetitive patterns of behavior, interests, or activities
            (6). self-injurious, violent, destructive, or other maladaptive behavior
        05. anticipated timeline for goal achievement based on the initial assessment and subsequent interim assessments over the duration of the intervention
    c. number of hours per week requested, with justification and supporting documentation for the specific number of hours based on member needs (see the *Service Limits for ABA Therapy* section for guidelines)
    d. a clear schedule of services planned and documentation that all identified interventions are consistent with ABA techniques
    e. plans for parent/guardian training and school transition
    f. documentation that ABA services will be delivered by an appropriate provider (see *Practitioner Requirements for ABA Therapy*)

Given that a member continues to meet criteria for ABA, documentation requirements for the continuation of services include
1. documentation of symptoms meeting criteria for autism and rationale that the member would benefit from ABA
2. individualized treatment plan is submitted with the following updates:
    a. measurable progress to date for each goal in the treatment plan
    b. revised anticipated timeline for goal achievement based on the initial assessment and subsequent interim assessments over the duration of the intervention
    c. clinically significant progress in the following areas:
        01. social skills

02. communication skills
03. language skills
04. adaptive functioning
05. behavior

d. updates to any section of the plan as applicable (eg, hours per week, schedule of activities, parent/guardian training, school transition)

3. documentation that ABA services are delivered by an appropriate provider

C. Crisis Intervention
A short-term emergency service, available 24 hours a day, 7 days a week, for face-to-face contact with the member including, but not limited to, crisis assessment, planning and counseling specific to the crisis, intervention at the site of the crisis when clinically appropriate, and prehospital assessment. It does not apply to group settings, time spent in inpatient settings, routine intakes provided after traditional hours, or for non-face-to-face services and is limited to acute episodes despite other BH service provision. Collateral contacts must be in addition to member contact. Documentation requirements include the following:
1. member at imminent risk of harm to self or others documented within 1 hour of initial contract with provider or member is experiencing a new symptom placing member at risk documented within 4 hours of initial contact with provider
2. documentation of resolution of crisis and transition of member to routine care through linkage to services
3. delivery completed in emergency and non-routine fashion
4. member-centered and individually delivered services

D. Intensive Outpatient Treatment (IOT)
A treatment program that lasts at least 3 hours a day, 3 days per week, and provides multiple service components for SUD in a group setting. The IHCP requires 120 minutes of interventions per 3-hour session with up to 20 minutes of break time per 3 consecutive hours. Direct service providers are not required to be licensed addiction counselors or clinical addiction counselors but must hold an addiction credential or have training and experience in addiction treatment. Additional documentation requirements are as follows:
1. age-appropriate services that are individualized
2. access to additional support services, if needed
3. rationale for how the service benefits the member, including group settings

E. Medication-Assisted Treatment for Opioid Use Disorder (MOUD)
Services are provided as part of a comprehensive treatment plan via 3 medications: methadone, buprenorphine, naltrexone. Documentation requirements include, at a minimum, the following:
1. medical necessity criteria according to IHCP standards
2. drug testing at least 8 times per year at random intervals to verify discontinued of use of all illicit and nonprescribed substances
3. a full evaluation and medical exam completed by provider that demonstrates medical necessity and rationale that services are the most appropriate treatment option

4. proof of counseling and behavioral therapy services
5. member length of treatment

OTPs will include documentation in each member's record that a good faith effort determined whether the member is enrolled in any other OTP. Members enrolled in an OTP will not obtain treatment in any other OTP except in circumstances involving an inability to access care at the member's OTP of record (eg, travel for work or family events, temporary relocation, OTP's temporary closure). If the medical director or program practitioner of the OTP in which the member is enrolled determines that such circumstances exist, the member may seek treatment at another OTP, provided the justification for the particular circumstances are noted in the member's record at both locations.

