Policies and Procedures Manual

May 2022 Edition 8

Dear Provider,

It is our pleasure to welcome you to Recovery Works. This program is designed provide support services to individuals in the criminal justice system. Recovery Works is a gap funding program, to be used as supplemental funding until the individual is connected to insurance. Recovery Works is dedicated to increasing the availability of specialized treatment and recovery services in the community for those who may otherwise face incarceration. Treatment and/or recovery services are intended to supplement community supervision strategies to decrease recidivism.

In order to help facilitate a successful program, this manual has been produced to be a ready reference to providers. This manual contains all of the policies and procedures for Recovery Works in Indiana. This resource will continually evolve over the life of the program, and updates issued as needed. **It is imperative for providers to insert all policy and procedure memos issued by DMHA and, when directed, to replace the full contents with the newest version of the manual.**

The program staff is dedicated to providing the support you need to successfully implement Recovery Works at your agency and in your community. Please do not hesitate to contact us at Recovery.Works@fssa.IN.gov when you have questions or concerns about the program. Thank you for joining the Recovery Works network and providing participants with an opportunity for a brighter future.

Sincerely,

Recovery Works Program Staff

SECTION 1: RECOVERY WORKS PROGRAM POLICIES

SECTION 2: DESIGNATED AGENCIES AND PROVIDERS

Throughout the manual you will note sections that are highlighted. These areas have been changed or added since the last edition. Please take time to thoroughly review these sections.

BACKGROUND

In the general public, the prevalence rate of people who have a serious mental illness or of state and 45% of federal prison inmates have a diagnosed serious mental illness. Just under three-quarters of those are incarcerated in our state prisons (74%), and just under two-thirds (64%) in our federal prisons, have a substance use disorder diagnosis. Of the population who return to prison, the percentage of persons with a substance use disorder reaches 75%. There is a prevailing need for a partnership between the criminal justice system and mental health and substance use service providers, in order to reduce recidivism and encourage recovery.
In 2012, the Council of State Governments Justice Center (CSGJC) prepared a white paper titled "Adults with behavioral health needs under correctional supervision: a shared framework for reducing recidivism and promoting recovery," which provided an outline on how corrections, mental health and substance use disorder systems can share a commitment to help individuals successfully address their needs and avoid criminal justice involvement. In 2015, the Indiana General Assembly passed House Enrolled Act (HEA) 1006, "Criminal Justice Funding," which established the Forensic Treatment Services Program through the Division of Mental Health and Addiction (DMHA). This program will fund a voucher-based program to providers that offer specialized services to those struggling with mental illness and/or Substance-Use Disorder (SUD). This voucher-based system is intended to cover the cost of services for individuals without any alternate payer source (private insurance, Medicaid, and/or Healthy Indiana Plan (HIP) etc.). HEA 1006 granted $10 million for the 2016 state fiscal year of the program, and $20 million for the 2017, 2018, and 2019 state fiscal years. This voucher program, referred to as Recovery Works, will work with entities that are DMHA certified and/or housing providers who demonstrate competency in the treatment of populations with criminogenic risk factors.

Predictions based on the changes in the criminal code from HEA 1006 estimate that approximately 6,500 low level offenders will now need services within the community, rather than being sent to a correctional facility. Recovery Works focuses on pre-incarceration diversion services and post-incarceration re-entry services, which not only hopes to divert low-level offenders from incarceration to community services, but to reduce recidivism as well. Promoting recovery through community support and treatment/intervention is critical in reducing the number of persons with mental health and/or Substance-Use Disorder that are entering our criminal justice system.

WHAT IS RECOVERY?

In December 2011, Substance Abuse Mental Health Services Administration (SAMHSA) released a working definition of recovery and a set of guiding principles. This definition was the result of a comprehensive process that began with an August 2010 Dialogue Meeting and ended with a formal public engagement process in August 2011. At the time SAMHSA released the working definition, SAMHSA indicated they would continue dialogue to refine the definition and principles, and based on additional stakeholder input, SAMHSA then issued a slightly revised definition:

- **Recovery from Mental Disorders and/or s:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Four major dimensions that support a life in recovery:
- **Health:** overcoming or managing one's disease(s) or symptoms—for example, abstaining from the use of alcohol, illicit drugs, and non-prescribed medications if one has Substance-Use Disorder problem—and for everyone in recovery, making informed healthy choices that support physical and emotional wellbeing.
- **Home:** a stable and safe place to live.
- **Purpose:** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- **Community:** relationships and social networks that provide support, friendship, love, and hope.

GUIDING PRINCIPLES OF RECOVERY

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future: one where people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, cultures, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment, use of medications, and support from families and in schools, faith-based approaches, peer support, and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goals for those with Substance-Use Disorder (SUD). Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive

environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance-use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including social learning and the sharing of experiential knowledge and skills, play an invaluable role in recovery. Peers encourage and engage other peers by providing each other with a vital sense of belonging, supportive relationships, valued roles, and community. One helps themselves through helping others and giving back to the community. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationships and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover. Those who offer hope, support, and encouragement and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, and employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally based and influenced: Culture and cultural backgrounds in all of its diverse representations including values, traditions, and beliefs are key in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports

should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for his or herself. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have a responsibility to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect: Community, systems, and a societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's-self are particularly important.

It is important to keep the **Principles of Recovery** in mind when working with your participant on his/her recovery journey. While we understand, for some participants, choices may be limited; we do encourage participant choice through the individualized recovery planning processes as much as possible. When an individual is empowered to drive his/her own recovery process by choosing services they feel will be most beneficial to them, it allows the participant to begin to gain or regain control over their life. This self-determination and/or self-direction is one of the guiding principles of recovery.

MOTIVATIONAL INTERVIEWING

A recovery-oriented system of care is participant driven. Motivational Interviewing, one vehicle used in a recovery-oriented system, supports the relationship between a participant and a provider by empowering participants in their own recovery. Motivational interviewing can be utilized to help participants realize the discrepancies in their thought processes and then begin to move toward reaching their individual goals. Motivational interviewing focuses on exploring and resolving participants' ambivalence and centers on the motivational processes (what motivates this particular person) to bring about change.

Motivational Interviewing has three (3) key elements: collaboration between the provider and the participant, evoking the participant's ideas about change, and emphasizing the autonomy of the participant. These key elements are both participant-focused and participant-driven, which enables motivation interviewing to be utilized in a recovery-oriented system of care.

There are four principles employed by providers using Motivational Interviewing. Any of these principles functioning on its own can be ineffective, but when they are implemented together, they can effectively help participants move through the stages of change.

The four (4) principles are:

1. **Express Empathy:** Expressing empathy involves seeing, feeling, and thinking about things the way in which the participant does. Empathy helps participants sense their providers understand them individually and that they also care about the personal issues they are facing. This promotes the participant to being more open and honest with providers and thereby allowing for a more workable and helpful relationship to develop.
2. **Develop Discrepancy:** Developing discrepancy occurs when participants see the mismatch between where they are in life and where they want to be. When participants identify discrepancy between their current behaviors/circumstances and their values and plans the likelihood that they will become more motivated increases. Providers do not point out discrepancies, but help participants see inconsistencies that may exist by asking questions.
3. **Rolling with Resistance:** Rolling with resistance discourages providers from confronting participants when they begin to resist the change process. Actions and statements that show resistance remain unchallenged. By having the participant define the problem and develop their own solutions, there is little room for resistance. Providers can go along with what participants say, and then utilize these statements to help develop discrepancy.
4. **Supporting Self Efficacy:** Supporting self-efficacy is about encouraging participants to believer that change is possible. This approach credits participants with having the capacity and capability to change. This idea generates hope and allows participants who have previously tried recovery and failed to believe that success is possible. Self-efficacy is supported by highlighting participants' strengths instead of their failures.

