SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

MED-ASSESSMENT FOR MRO

(CMHC ONLY)

I. Service Description

A. This service standard applies to services provided to children involved with the Department of Child Services and/or Probation.

B. Provision of services will be through Medicaid Clinic Option (MCO), Medicaid Rehabilitation Option (MRO), and DCS Funding.

C. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid.

D. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

E. The Services not Eligible for MCO or MOR may be billed to DCS.

F. The DCS service model shall be used for this service standard.

G. This service standard includes the Initial Assessment- Clinic, Initial Assessment-Home, and Redetermination.

1. A client should only receive a referral for one of those assessments at any given time.

H. Initial Assessment

1. The purpose of this initial assessment is to have the following completed and summarized in a report:
    a) DMHA approved assessment
    b) Bio-psychosocial assessment
    c) Diagnosis (if applicable)
    d) Summary of CMHC Recommended Services

I. DCS will refer for an Initial Assessment-Clinic to be completed and billed to Medicaid Clinic Option (MCO).

1. If the FCM makes this decision, the FCM should complete a new referral for an Initial Assessment-Home.
2. In this instance, the Assessment time period of 7 (seven) calendar days will start over.
3. Note: The time period on the referral will be 6 months and will be used to authorize DCS match payment electronically for that time period.

J. If at the time the FCM makes the initial referral the FCM believes there are circumstances which would prevent the family from going to the clinic, DCS may choose to refer for an Initial Assessment-Home to be completed in the family's home.

1. The Initial Assessment-Home unit would be paid by DCS funding.

II. Service Delivery

A. Assessment

1. Face to face contact in a MCO approved setting is preferred.
2. This assessment should be completed with a report to DCS within 7 (seven) calendar days unless the services will require prior authorization (the child is not eligible for a preauthorized service package).
3. If a prior authorization for services is required, the assessment should be completed and a report returned to DCS within 17 (seventeen) days.
4. The report will include the DMHA approved assessment, a Biopsychosocial assessment, the child's diagnosis (if applicable), and the MRO Service Package or authorized services.
5. If the family is not responsive within 3 (three) days, the CMHC should contact the FCM to determine if the FCM wants to request the Initial Assessment to be completed in the home.

B. Redetermination

1. The redetermination requires face-to-face contact with the client and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which result in a completed redetermination.
2. The DMHA approved assessment tool must be completed at least every six months to determine the continued need for MRO services.
3. Reassessment may occur when there is a significant event or change in consumer status. Reimbursement is only available for one assessment per six months. .
4. CMHC will inform the referring worker of the need for a redetermination referral at least 14 days prior to the need for the approved referral.

III. Target Population

A. Assessments and Redeterminations are billable to Medicaid for Medicaid eligible clients. In addition, services must be restricted to the following eligibility categories:

1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.

2. Children and their families which have an IA or the children have the status of CHINS or JD/JS.
3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4. All adopted children and adoptive families.

IV. Goals and Outcomes

A. Goal #1: To obtain an Initial Assessment that will result in the identification of the MRO service package if applicable.

1. Objective: 95% of Initial Assessments will be completed within the designated time frames.

V. Minimum Qualifications

A. Initial Assessment:

1. 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 (1) of the following practitioners:
   a) A licensed psychologist
   b) A licensed independent practice school psychologist
   c) A licensed clinical social worker
   d) A licensed marital and family therapist
   e) A licensed mental health counselor
   f) A person holding a Master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
   g) An advanced practice nurse who is licensed, registered nurse with a Master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

B. Redetermination

1. Services must be provided by individuals meeting DMHA training competency standards for the use of the DMHA-approved assessment tool.

VI. Billable Units

A. Initial Assessment- MCO Clinic:

1. Initial Assessment-Clinic will be billed per assessment to clinic option for Medicaid eligible clients.
2. Medicaid shall be billed when appropriate.

B. Medicaid Billing Code Description

1. 90801 Diagnostic Interview

C. Initial Assessment-Clinic (DCS Paid)

1. Initial Assessment-Clinic will be paid per assessment by DCS for those clients who are not Medicaid eligible.

D. Initial Assessment-Home (DCS Paid)

1. Initial Assessment-Home will be paid per assessment by DCS.

E. Behavioral Health Level of Need Redetermination

1. Services through the Medicaid Rehabilitation Option (MRO) include Behavioral Health level of Need Redetermination.

2. Medicaid shall be billed when appropriate.

3. DCS funds should not be billed for this service.

F. Medicaid Billing Code Description

1. H0031 HW Mental Health Assessment, by non-physician

VII. Case Record Documentation

A. Case record documentation for service eligibility must include:

1. A completed, signed, and dated DCS/Probation referral form authorizing services
2. Documentation of regular contact with the referred families/children
3. Written reports no less than monthly or more frequently as prescribed by DCS/Probation
   a) Monthly reports are due by the 10th of each month following the month of service.
   b) Case documentation shall show when report is sent.
4. Copy of DCS/Probation Case Plan, Informal Adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

A. All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff.

B. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required.

C. Referrals are valid for a maximum of six (6) months unless otherwise specified by DCS/Probation.

D. Providers must initiate a re-authorization for services to continue beyond the approved period.

E. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

A. Services must be provided according to the Indiana Practice Model.

B. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness, and respect.

C. Providers will use the skills of engaging, teaming, assessing, planning, and intervening to partner with families and the community to achieve better outcomes for children.

X. Interpretation, Translation, and Sign Language Services

A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.

B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.

C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).

E. Sign Language should be done in the language familiar to the family.

F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.

H. No side comments or conversations between the Interpreters and the clients should occur.

XI. Trauma Informed Care

A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (http://www.samhsa.gov/nctic/):

1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC

seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

B. Trauma Specific Interventions: (modified from the SAMHSA definition)

1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XII. Training

A. Service provider employees are required to complete general training competencies at various levels.

B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.

C. Training requirements, documents, and resources are outlined at: http://www.in.gov/dcs/3493.htm

1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.
2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XIII. Cultural and Religious Competence

A. Provider must respect the culture of the children and families with which it provides services.

B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.

C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.

1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
3. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.

E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XIV. Child Safety

A. Services must be provided in accordance with the Principles of Child Welfare Services.

B. All services (even individual services) are provided through the lens of child safety.

1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statue, IC 31-33-5-1.

C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.