Initial and Periodic Assessments and Examinations for OTP Admits

1. Initial medical exams are required for members and are comprised of 2 parts:
   a. a screening exam to ensure criteria are met for admission with no contraindications for treatment with MOUD
   b. full history and exam with lab testing as determined to be required by an appropriately licensed practitioner

   Both parts must be completed by an appropriately licensed practitioner. If the licensed practitioner is not an OTP practitioner, the screening exam must be completed no more than 7 days prior to OTP admission. If the exam is performed outside the OTP, written results and narrative, as well as available lab testing results, must be transmitted consistent with applicable privacy laws to the OTP and verified by an OTP practitioner.

   A full in-person physical exam, including results of serology and other tests considered to be clinically appropriate, must be completed within 14 calendar days of admission and can be completed by a non-OTP practitioner, if the exam is verified by a licensed OTP practitioner as true and accurate and transmitted in accordance with applicable privacy laws. Serology testing and other testing deemed medically appropriate by the licensed OTP practitioner based on the screening or full history and exam, drawn not more than 30 days prior to admission, may form part of the full history and exam.
2. Initial physical and BH assessments will be conducted with every member admitted to an OTP and will include, but is not limited to, screening for imminent risk of harm to self or others, within 14 calendar days following admission by appropriately licensed/credentialed personnel. Assessments must address
   a. the need for and/or response to treatment
   b. treatment intervention adjustment(s), including MOUD, as necessary
   c. a patient-centered plan of care

   The full, initial psychosocial assessment (also to be completed within 14 calendar days of admission) must include preparation of a care plan including
   a. member goals and mutually agreed-upon actions for meeting goals, including harm reduction interventions

b. member needs and goals in the areas of education, vocational training, and employment
c. the medical and psychiatric, psychosocial, economic, legal, housing, and other recovery support services needed and desiring to pursue
d. the recommended frequency with which services are to be provided

The plan must be reviewed and updated to reflect responses to treatment and recovery support services and adjustments made that reflect changes in the context of the member's life, current needs for and interests in medical, psychiatric, social, and psychological services, and current needs for and interests in education, vocational training, and employment services.

3. Periodic physical examinations should occur not less than 1 time each year, be documented in the member's clinical record, and be conducted by an OTP practitioner, including
   a. review of MOUD dosing
   b. member treatment response
   c. other SUD treatment needs
   d. member-identified goals
   e. other relevant physical and psychiatric treatment needs and goal

F. Peer Recovery Services
Individual face-to-face services delivered as part of MAT services for up to 365 hours (1460 units) per rolling 12-month period without PA (or additional via PA) by qualified individuals certified by the Division of Mental Health and Addiction (DMHA) and under supervision by a practitioner. Documentation must
1. provide proof of a structured, scheduled activity
2. promote socialization, recovery, self-advocacy, development of natural supports, or maintenance of community living skills

G. Psychiatric Services
Certain psychiatric codes in combination are subject to 20 units per member per provider per rolling 12-month period without PA. See the *Psychiatric Service Procedure Codes with 20-Unit Limit table on Mental Health and Addiction Services Codes* for additional information. For units beyond this limit, providers must attach a current treatment plan and progress notes explaining the necessity and effectiveness of therapy.
1. Psychiatric diagnostic evaluations have unit limitations in accordance with 405 IAC 5-20-8 (14). Codes used may not be billed on the same day as an evaluation and management (E/M) service performed by the same individual for the same member or on the same day as psychotherapy services.
2. Psychotherapy with E/M on the same day must be reported using codes specific for psychotherapy performed with E/M services as add-on codes to the E/M service. The services must be significant and separately identifiable with appropriate modifiers, if applicable.
3. Psychiatric services with health and behavior assessment or intervention on the same day, providers report only the predominant service performed.

H. Psychological and Neuropsychological Testing
IHCP requires PA for testing. See the *Behavioral Health Practitioner Qualifications* section of the *Behavioral Health Services Manual* for additional guidance. Psychological testing includes psychological diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (eg, MMPI, Rorschach, WAIS), both face to face time with the client and time interpreting test results and preparing the report. The medical record must indicate the presence of mental illness for which testing is indicated and aid in diagnosis and therapeutic planning, as well as recording test(s) performed, scoring, and interpretation. Reports and other documentation may include
1. client history, mental status, and disposition
2. psychometric, projective and/or developmental tests
3. consultations with referral sources
4. other evaluation/interpretation of hospital records or psychological reports
5. other accumulated data for diagnostic purposes
6. names, signatures, credentials of staff involved in testing and report writing