Recovery Works requires that providers utilize Motivational Interviewing techniques to encourage and empower participants to enter and stay in recovery. The principles and elements of Motivational Interviewing support a recovery-oriented approach and a participant/provider partnership that will allow participants to be successful in maintaining their recovery. In addition, all direct services providers must attend an in person Motivational Interview training within ninety (90) days of hire. For more information, visit the Motivational Interviewing website listed here: http://motivationalinterview.net/.

RECOVERY WORKS VISION

Every person should have the opportunity to live a healthy, hopeful, fulfilled life in the community. Recovery Works provides community-based interventions that ensure both the safety of the community and the recovery of the individual needing treatment rather than incarceration.

RECOVERY WORKS VALUES

Decency: all people should be treated with respect and their needs responded to quickly

Fortitude: never giving up

Hope: a positive future view

Integrity: do the right thing even when no one is looking

Parity: every person deserves the same opportunity

Quality: service should be of the highest caliber

PROGRAM POLICIES

GENERAL POLICIES

SERVICE ETHICS

Recovery Works Providers agree to abide by the following service ethics when serving Recovery Works participants:

- ***Effective recovery support and treatment attend to the whole person, not just his or her illness.*** To be effective, all components of recovery must be considered and each area of life, including social, vocational, educational, physical, and mental health, and environment must be assessed for strengths and addressed appropriately. Not everyone's recovery looks the same; therefore, not everyone's recovery plan should look the same. It is imperative that the whole person be addressed and each barrier to recovery planned for. It is equally imperative that providers utilize an individualized treatment approach, as opposed to a "one size fits all" approach.
- ***The participants' recovery process is their own.*** There is no one path to recovery and no one service that is appropriate for every individual. The participants' services need to be tailored to their individual needs and strengths. This means services need to be appropriate for the stage of recovery a participant is in and should be driven by the participant. Remember, providers are not the experts in relation to participants' personal lives and struggles; therefore, their recovery should be approached as a partnership and not as an expert/consumer or teacher/student relationship.
- ***An individual's recovery plan must be assessed continually and modified regularly to ensure that the plan meets the person's changing needs.*** A person many require varying combinations of services, both clinical and recovery support, during the course of recovery. It is vital that Recovery Works services be appropriate to the individual's age, gender, ethnicity, language, culture, and stage in his or her recovery. If a participant's plan is not changing, then the plan is not working. A participant should be making progress throughout their involvement with the program and therefore, will not have the same needs throughout. It is important to keep up with a participant's progress to ensure that he or she is offered the most pertinent services at the right time. At no time should a participant receive services because "everyone else receives this service." If a participant's plan is not changing, then the plan is not working. A participant should be making progress throughout their involvement with the program and therefore, will not have the same needs throughout. It is important to keep up with a participant's progress to ensure that he or she is offered the most pertinent services at the right time. At no time should a participant receive services because "everyone else receives this service."

- ***To promote recovery, it is necessary to maintain services for however long they are needed.*** This will depend on each individual participant's needs and will require a vast array of coordinating, funding sources and partners as Recovery Works funding is limited. It is important that providers and participants understand that Recovery Works will not be able to fund everything participants need. Therefore, knowing the services available locally and helping participants access them is important. Each community has programs and resources that are available at low or no cost to participants and these can, and should, be utilized to help facilitate the continuation of recovery after Recovery Works funding is used. If you are unsure of the resources in your area, you can contact 2-1-1 for assistance in familiarizing yourself with available community resources.
- ***All documentation must be complete and accurate.*** This includes, but is not limited to, the length of encounters with participants (no rounding up is permitted, only actual times will be recorded), who rendered the service, individual contribution to the service etc. If documentation is not accurate and complete, it can be deemed fraud and may result in termination of contract and/or prosecution. In addition, files must be organized and legible.

CONFIDENTIALITY

Confidentiality of participant information is an ethical obligation for all providers and a legal right for every participant. Providers may have access to confidential information regarding alcohol and substance use disorder patient records. Recovery Works providers agree that this information is confidential and promises to ensure that any information, regardless of form, disclosed to the provider for the purposes of this program will not be disclosed or discussed with others without the prior written consent of the participant. Recovery Works providers must comply with confidentiality of participant information and protected health information requirements as set forth in HIPAA, 42 CFR Part 2, IC 16-39, and any other state or federal regulations. Providers must obtain a completed release of information from each Recovery Works participant, and for each party to whom information is disclosed. This includes a release to communicate with criminal justice partners.

Providers should use the unique participant identification number assigned by WITS when referring to Recovery Works participants in written communications, including e-mail. The provider may not disclose protected health information in e-mail communications.

PROGRAM COMPLIANCE WITH HEALTH AND SAFETY REGULATIONS

Recovery Works Providers must serve all participants in safe facilities. Facilities used by a program are required by law to be in compliance with fire and safety standards established and enforced by local and state fire officials. Also, all health, safety, and occupational codes must be met at the local level.

Programs must meet all requirements of the Americans with Disabilities Act of 1990. The ADA requirements state that all sites should be accessible to the disabled in the greatest extent

feasible and during renovations and new construction, certain standards must be met. For existing structures, any changes that increase accessibility without changing the fundamental structural viability of the facility must be planned and implemented in a timely and diligent manner.

DRUG-FREE WORKPLACE

Providers hereby covenant and agree to make a good faith effort to provide and maintain drug free workplaces. Providers will give written notice to the State within ten (10) days after receiving actual notice that they or one of their employees have been convicted of a new criminal drug violation. False certification or violation of this Agreement may result in sanctions including, but not limited to, suspension and/or termination of Provider Agreement.

Providers certify and agree that they will provide a drug-free workplace by:

A. Publishing and providing to all its employees a statement notifying them that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the provider's workplace and specifying the actions that will be taken against employees for violations of such prohibition.

B. Establishing a drug-free awareness program to inform its employees of (1) the dangers of substance-use disorder in the workplace; (2) the provider's policy of maintaining a drug-free workplace; (3) any available substance-use disorder counseling, rehabilitation, and employee assistance programs; and (4) the penalties that may be imposed upon an employee for substance-use disorder violations occurring in the workplace.

C. Notifying all employees in the statement required by subparagraph (A) above that as a condition of continued employment, the employee will (1) abide by the terms of the statement; and (2) notify the provider of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

D. Notifying the State in writing within ten (10) days after receiving notice from an employee under subdivision (C)(2) above, or otherwise receiving actual notice of such conviction.

E. Within thirty (30) days after receiving notice under subdivision (C)(2) above of a conviction, imposing the following sanctions or remedial measures on any employee who is convicted of substance use violations occurring in the workplace: (1) taking appropriate personnel action against the employee, up to and including termination; or (2) requiring such employees to satisfactorily participate in a substance-use disorder assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency.

Making a good faith effort to maintain a drug-free workplace through the implementation of subparagraphs (A) through (E) above.

CONFLICT OF INTEREST

Recovery Works providers must establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private financial gain for themselves or others, such as those with whom they have family, business, or other ties.

Therefore, each institution receiving Recovery Works funds must have written policy guidelines on conflict of interest and avoidance thereof. These guidelines should reflect state and local laws and must cover financial interests, gifts, gratuities and favors, nepotism, and other areas such as political participation and bribery. These rules must also indicate how outside activities, relationships, and financial interests are reviewed and reported by the responsible and objective institution official(s).

IDEMNIFICATION

The Provider agrees to indemnify, defend, and hold harmless the State, its agents, officials, and employees from all claims and suits including court costs, attorney's fees, and other expenses caused by any act or omission of the Provider and/or its subcontractors, if any, in the performance of their Provider Agreement. The State shall not provide such indemnification to the Provider.