I. Screening and Brief Intervention (SBI) Services
SBI identifies and intervenes with members at risk for substance-related problems or injuries using established systems, such as trauma centers, emergency rooms, community clinics, and school clinics, to screen members for substance misuse and, if necessary, provide brief interventions or referrals to appropriate treatment. Screening is limited to 1 structured SBI per member, every 3 years, by the same provider or 1 time per year per member per provider. Place of Service codes can be located in the *Behavioral Health Services Manual*.

III. Inpatient BH Services
Psychiatric hospitals must meet conditions according to 405 IAC 5-20-3. Members must meet medical necessity for inpatient services, including certification of need (CON) for services according to 405 Ind. Admin. Code 5-20-5. IHCP's *Behavioral Health Services* and *Inpatient Hospital Services Provider Manual* outlines reimbursement details, provider types, restrictions for inpatient stays, and information regarding institutions for mental diseases (IMD). The *Prior Authorization* module describes instructions for the submission of PA requests for inpatient admissions. PA forms can be located on the in.gov website. The IHCP requires providers to include specific documentation of the assessment or reassessment when requesting PA for residential SUD treatment by use of the appropriate forms also located at in.gov.

A. Certification of Need (CON)
The CON (1261A Form) 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 (42 CFR 441.152(a) and 42 CFR 441.153). Additional precert details, CON timeframes, and PA criteria are found in the *Behavioral Health Services Provider Manual* or 405 IAC 5-20-5.

B. Plan of Care (POC)
Additional information regarding the POC is located in 405 IAC 5-20-4. For members 22 years old or older, the attending or staff physician must develop and

submit a POC 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 POC within 14 days of the admission date and review the plan at least every 30 days. The POC is developed as a result of a diagnostic evaluation that includes an examination of the medical, psychological, social and behavioral aspects of the member's presenting problem and previous treatment interventions. The following components must be documented in each member's POC:

1. treatment objectives and goals, including an integrated program of appropriate therapies, activities and experiences to meet objectives
2. at the appropriate time, a post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the community to ensure continuity of care when returning to family and community upon discharge

Periodic reviews will ensure that appropriate services are being provided and continue to be medically necessary. The reviewing physician or interdisciplinary team will recommend adjustments in the plan, if any. The review and update of the POC must be in writing and part of the member's record.

C. Criteria for Admission to be Documented
   1. Psychiatric admissions must document the following factors:
      a. current or recent suicide ideation with plan and potential means with lethal intent
      b. current or recent serious, violent, impulsive and unpredictably dangerous homicidal ideation with plan and potential means with lethal intent
      c. current or recent harm to self or others with plan and potential means with lethal intent
      d. unable to care for self due to a psychiatric condition such that imminent, life-threatening deterioration has occurred
      e. acute psychotic symptoms, severely bizarre thinking, and psychomotor agitation or retardation that cannot be safely treated at a less-restrictive level of care

      Emergency acute psychiatric inpatient admissions are available for members with a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in danger to the individual, others or death of the member.
   2. Admission for SUD are based on ASAM Patient Placement Criteria, Level 4. Inpatient detoxification, rehabilitation, and aftercare for chemical dependency is reviewed on a case-by-case basis but will include consideration of
      a. treatment, evaluation and detoxification based on the stated medical condition and/or primary diagnosis for inpatient admission
      b. need for safe withdrawal from alcohol or other drugs
      c. a history of recent convulsions or poorly controlled convulsive disorder
      d. reasonable evidence exists that detoxification and aftercare cannot be accomplished in an outpatient setting

3. Criteria to be documented for inpatient detoxification includes the following:
   a. evidence of symptoms of withdrawal requiring close medical monitoring or continuous observation:
   b. history of severe withdrawal reaction (eg, seizures, delirium tremens, psychotic episode)
   c. intoxicated with a history of recent, severe idiosyncratic intoxication (eg, violence, blackouts while under the influence)
   d. a coexisting medical and/or psychiatric condition requiring medical and psychiatric services
   e. recent history of alcohol/other drug abuse with inability to control abuse outside a restrictive 24-hour-care environment demonstrated by documented recent failed attempts
   f. dependency or abuse contributes to severe social and/or emotional dysfunction in 1 or more life spheres (eg, vocational, familial, social)