NON-SUPPLANTATION CLAUSE

Recovery Works is a funding source of last resort. If services offered can be paid for by other state or federal programs/grants (e.g., Substance Abuse Prevention and Treatment Block Grant, Vocational Rehabilitation, Department of Child Services (DCS), Veterans Administration, etc.), private insurance, Medicaid, and/or Healthy Indiana Plan, Recovery Works cannot be billed for the services.

An individual already receiving services through another program is ineligible for the same services through Recovery Works. It is not acceptable to remove a person from the alternate payer source and transfer them to Recovery Works.

EXCLUSIONS

Recovery Works funds may not be used to:

- Pay for the purchase or construction of any building or structure to house any part of the program.
- Provide outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision.
- Pay for incentives to induce individuals to enter treatment.

- Pay for a participant's manual labor and/or employment through a provider, criminal justice partner or any of its contractors.
- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.
- Pay for pharmacology for HIV antiretroviral therapy, sexually transmitted infections (STI), TB, and hepatitis B and C.
- Pay for services in a Recovery Residence that is not DMHA Certifications Team certified and meeting all standards of Recovery Works.

SANCTIONS

Recovery Works reserves the right to implement sanctions for providers who do not follow the policies and procedures of any aspect of the Recovery Works Program. Possible list of sanctions includes but not limited to:

- Suspension of new Recovery Works referrals
- Suspension from the Recovery Works Program for a period up to 3 years
- Monetary payment of services rendered
- Inability to access the Recovery Works systems

Recovery Works will attempt to provide sufficient notice (ex. 14 days) prior to sanctions being imposed. In some instances, this may not be possible, and Recovery Works may notify the provider as the emergency sanction is being imposed.

These sanctions also apply to all criminal justice partners and/or designated service providers. List of possible CJP sanctions include but is not limited to:

- Suspension of ability to make referrals
- Denial of provider payment for services derived from CJP referrals
- Termination of CJP's ability to participate in the Recovery Works Program
- Recovery Works disseminating referrals on behalf of the CJP

Recovery Works will work with each CJP and DSP to ensure successful implementation of Recovery Works Policies and Procedures. Any questions regarding Recovery Works Policies and Procedures as well as sanctions should be directed to the Recovery Works Team via the Recovery Works email: recovery.works@fssa.in.gov.

SUSPENSION AND TERMINATION

Recovery Works may, by written notice to the Agency and/or Provider, terminate the whole or any part of the Agency Agreement for any reason, including the following (but not limited to):

Recovery Works may suspend a provider at any time due to negligence, fraud, or violation of Recovery Works Policies and Procedures. Recovery Works shall notify the Agency/Provider in

writing of their failure to comply and immediate suspension. Should the Agency/Provider not remedy such failure within a period of time specified in writing by Recovery Works, the Agency Agreement may be terminated.

If the Agency or any of its officers, employees or agents commits participant abuse, neglect or exploitation, malpractice, fraud, embezzlement, or other serious misuse of funds during the term of provider agreement, Recovery Works may terminate the Agency Agreement immediately upon written notice to the Agency.

Financial limitations such as loss or expenditure of funds.

If negative action is taken by any State entity against an Agency, provider or employees of the agency.

The Agency agrees that the existence of a dispute notwithstanding, will continue, without delay, to carry out all its responsibilities under the Agency Agreement that are not affected by the dispute. Recovery Works or the Agency may terminate the Agency Agreement without cause upon thirty (30) days written notice to the other party.

If an agency is terminated, they may not reapply to become a Recovery Works agency/provider for three (3) years

Designated Agencies and Providers

RECOVERY WORKS PROVIDER CERTIFICATION

All treatment providers must be a DMHA certified CMHC, ASO, ASR, PIP, or OTP agency prior to becoming an approved Recovery Works designated agency. DMHA Certifications has recently taken over Recovery Residence certification and applications. The certification process involves the completion of necessary forms and attending all required trainings. Successful certification will authorize agencies to obtain reimbursement for providing services to Recovery Works participants. As of July 1, 2019, all treatment providers are required to be enrolled as a Medicaid/HIP provider, as well as be credentialed by all 4 Managed Care Entities.

Please note, the Indiana Affiliation of Recovery Residences (INARR) is no longer completing Recovery Residence certifications for Recovery Works. Previous certifications completed prior to July 1, 2021, will be honored up to two (2) years.

> ***Example: A designated provider was certified by INARR on April 1, 2020. This certification is honored until April 1, 2022.***

DIAGRAM 1: WHAT ARE THE STEPS TO BECOMING A DESIGNATED Recovery Works AGENCY?

Complete DMHA Certification for Recovery Residence and/or Treatment Provider
↓
Visit Recovery Works Forms and Applications page to download the application
↓
Complete the application in its **entirety**- each service line must be complete
↓
Send application as well as Insurance welcome letters, DMHA certifications, W9 form, and Direct Deposit form to the Recovery Works email: **Recovery.Works@fssa.IN.gov**
↓
Recovery Works staff will review the application.
↓
Upon approval, Recovery Works will email the Agency Agreement and Approval Letter
↓
Agency must return **signed Agency Agreement**
↓
Staff must complete required trainings-DARMHA/WIITS, Policy and Procedure, MI, Recovery Model, ANSA, etc.
↓
Agency will be set up in WITS and DARMHA systems
↓
Referrals can be accepted, and billing can begin

QUALIFICATIONS FOR DESIGNATED SERVICE PROVIDERS (DSP)

After becoming a Recovery Works designated agency, individual providers within the agency can become designated service providers (DSP). In order to be an approved designated service provider, individuals will have basic educational and/or licensure requirements. Based on the Indiana Professional Licensing Agency (IPLA) standards and Indiana Code, providers must practice within the established scope of work for the provider's degree, licensure, and/or experience. Designated service providers for Recovery Works will be qualified within one of the following designations:

Designated Service Provider Qualifications

DSPs delivering service must meet appropriate federal, state, and local regulations for his/her respective disciplines. Specific provider qualifications, program standards, and exclusions are included in each service definition.

Three predominant categories of providers may provide Recovery Works program services:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Licensed Professional- A licensed professional is defined by any of the following provider types:

- Psychiatrist
- 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)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *IC 25-23.6-10.5*

Qualified Behavioral Health Professional- A QBHP is defined by any of the following provider types:

- An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined previously; 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 (RN) 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 previously, 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
    - Marriage and family therapy from an accredited university

- A licensed independent practice school psychologist under the supervision of a licensed professional, as defined previously
- An authorized health care professional (AHCP):
    - 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 (NP) or a clinical nurse specialist (CNS), 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- An OBHP is defined by any of the following provider types:

- An individual with an associate degree or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards **set forth by the designated agency** and supervised by a licensed professional or QBHP, defined above.
- A licensed addiction counselor (LAC), as defined under *IC 25-23.6-10.5*, supervised by a licensed professional or QBHP, defined above.

Information taken from Indiana Medicaid Manual and Indiana Professional Licensing Agency standards and codes. All agencies must have an internal version of OBHP's (for each job description) in addition to the above Recovery Works definition. This copy must be readily available upon request by Recovery Works if the provider has employed an OBHP (current and past).

PERSONNEL POLICIES

ORIENTATION

The Recovery Works designated agency shall provide an orientation that includes an explanation of mission or purpose statement for support services, job description or duties, review scope of work, overview of written policies and procedures, and code of ethics explained and signed by the employee. In regard to Recovery Works, providers must provide all staff with information about the agency's participation in the Recovery Works program, including where call or inquiries about Recovery Works should be directed. Additionally, agency staff should be informed about the Recovery Works referral process. This is to ensure that the best interests of the participant(s), including continuity of care, are maintained to the best of the provider's ability.