D. Bridge Appointments

Bridge appointments are face-to-face, follow-up appointments in an outpatient setting on the day of discharge from an inpatient hospitalization for BH issues when no outpatient appointment is available within 7 days of discharge. The goal is to provide proper discharge planning while establishing a connection between the member and the outpatient treatment provider. Documentation must be maintained in the member's chart indicating the reason the bridge appointment service was necessary. The member must have 1 or more documented and identified barrier(s) to continuing care, such as

1. special needs
2. divorce or custody issues
3. work conflicts
4. inability to schedule within 7 days
5. history of noncompliance
6. complex discharge plans

During the bridge appointment, the provider should ensure, at minimum, that

1. Member understands the medication treatment regimen as prescribed.
2. Member has ongoing outpatient care.
3. Family understands discharge instructions for the member.
4. Barriers to continuing care are addressed.
5. any additional questions from the member or family are answered

E. Documentation Requirements for Psychiatric Hospitals (42 C.F.R. 482.61)

1. Assessment /Diagnostic Data

   Medical records must stress the psychiatric components of the record, including a history of findings and treatment provided for condition for which the member is hospitalized, including
   a. identification data with member's legal status
   b. provisional or admitting diagnosis at the time of admission, including the diagnoses of intercurrent diseases
   c. reasons for admission as stated by the member and/or others significantly involved

   d. social service records, including reports of interviews with member, family members, and others, with an assessment of home plans, family attitudes, and community resource contacts, as well as a social history
   e. when indicated, a complete neurological examination at the time of the admission physical examination
2. Psychiatric Evaluation
   Each member must receive a psychiatric evaluation within 60 hours of admission that includes
   a. a medical history and any previous treatment, including medication
   b. psychiatric history and any previous treatment, including medication
   c. substance use and/or withdrawal history, including any treatment
   d. social history
   e. mental status
   f. the onset of illness and the circumstances leading to admission
   g. a description of member attitudes and behavior
   h. an estimated intellectual functioning, memory functioning, and orientation
   i. an inventory of member assets in descriptive, not interpretative, fashion
3. Treatment Plan
   A written plan for each client must be based on strengths and disabilities and documented to include all active therapeutic efforts, including the following:
   a. a substantiated diagnosis
   b. short-term and long-range goals
   c. the specific treatment modalities utilized
   d. the responsibilities of each member of the treatment team
   e. adequate documentation to justify the diagnosis and the treatment and rehabilitation activities planned
4. Progress Notes
   Progress notes must be documented in accordance with State scope-of-practice laws and hospital policies by the following qualified practitioners:
   a. doctor(s) of medicine or osteopathy or other licensed practitioner(s) responsible for care of the member
   b. nurse(s)
   c. social worker(s) (or social service staff)
   d. therapists
   e. when appropriate, others involved in active treatment modalities
   The frequency of progress notes is determined by the condition of the member but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated and precise assessment of the patient's progress in accordance with the original or revised treatment plan.
5. Discharge Planning and Summary
   Each discharged member record must have a discharge summary, including
   a. a recapitulation of the members hospitalization
   b. recommendations from appropriate services concerning follow-up or aftercare

c. a brief summary of the member's condition at discharge

IV. Acute Partial Hospitalization (PH) Services

PH is subject to PA. Programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care or serve as a substitute for an inpatient admission. Services are individualized with treatment goals that are measurable and medically necessary. Treatment goals must include specific time frames for achievement of goals and be directly related to the reason for admission. Programs must not mix members receiving PH services with members receiving outpatient BH services.

A. Members must have a diagnosed or suspected BH condition and a short-term deficit in daily functioning or an assessment that indicates a high probability of serious deterioration of general medical or BH. Documentation requirements include the following:
   1. services must be ordered and authorized by a psychiatrist
   2. services require PA pursuant to 405 IAC 5-3-13(a)
   3. a face-to-face evaluation and an assignment of a BH diagnosis must occur within 24 hours following admission
   4. a psychiatrist must actively participate in case review and monitoring of care
   5. documentation of active oversight and monitoring of progress by a professional listed in the *Behavioral Health Services Module* must appear in the member's clinical record
   6. at least 1 individual psychotherapy service or group psychotherapy service must be delivered daily
   7. for members under 18 years of age, documentation of active psychotherapy, including a minimum of 1 family encounter per 5 business days of episode of care is required
   8. 4-6 hours of active treatment per day provided at least 4 days a week

B. Exclusions

   Services may be provided for consumers of all ages but are not appropriate for the following members:
   1. members at imminent risk of harm to self or others
   2. members currently residing in a group home or other residential care setting
   3. those who cannot actively engage in psychotherapy
   4. members with withdrawal risk or symptoms of an SUD whose needs cannot be managed at this level of care
   5. those who by virtue of age or medical condition cannot actively participate in group therapies

C. The individualized treatment plan must identify the following:
   1. coordinated services to be provided around individual member needs
   2. behaviors or symptoms resulting in admission and associated treatments
   3. functional changes necessary for transition to a lower intensity of service and means through which progress will be evaluated
   4. criteria for discharge and planned transition to community services

D. Reauthorization criteria for stays exceeding 5 days must document 1 of the following:
   1. clinical evidence indicates the persistence of problems that caused the admission to the degree that would necessitate continued treatment
   2. current treatment plan must include documentation of diagnosis, discharge planning, individualized goals of the treatment and treatment modalities needed and provided
   3. member progress confirms that the presenting or newly defined problems will respond to the current treatment plan
   4. daily progress notes, written and signed by the provider, document the treatment received and the member's response
   5. severe reaction to the medication or need for further monitoring and adjustment of dosage in a controlled setting (documented daily in the progress notes by a physician)
   6. clinical evidence that disposition planning, progressive decreases in time spent in the PH program and attempts to discontinue the program have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate inpatient hospitalization

V. Psychiatric Residential Treatment Facilities

ICHP reimburses medically necessary services for psychiatric residential treatment facilities (PRTF) with PA processed by Gainwell for fee-for-service and managed care members. See the *Behavioral Health Services Module* for additional info on documentation requirements and authorization criteria or 405 IAC 5-20-3.1.

VI. Residential SUD Treatment

IHCP provides coverage for short-term, low-intensity and high-intensity residential treatment for OUD and SUD in settings of all sizes, including facilities that qualify as institutes of mental disease (IMDs), when the facility is enrolled with the IHCP as an SUD residential addiction treatment facility. PA is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on ASAM Patient Placement Criteria Levels. All documentation needs to support the ASAM dimensional criteria for the requested level of care. Specific documentation requirements may be submitted on the provider portal, by fax, or by mail with use of the appropriate IN forms.

Medical records maintained by psychiatric hospitals must permit determination of the degree and intensity of the treatment provided in the facility. If a facility determines that a member requires more time than was initially authorized, a PA update request should be submitted showing that the member has made progress but can be expected to show more progress given more treatment time or that the member has not made progress but has been assessed to have the ability to make progress at the current level of care. Records must also show that member continue to meet ASAM dimensional criteria for the requested level of care. An additional length of stay can be approved based on documentation of medical necessity.

Practitioner interaction requirements state that initial evaluations must be completed in person. Follow-up face-to-face evaluations during the member's stay may be conducted through telemedicine if necessary. A physician (eg, psychiatrist), PA, or APRN must see the member face-to-face at least every 7 days during the stay. Services included in payment and reimbursement details are located in the *Behavioral Health Services Module*.

VII. Inpatient Hospital Admissions

Information on hospital inpatient admissions can be located in the *Inpatient Hospital Services Provider Reference Module*, including documentation requirements and additional payment information. PA is required for all Medicaid-covered psychiatric inpatient stays reimbursed under the level-of-care (LOC) payment methodology, as well as substance abuse stays reimbursed under the diagnosis-related group (DRG) methodology. Both reimbursement methodologies are described in 405 IAC 1-10.5.