PERSONNEL MINIMUM REQUIREMENTS

The agency shall employ or recruit individuals with the necessary qualifications to effectively execute their position. Paid personnel who provide support services must attend any required credentialing training. All paid employees providing Recovery Works services must meet the minimum staff requirements as outlined in the Qualifications for Certification section.

PERSONNEL FILE

The purpose of this file is to show qualifications and experience of personnel. Personnel include all individuals that work with Recovery Works participants, regardless of whether they are hourly employees, salary employees, or contractors. Personnel files may be reviewed by Recovery Works administrative staff for verification that rendering staff meet the minimum qualifications. The file shall contain a minimum of the following items:

1. Job description or scope of work
2. Resume and a list of volunteer or life experiences, including evidence of applicable training for the job hired
3. License, certification, or related credentials (all documentation must be up to date through the last date of employment, this includes current licensure)
4. Proof of Completion of the following mandatory trainings (checklist available online):
    - Policies and Procedures Training for all staff supervising those involved in Recovery Works
    - DMHA Online: Recovery Model for all staff involved in Recovery Works
    - DMHA Online: Working with the Justice Involved for all staff involved in Recovery Works
    - Motivational Interviewing for all staff that have direct care responsibilities
    - Personal Safety or Non-violent Crisis Intervention training for all staff that have direct care responsibilities
    - Recovery Works Diversity Equity and Inclusion Training
    - CEUs for forensic, mental health, and/or -related trainings each year

When an audit occurs, Recovery Works auditors must be able to view the personnel file, and identify the specific job description, personnel qualifications (i.e., current licensure, certification, etc.). Recovery Works reserves the right to disqualify any service(s) for which a personnel file is not complete and accurate as to the service provided.

RECOVERY WORKS TRAINING POLICY

Recovery Works training requirements can be found on the Recovery Works website by navigating to resources—training. Appropriate Recovery Works designated providers must attend or have certification/proof of attendance in:

- **DARMHA/WITS Training:** Online PowerPoint or in-person session, must be viewed by those that will be performing billing responsibilities and/or entering data. The DARMHA/WITS user manual should also be printed and provided to each employee using the systems.

- **Online Policies and Procedures Training:** In-person session, must be viewed by supervisors of Recovery Works staff prior to the start of billing.
- **ANSA Training:** Online training, please review criteria on Schoox website, ALL staff that will be performing assessments must be ANSA certified prior to accepting Recovery Works referrals. Staff must recertify prior to certification expiration date to continue rendering services.
- **DMHA Online: Recovery Model**: Online webinar, must be viewed by all staff that are working directly with Recovery Works participants, must be viewed within 45 days of becoming a provider or employment.
- **DMHA Online**: **Working with the Justice Involved**: Online webinar, must be viewed by all staff that are working directly with Recovery Works participants, must be viewed within 45 days of becoming a provider or employment.
- **Motivational Interviewing**: In-person training, must be taken by all staff that are working directly with Recovery Works participants.
    - Exceptions: Licensed Professionals, and QBHPs who have received Motivational Interviewing supervision and who have attended a MINT (Motivational Interviewing Network of Trainers) training within the last three (3) years are eligible to view a webinar in order to verify competence, all others must take training as close to 90 days of becoming a provider or employment as possible. For those that have received MI supervision and training within the past three (3) years, you can view the webinar at http://bit/ly/motivationalinterviewingwebinar.
- **Personal Safety or Non-violent Crisis Intervention training:** In-person training, must be taken by all staff that are working directly with Recovery Works participants, must take training as close to 90 days of becoming a provider or employment as possible. (**Note: This should be offered in house and detailed documentation must be provided to RW)**
- Recovery Works Diversity Equity and Inclusion Training: In-person training, must be taken by all staff that are working directly with Recovery Works participants, must take training within 90 days of becoming a provider or employment.

Once a provider has completed the training, they must keep the certification/attendance verification in the personnel file. A training checklist can be found on the Recovery Works website, which is sufficient documentation for the online webinars. It may also be reviewed by Recovery Works administrative staff for verification at any time.

Recovery Works requires that DSPs obtain CEUs for forensic, mental health, and/or Substance Use Disorder-related trainings each year. **Each year, DSPs, must designate 20% (4 hours) of their CEUs to forensic-related topics and 20% (4 hours) to mental health and/or Substance Use Disorder—related topic.** Certificates should also be kept in personnel files.

In addition to the trainings above, there are three (3) types of access to the Web Infrastructure for Treatment Services (WITS) or Voucher Management System (VMS). They are as follows:

- **Rendering Staff:** These are the individuals at your agency who directly provide the services to the participants and will be signing the contact logs. They will have accounts in WITS, but it will only show as rendering staff. They will not receive a login or password, but their names need to be in the system as rendering staff, so that the agency can bill appropriately with the proper rendering staff recorded. Providers MUST properly record in WITS who the rendering staff for service is.
- **Data Entry:** These individuals will have access to the system to input participant data and billing encounters.
- **Release to Billing:** These individuals have all of the above access and are also permitted to release the information to the state government to be reimbursed for service(s) rendered. This is the highest level of access to the WITS system for a provider.

All personnel that have data entry or release to billing access, must successfully complete the Recovery Works Policies and Procedures Training and DARMHA/WITS Training. Training will provide detailed instruction on the WITS system. The DARMHA/WITS user manual should also be printed for each person with either of these access levels. Additional access of "agency reporting" is also available for those with data entry or release to billing levels who would like to view participant overall expenditures. If a provider needs one on one training for clarification purposes, you may contact Recovery Works.

RECOVERY WORKS PILOT PROGRAMS

Recovery Works recognizes the importance of growth and opportunity to help ensure the maximization of the Recovery Works mission and values. Pilot programs are initiated to explore potential of service need and/or data collection of future decisions.

Opportunities for participation in pilot programs will be communicated via email with clear and concise deadlines for applicants and specifications about the pilot. All pilot program agencies will be required to follow the guidelines of the program.

SERVICE CHANGES

Designated Recovery Works agencies may only claim for services that they provide directly and for which they have been approved to provide. An application addendum is required if a designated Recovery Works agency would like to change a recovery support or clinical service that is being offered, for which voucher reimbursement is requested. This application can be found on the Recovery Works Website. Notifications of changes must be submitted to Recovery Works via JIRA prior to the new services being rendered. If services are claimed for which a provider has not been authorized to provide, the provider will be responsible for reimbursement of those funds to Recovery Works.

Example: if the agency would like to add or remove a current service being offered, an Application addendum is required. If there is a change or addition to the geographical

location where such services are provided, and application addendum is required. This also extends to new housing locations that are offered. There is a Change of Contact Form also available on the Recovery Works website which can be completed and sent via JIRA

The Division of Mental Health and Addictions maintains responsibility for approving application addendums prior to Recovery Works approval. DMHA should be contacted in the event that an agency would like to provide additional Recovery Works services or change facility information. All addendums must be submitted and approved prior to implementing changes.

STAFF CHANGES

Providers must inform Recovery Works administration of staff changes within **ten (10)** business days of said change. This policy shall apply to vacancies as well as new hires as well as changes in responsibility; but shall only apply to positions that have responsibilities that include provision or supervision of the provider's Recovery Works services (example: administrative staff that have access to WITS, clinical staff, rendering staff, house managers, etc.).

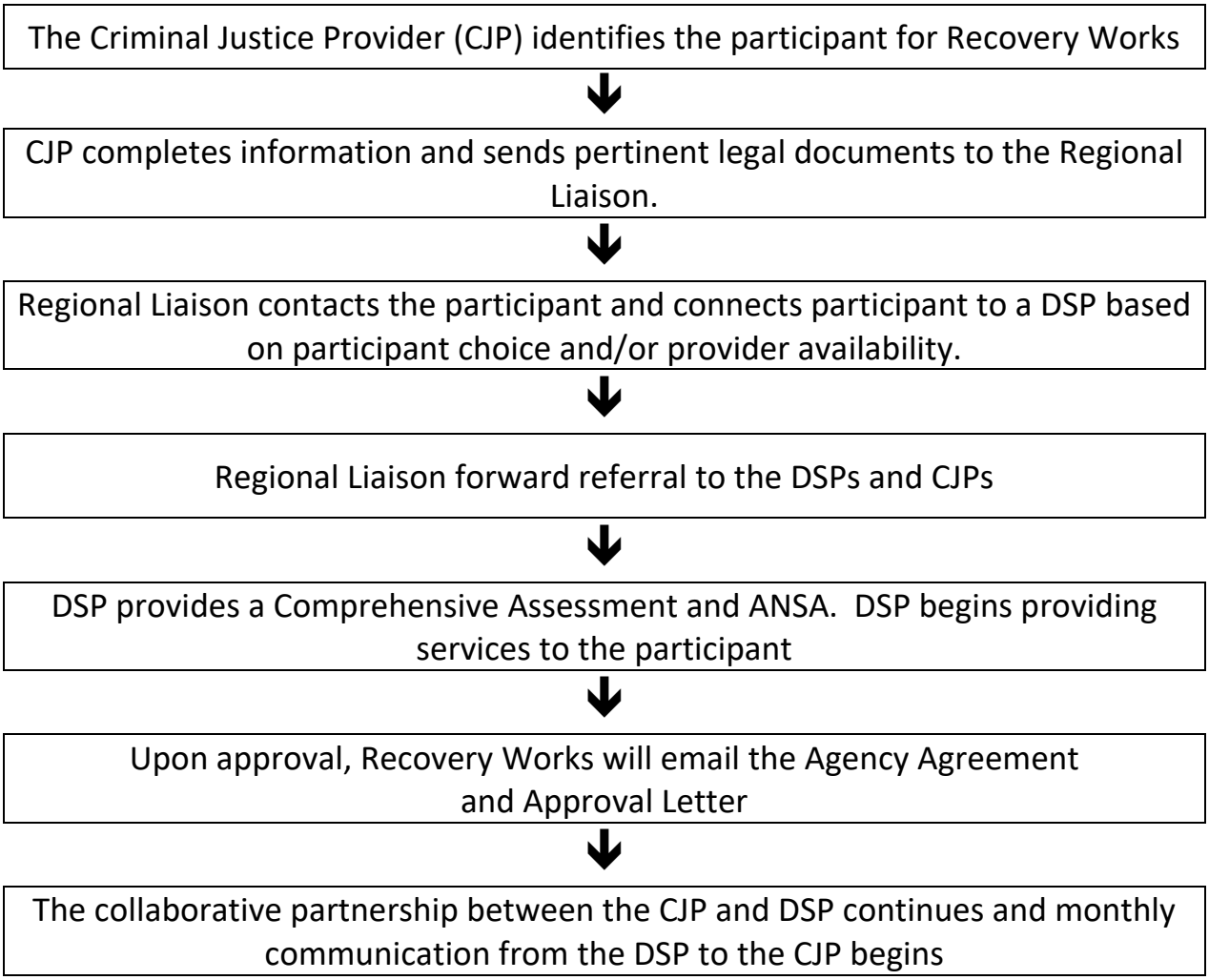
For staff with WITS access, a WITS Access Spreadsheet must be submitted to notify Recovery Works administration staff of needed changes in the WITS system. This spreadsheet can be found on the Recovery Works website. Once the spreadsheet is completed it must be submitted via JIRA. Failure to notify Recovery Works will result in a 30+ day suspension of billing privileges and/or reimbursement of services for staff who may have provided services.

WHO IS CONSIDERED A CJP?

A CJP is a Criminal Justice Provider. These are the individuals that oversee or assist a participant while they are in the Criminal Justice System. Some examples are a Probation Officer, Parole Officer, Community Corrections Officer, Judge, Court Liaison, Public Defender, Prosecutor, Private Attorney, Parole Liaison, Jail Staff. All entities who are CJP's must have access to participant criminal history information. This information must be sent to the Regional Liaison when making a referral. If you have any questions as to whether an entity/individual qualifies as a CJP, please reach out to Recovery Works.

SCOPE OF WORK

Both the Criminal Justice Provider (CJP) and Designated Service Provider (DSP) are an integral component of Recovery Works. Employees whose duties do not include direct participant contact are not subject to the forgoing qualifications. Recovery Works vouchers will only pay for DSPs in support of participants' recovery activities as outlined in their plan of care.



DESIGNATED SERVICE PROVIDERS (DSP) WILL:

- Accept referrals from Regional Liaison and contact participant within two (2) to five (5) business days. **Exception: For incarcerated participants, providers will have two (2) to five (5) business days from the date of RELEASE as opposed to date of referral.**
- Obtain participant consent and release of information for DSP to communicate about participant.
- Perform a comprehensive bio-psycho-social assessment and administer the Adult Needs and Strengths Assessment (ANSA) **within fourteen (14) calendar days** to help assist the

participant in prioritizing services that will be most beneficial to the participant's recovery.

- Develop an individualized treatment plan, utilizing the participant's voice and choice. The intention of this plan is to assist the participant in beginning to plan their recovery and understand recovery as a long-term, lifestyle change. This is to be reviewed every ninety (90) days and updated as needed. If there is not a diagnosis of mental health and/or substance abuse, the participant does not qualify for Recovery Works services. It is not appropriate for a service provider to include a diagnosis to satisfy a request from an outside entity for services.
- Provide services based on participant's treatment plan, which is expected to be individualized to the participant's needs. Treatment plans should not be standardized based on an agency's specific treatment requirements.
- Communicate and document all of the participant's progress with his/her CJP.
- Will submit billing claims into the Web Infrastructure for Treatment Services (WITS).
- Develop a method for tracking participant expenditures to ensure the participant does not exceed any of the funding buckets. It is the responsibility of the agency to ensure proper expenditure for each participant. If questions exist regarding funding availability, please contact Recovery Works.
- Will make a referral in WITS to another Recovery Works Designated agency and/or provider to provide the services if DSP is unable to provide services on the participant's treatment plan.
- Ensure that participants remain connected to the program through ongoing contact (phone and in person), motivation and support.
- Maintain an ongoing electronic and/or physical record of all contact with participants. This includes maintenance of a physical file containing participant demographic and contact information, signed Release of Information documents, problem-solving court session documentation and any other ancillary information relevant to the participant. Maintenance of the electronic record will require agencies to create participant profiles, authorize vouchers for all services, and claim payment for DSP activity. Recovery Works participant files are to be stored in compliance with the Health Information Portability and Accountability Act (HIPAA) and other applicable state and federal privacy provisions, including, but not limited to, 42 CFR Part 2.

NEW PARTICIPANT PROCEDURE

1. The Criminal Justice Provider (CJP) will identify the participant in need of Recovery Works.
2. Upon identification, the CJP will send the Criminal Justice Information Sheet as well as pertinent criminal justice documentation to the Regional Liaison.
3. The Regional Liaison will contact the Participant, collect data and distribute referrals to the Direct Service Provider (DSP).