E. Conditions of Coverage

Retrospective audit shall include postpayment review of the medical record to determine whether the service was medically necessary.

F. Related Policies/Rules

State and Federal Legislation and Documents

A. Community Mental Health Centers; Governmental Units, IND. CODE § 12-15-5-21 (2020).
B. Reimbursement for Clinical Addiction Counselors; Clinical Supervision Requirement, IND. CODE § 12-15-5-16 (2016).
C. Reimbursement for Students; Conditions; Policies, IND. CODE § 12-15-5-15 (2017).

G. Review/Revision History

	DATE	ACTION
Date Issued	04/28/2021	New policy. Approved at Committee.
Date Revised	05/11/2022 05/10/2023 06/19/2024	Removed Covid red box and DOB; updated references. Added II.C.4. Updated references. Approved at Committee. Annual review. Added MHPAEA info. Rewrote based on Behavioral Health Services Module from IHCP. Updated F & H. Approved at Committee.
Date Effective	11/01/2024	
Date Archived		

H. References

1. Behavior Analysts, IND. CODE § 25-8.5 (2023).
2. Behavioral Health and Human Services Professionals, IND. CODE § 25-23.6 to 11 (2023).

3. *Behavioral Health Services Mental Health and Addiction Treatment Provider Reference Manual*. Indiana Health Coverage Programs; 2022. Accessed May 17, 2024. www.in.gov
4. Certified Community Behavioral Health Clinics; Implementation; Certification; Requirements; Reimbursement for Eligible Services; Demonstration Program; Rules, IND. CODE § 12-15-1.3-25 (2023).
5. Clinical Records. 410 IND. ADMIN. CODE 17-15-1 (2020).
6. Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals, 42 C.F.R. § 482.61 (2020).
7. Coverage for Treatment of Opioid or Alcohol Dependence; Office Requirements; Report Use of Medications to Committee, IND. CODE § 12-15-5-13 (2019).
8. Eligible Providers for Supervising Treatment Plan, IND. CODE § 12-15-5-14.5 (2020).
9. *Expanded Scope of Licensed Behavioral Health Professionals to Certify a Mental Health Diagnosis*. Indiana Health Coverage Programs; 2021. IHCP bulletin BT202137. Accessed May 17, 2024. www.in.gov
10. Federal Opioid Use Disorder Treatment Standards, 42 C.F.R. § 8.12 (2024).
11. Individualized Mental Health Safety Plan; Requirements, IND. CODE § 12-21-5-6 (2021).
12. Inpatient Detoxification, Rehabilitation, and Aftercare for Chemical Dependency, 405 IND. ADMIN. CODE 5-17-5 (2023).
13. *Inpatient Hospital Services Provider Reference Module*. Indiana Health Coverage Programs; 2023. Accessed May 17, 2024. www.in.gov
14. Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs, 42 C.F.R. § § 441.150 to 441.184 (2024).
15. Intensive Outpatient Treatment Program, IND. CODE § 12-15-5-20 (2020).
16. Legal Recognition of Electronic Records, Electronic Signatures, and Electronic Contracts, IND. CODE § 26-2-8-106 (2022).
17. Medical Records, 405 IND. ADMIN. CODE 1-1.4-2 (2023).
18. Medically Necessary Service Defined, 405 IND. ADMIN. CODE 5-2-17 (2023).
19. Mental Health Services, 405 IND. ADMIN. CODE 5-20-1 to 8 (2023).
20. Minimum Standards for the Provision of Services by Opioid Treatment Facilities and Programs, 440 IND. ADMIN. CODE 10-1 to 4 (2023).
21. Prior Authorization, 405 IND. ADMIN. CODE 5-3-1 to 14 (2023).
22. Private Secure Facilities, 465 IND. ADMIN. CODE 2-11-1 to 89 (2023).
23. Psychologists, IND. CODE § 25-33 (2023).
24. Recovery Audits; Development, Review, and Certification of Plans of Treatment, IND. CODE § 12-15-13.5-6 (2020).