4. The Regional Liaison will distribute the referral based on participant choice, anticipated participant need and/or provider availability.
5. Upon receipt of the Recovery Works Referral form from the Regional Liaison, **the DSP is expected to verify participant's eligibility** and **must** contact the participant within two (2) to five (5) business days and schedule an in-person appointment. Agencies may choose to provide "Open Access" appointments to their participants. If agencies choose this route, Recovery Works participants MUST be seen on the day they show up for the open access appointment. At the in-person appointment, the DSP will:
    - Perform a Comprehensive Mental Health and Substance Use Disorder assessment
    - Perform the Adult Needs and Strengths Assessments (ANSA)
    - Enter all participant information into DARMHA—demographic, diagnosis, NOMS, ANSA

5. After completion of the Comprehensive Mental Health and Substance Use Disorder assessment and ANSA, an individual treatment plan is developed that addresses all areas of potential need. The intention of this plan is to assist the participant in beginning to plan their recovery and understand recovery as a long-term, lifestyle change. This needs to be reviewed and updated at a minimum of every ninety (90) days. The DSP will speak with the participant to determine which services will be most beneficial to the participant's recovery based on individual needs. These services will then be recorded on the treatment plan.

To allow the participant to receive the services on his/her treatment plan, the DSP will be responsible for creating vouchers and encounters within WITS for the participant based on his/her treatment plan. Vouchers and encounters must be created in WITS for each Recovery Works service the participant is to receive as reflected on the participant's treatment plan.

Additionally, each encounter for Recovery Works services shall only contain one type of service and should not be bundled (contain more than one (1) type of service). The only exception is housing. Housing may be entered in 7-day increments, as long as all requirements are met for the participant in the house.

PARTICIPANT RECORD REQUIREMENTS

1. Completed Recovery Works Referral Form
2. Pertinent Criminal Justice Documentation DSP may not print MyCase or other online material as documentation. All documentation must come from the Regional Liaison via the CJP. The documentation must show how the participant qualifies from a criminal justice standpoint.
3. Participant's Comprehensive Mental Health and Substance Use Disorder Assessment and ANSA results; results must indicate a DSM V or ICD 10 Substance Use Disorder, Mental health Diagnosis or co-occurring diagnosis.

4. Completed Release of Information Form(s) – This includes a ROI to speak with the criminal justice partner.
5. Supporting documentation for billing claims – This includes session notes, which clearly outlines the session (date, time, individual contribution etc.), and supports the service and amount of time utilized (see billing standards). All sessions with a participant must be individually documented with participant individual contribution to the session included. This includes problem-solving case management forms.
6. Supporting documentation for insurance and/or progress toward gaining access to insurance – All progress towards gaining insurance must be documented to show current state (has coverage, in process etc.). If at any time the participant loses his/her insurance, he/she is no longer eligible for Recovery Works until they are reconnected and able to utilize insurance (this excludes loss due to incarceration).

Although Recovery Works does not require that documentation be placed in a participants' clinical records in a specific order, agencies are asked to use a consistent procedure and order in the development and maintenance of participants' records. This will decrease agency staff confusion and make the compliance check process more efficient.

PROCEDURES

ASSESSMENTS

In order for a participant to be eligible to receive Recovery Works treatment services, they must receive a face-to-face comprehensive assessment that results in a Substance Use Disorder, Mental Health Disorder, or Co-Occurring Disorder diagnosis designated by the DSM 5 (Diagnostic and Statistical Manual) or ICD 10 (International Statistical Classification of Diseases). **If participants do not have a diagnosis, they are not eligible to receive Recovery Works funded services.** In the instance that a participant does not have a diagnosis, we ask that the DSP inform the CJP that the participant is not eligible based on diagnosis criteria. A completed assessment that does not result in a DSM 5 or ICD 10 Substance Use Disorder, Mental Health Disorder, or Co-Occurring Disorder diagnosis is not billable through Recovery Works. If a Recovery Works participant is already receiving services from a designated Recovery Works agency prior to receiving a referral, that same provider may choose to skip the initial comprehensive assessment and continue services. If you feel that the participant has had a significant change since the last comprehensive assessment, or it has been longer than six (6) months, we ask that a new assessment be done. The new assessment can be claimed for under Recovery Works.

INSURANCE

MEDICAID ACCEPTANCE:

Effective **July 1, 2019**, all Recovery Works treatment providers, who are DMHA certified to provide treatment services, must be enrolled as a Medicaid/HIP provider and credentialed with all Managed Care Entities. Recovery Works will no longer accept any treatment provider who is not currently enrolled in Medicaid/HIP and credentialed with the Managed Care Entities. Agencies are required to bill Medicaid/HIP for all services covered under Medicaid/HIP. The Recovery Works program is a payer of last resort. It is imperative that providers accept and bill insurance for participants to conserve a participant's overall expenditure and funding.

INSURANCE FOLLOW-UP:

The Recovery Works program is a payer of last resort. If a participant has any other payer source (i.e., private insurance, Medicaid, HIP 2.0, etc.) he/she must go to a provider that accepts his/her insurance coverage.

> *For example, if Angie has insurance, and she chooses to go to a provider that is outside of her insurance network, Angie has to pay for those services out of pocket. Recovery Works cannot be used at the provider Angie wishes to go to.*

The same goes for out Recovery Works participants. If a participant chooses to go to a provider that does not take their insurance, Recovery Works cannot be utilized to pay for services.

Please consider the following scenarios:

1. **Participant has Medicaid, HIP 2.0, or other insurance coverage:** he/she will need to select a provider who accepts his/her coverage.
2. **Participant is eligible for Medicaid or HIP 2.0**: he/she will need to sign up for coverage. The provider receiving the referral shall connect the participant with a navigator or provide assistance to get the participant enrolled. Upon approval, the participant will need to receive services from a provider who accepts his/her coverage.
3. **Participant is "pending" coverage for Medicaid or HIP 2.0**: he/she will need to select a provider who accepts his/her pending coverage. The provider will bill the insurance for retro payment, and Recovery Works funds can be used to cover any claims for eligible services that are denied for the pending period. If the individual is denied coverage from Medicaid, HIP 2.0, or other insurer, a request can be made via JIRA to cover services.
4. **Participant is ineligible for insurance coverage through another payer source or has been denied:** A JIRA request containing the denial form, plan of services, and reason of ineligibility should be submitted to determine if services will be covered through Recovery Works. At no time should providers bill for services resulting from a denial without the prior approval of Recovery Works.

It's imperative that our participants are choosing providers accordingly, as preservation of funding for the individual is crucial to their recovery.

Recovery Works Designated Services Providers (DSP) have **fourteen (14) business days** from the date of the participant's intake to assist with completion of necessary documents to obtain insurance and/or third-party payer source. **Within 30 days from intake**, all paperwork must be completed and submitted (if not initially submitted with the original application). If a participant does not wish to gain access to insurance or does not follow through with the necessary requirements of obtaining/maintaining insurance, they are no longer eligible for Recovery Works funding. **Documentation of these activities must be included in the participant's record and will be reviewed during audits.** If action is not taken to assist the participant in gaining access, then they are ineligible for Recovery Works. If it is found that no actions were taken to assist the participant in gaining insurance, the agency will be responsible for reimbursement for all services provided. All participants must have active insurance within 45 days of beginning treatment. If barriers exist to the individual obtaining insurance within 45 days, notification must be given to Recovery Works regarding said barriers, along with a JIRA request to continue billing Recovery Works. Case Management services can be billed to Recovery Works for activities related to helping the participant secure the necessary documentation. All activities must be documented in a progress note and must meet all Recovery Works guidelines.

Assistance with completion of necessary applications includes, but is not limited to, an of the following:

- Connect participant with a navigator and follow up with participant and navigator to ensure application submission is completed within 30 days from intake.
- Help participant obtain personal documents needed for application, presumptive eligibility, or private insurance.
- Designating a staff employee to sit with the participant while the participant completes an application online for insurance or Medicaid.

Recovery Works is the payer of last resort. Therefore, services available through insurance must be billed to insurance prior to requesting additional services through Recovery Works. If insurance companies deny services, a reason for denials must be forwarded to Recovery Works through JIRA when requesting services and/or approval for services within 60 days.

Please note, a hospital indemnity plan or medical plan only does not satisfy the requirement for insurance. The DSP is still expected to connect the participant to insurance for substance use and/or mental health needs. Case Management services may be utilized to help the participant gain the necessary documentation if necessary.

If a participant's insurance does not cover a service, Recovery Works may be utilized to cover the service. This should be done on a short term non-intensive basis. The participant's primary method of treatment should include the services offered by his/her insurance. If DSP's have questions or specific participant circumstances, please contact Recovery Works.

INSURANCE DENIALS AND MEDICAL NECESSITY

If an individual is released from jail, and the insurance company denies treatment due to lack of medical necessity, Recovery Works will consider the denial up to the number of days listed below. This policy is for insurance denials based on medical necessity due to incarceration only and cannot be utilized for any other denial explanation. Coverage should be utilized to help stabilize the participant, as well as help the participant transition to a lower level of care. Providers will need to still send the actual denial and all pertinent documentation utilizing the JIRA system. All services provided will be billed as a bundle (all inclusive), and additional billing for services is prohibited.

Maximum number of days billed without a Prior Authorization is:

Residential Level 3.5: Maximum of 3 days

Residential Level 3.1: Maximum of 5 days

Insurance denial form is on the Recovery Works website, must be submitted via JIRA system.

Reasons Recovery Works would decline funding for denials:

1. Not medically necessary: that the participant's level of care does not support the treatment they are receiving/received or seeking to receive.
2. Out of network insurance denials: the provider submitted a claim to an insurance company that does not fall within the participant's coverage. The participant would have coverage, if he/she would visit a provider within network.
3. Provider error: the provider submitting the claim did not fill out the form properly or within a timely manner. Examples include billing the incorrect service code or not meeting the submission deadlines.
4. Lack of Participant follow through: they did not cover the copay, complete documentation, or etc.

***Above list is not all inclusive**

EMERGENCY PROCEDURES (i.e., COVID-19)

All emergency procedures will be communicated directly to the provider via the Recovery Works distribution list. Providers are encouraged to include more than one employee on the distribution list to ensure proper dissemination of information.

REFERRALS

REFFERAL POLICIES

ABSENCE IN TREATMENT

- If a participant leaves treatment or there is a gap in services **up to** 30 days, additional documentation from the original referral source is required.

- If a participant is absent for more than thirty (30) days, only a new Information Sheet will suffice from the Criminal Justice Partner to the Regional Liaison (the above documentation will not suffice).

CURRENT PARTICIPANTS

- If a potential participant is receiving services from a provider, and it is determined he/she could benefit from Recovery Works, the provider must send the participant back to the criminal justice partner to initiate the criminal justice Information Sheet.
- Criminal Justice partners may not send participants directly to a provider
- Providers may not accept an anticipated Recovery Works participant without the criminal justice partner following the referral process
- Criminal Justice Partners and/or Providers who attempt to circumvent the Recovery Works Referral Policies and Procedures by sending participants directly to providers in lieu of the current process are subject to **immediate suspension** of the ability to make and/or receive referrals. Participants who have been at the agency under 90 days are subject to being referred to an alternate agency and/or being unable to utilize Recovery Works funding for services.
- Regional Liaisons will record data regarding participants requesting referrals who are already involved with an agency. Agencies should not accept Recovery Works participants from any entity except the Regional Liaison. Participants may be delegated to another agency if it is found the agency and/or CJP did not utilize the Recovery Works referral process and/or if the participant is at the agency less than 90 days.

The CJP must share necessary collateral information with the Regional Liaison. This includes documentation that verifies the individual's felony information and current open case. This information can include court documentation, arrest records, legal information, assessments, etc. It is the responsibility of the CJP and DSP to ensure eligibility. All Information Sheets must be completed entirely and participants must meet Recovery Works eligibility requirements for the referral to be considered valid.

Criminal Justice Partners (CJPs) are expected to adhere to all Recovery Works Policies and Procedures, including but not limited to **participant choice.** Criminal Justice Partners who utilize a "preferred provider" list may not utilize Recovery Works to make referrals to those preferred providers (excluding certified Problem-Solving Courts and in house jail services).

If CJP's have questions or concerns regarding a Direct Service Provider (DSP), it is **STRONGLY** encouraged that they contact Recovery Works to investigate the claims. CJP's are prohibited from using a "preferred provider" list when seeking participant choice. It is not appropriate for a CJP to suspend or prevent DSP's from receiving Recovery Works referrals.

CJP's may not require potential providers to complete a presentation, demonstration or gain any other internal approval prior to participants utilizing Recovery Works . All DSP's have been approved by DMHA and Recovery Works and are open and available for referrals. Any changes or concerns should be directed to Recovery Works.

Direct Service Providers (DSPs), Criminal Justice Partners (CJP's) and subcontractors shall comply with requisite affirmative action requirements, including reporting, pursuant to 41 CFR Chapter 60, as amended, and Section 202 of Executive Order 11246 as amended by Executive Order 13672.

It is not acceptable for providers to receive Recovery Works referrals, and not process the individual as a Recovery Works participant. If a provider no longer wish to be a Recovery Works provider, notification must be sent to Recovery Works. CJP's and/or providers not in compliance with the Recovery Works Policies and Procedures may be denied the ability to accept and/or make Recovery Works referrals. CJP's who have participants who report issues with being connected to Recovery Works, please email the Recovery Works email here: Recovery.Works@fssa.in.gov.

REFERRAL PROCESS

STANDARD REFERRALS

All referrals must flow through the Recovery Works Regional Liaison. All Criminal Justice Partners must utilize the standard process unless specified below (i.e., Work Release, Incarcerated Participants etc.).

The referral process must begin with the Criminal Justice Partner. In order for a referral to be valid the following steps must be followed:

1. The Criminal Justice Partner identifies the participant and completes a Criminal Justice Information Sheet.
2. Criminal Justice Partner forwards the Information Sheet and pertinent criminal justice documentation to the Regional Liaison.
3. The Regional Liaison will contact the participant within 24 hours. The Regional Liaison will collect and record data and forward the referral and collateral case information to the Direct Service Provider (DSP).
4. Direct Service Provider (DSP) will provide monthly reports to the Criminal Justice Partner.

INCARCERATED PARTICIPANT REFFERALS

1. **Participant is incarcerated and seeking services from a Recovery Works provider who provides services IN HOUSE services. This provider comes into the jail to provide services as the participant is UNABLE to leave the facility to access services.**

   Step 1: The Criminal Justice Partner completes Information Sheet and send to RecoveryWorks@paceindy.org

   - On the information sheet, please specify that the individual is seeking Re-Entry service. In addition, participant choice should also be included.

   Step 2: The Regional Liaison will collect data and process the referral based on participant choice and provider availability.

   - Please note, specific facilities must register with Recovery Works by completing the Recovery Works Jail Information Form.
   - The Regional Liaison will NOT contact the participant, as the participant is incarcerated.

   Step 3: The Regional Liaison will forward the referral to the identified provider.

   - If the jail has not registered their facility with Recovery Works, the Regional Liaison will return an email stating there are no providers active within the jail.
   - The service provider will reach out to the participant and initiate services.

2. **Participant is incarcerated and seeking services UPON RELEASE from the facility. The participant may/may not have a definitive release date.**

   Step 1: The Criminal Justice Partner completes Information Sheet and send to RecoveryWorks@paceindy.org.

   - On the information sheet, please specify that the individual is seeking services within the upon release (Outpatient). Also, be sure to obtain participant choice from the participant.

   Step 2: The Regional Liaison will collect data and process the referral.

   - The Regional Liaison will not contact the participant, as the participant is incarcerated.
   - The Regional Liaison will utilize participant choice, provider availability and anticipated needs when determining a provider.

   Step 3: The Regional Liaison forward the referral to the provider and email the CJP listed on the form with the provider the participant is referred to.

   - CJP and DSP begin communication. CJP gives information to the participant to access upon release.

- When completing the information sheet, aim for 10 days post release when a release date is known in

Participants seeking referrals while incarcerated must be within 30 days of their release date. For jail services, you may utilize the participants next court date the first time. If the participant is not released at the particular next court date, you must wait until there is a definitive release date for the participant before submitting another Information Sheet.

WORK RELEASE FACILITIES

All Work Release facilities must register their facility and in-house service providers via the form provided. Criminal Justice partners may visit our website to access the form.

- Work release facilities in which participants do not have the ability to access services outside the facility, process #1 above will be utilized.

- If participants are able to leave the facility for treatment, process #2 above will be utilized. Please note, only participants who have restricted movement (may not leave the facility for treatment) will be able to utilize the preferred provider option. All other Work Release participants must utilize process #2 above.

AGENCY DESIGNATION

Designated Service Providers (DSPs) are categorized as either treatment providers or Recovery Residence (housing) providers.

Treatment Providers are:

- DMHA certified as a CMHC, ASO, ASR, PIP, or OTP agency—can include level IV recovery residences.
- Responsible for the clinical comprehensive assessment, ANSA, diagnosis, and treatment plan.
- Required to enter necessary information into DARMHA and WITS.
- Able to build vouchers for their agency and housing providers.
- Capable of making internal referrals within WITS to housing providers—allows housing providers to be paid directly.

Recovery Residence (housing) Providers are:

- DMHA Certifications Team certified as a level II, III, or IV recovery residence.
- Able to accept participants prior to connection to treatment for an assessment.
- Required to communicate with treatment providers and CJP regarding participants.
- Must refer participants to a treatment provider within 7 days of intake and follow up on treatment.
- May only claim for the daily housing rate as well as a daily per diem.

Recovery Works Forms

RECOVERY WORKS DESIGNATED AGENCY AND PROVIDER APPLICATION

The Recovery Works Application is a form that allows the Recovery Works Administrative team to approve and designate agencies to provide Recovery Works services throughout the State of Indiana.

Once an application is received as the state office, the administrative team will review the application. If the application is incomplete, the provider will receive the application back to be corrected. The application will then be passed to the DMHA Certifications Team where they will then approve all certifications and licensures of the agency and providers. All providers must be in good standing with all divisions under the Family and Social Services Administration. It is the agency's responsibility to report to DMHA any adverse sanctions, terminations, and arrests, which would affect the eligibility of the provider to provide services. A provider application must include documentation that previous sanction(s) have been remedied.

For Recovery Residences, it is required that all Recovery Residences are certified through the Indiana Affiliation of Recovery Residences (DMHA Certifications Team). Only Level IV Recovery Residences are also required to be certified by DMHA as an addictions provider.

Once the Recovery Works administration team receives the application back from DMHA certification, the application will be approved or denied. Regardless of approval status, the agency will receive notification via email with their current status.

Recovery Works will request that approved agencies send other documents including W-9, direct deposit, DARMHA, and WITS forms. After completing the entire process, approved agencies will receive the Policies and Procedures Manual, a list of training requirements, a formal approval letter, and the Agency Agreement that will need to be signed and returned by the appropriate agency party.

Treatment Provider files will contain a minimum of:

- Recovery Works application
- Proof of clearances from DMHA certification, DOR, and DWD
- List of personnel/providers within agency
- W-9 and direct deposit paperwork
- DARMHA and WITS access forms
- Agency approval letter
- Signed agency agreement

SIDE ONE OF THE APPLICATION

Information provided on this application, specifically phone number, email and insurance policies, will be uploaded to the provider list on the Recovery Works website.

Every service line must be filled out. If your agency provides a service, you will mark an "x". If your agency does not provide a service, you will write who you will partner with to provide the service.

RECOVERY WORKS DESIGNATED AGENCY AGREEMENT

The Recovery Works Agency Agreement is an agreement between DMHA and the Recovery Works Designated Agency. This agreement operates similarly to a contract between the two agencies and can be terminated by either party with a 30-day written notice. Once an agency is approved to become a designated Recovery Works Agency, they will receive written notification, along with the agency agreement. The agency is asked to have the appropriate party sign the agreement and return the agreement to the Recovery Works administration in a timely manner. Once the agreement is returned, your agency officially becomes a Designated Recovery Works Agency. At this point, you will be ready to attend a New Provider Training Session prior to billing.

RECOVERY WORKS REFERRAL FORM

The Criminal Justice Provider (CJP) will identify the participant and forward information, and the Criminal Justice documentation to the Regional Liaison. The Recovery Works Referral Form will be completed by the Regional Liaison **only** and emailed to the Designated Recovery Works Agency.

Once received, Recovery Works Providers will have two (2) to five (5) business days to accept the referral, contact the participant, and schedule an appointment with the participant. It is expected that the assessment is completed within ten (10) days from the date of referral acceptance. A self-referral cannot be accepted.

The referral process MUST begin with a Criminal Justice Partner (CJP) identifying the participant. It is unacceptable for Designated Service Providers (DSP) to send an Information Sheet to a Criminal Justice Partner (CJP) for a signature. If upon intake, it is determined that a participant may be eligible for the program and have a need for the program, DSPs must encourage participants to speak with their Criminal Justice Partner (CJP) to begin the process. Any services provided without utilizing the standard Recovery Works Referral Process will be denied.

It is not acceptable for providers to receive Recovery Works referrals, and not process the individual as a Recovery Works participant. If the individual does not qualify for Recovery Works, please note that in the participant file. Criminal Justice Partner (CJP)'s who have participants who report cash balances or issues with being connected to Recovery Works, please email the Recovery Works email at: Recovery.Works@fssa.in.gov.

RECOVERY WORKS PRIOR AUTHORIZATION FORM

The Prior Authorization form will be utilized by Recovery Works Designated Service Providers (DSPs) that wish to provide services that require a Prior Authorization, or to request a service cap increase for extenuating circumstances. The provider will complete the online, PDF fill-in form in its ENTIRETY and email the document to Recovery.Works@fssa.in.gov with the participants WITS ID # ONLY, no personal health information. For more information on how to complete Prior Authorizations (PAs) properly, please review our webinar which can be found at www.RecoveryWorks.fssa.in.gov. Clinicians may bill up to a maximum of 30 minutes (2 units) of case management when completing Prior Authorizations. When completing a Prior Authorization, please note, answering all the questions completely is required and not an optional part of the process. It will expedite the approval process and reduce the likelihood of a denial if all the directions are followed. Should you need to select multiple services for a Prior Authorization, you will need to complete individual Prior Authorization forms for each service that you are requesting. Recovery Works will not provide a denial for a Prior Authorization for the sole purpose of requesting an alternate funding stream. All aspects of the Prior Authorization process must be followed prior to Recovery Works denying the Prior Authorization.

RECOVERY WORKS INFORMATION SHEET

Due to compliance standards, the Recovery Works Information Sheet will not be available online. Criminal Justice partners who seek to receive a form may contact PACE (recoveryworks@paceindy.org). An email will be sent utilizing the Recovery Works Criminal Justice Partner Distribution List.

Recovery Works Funding Categories

FUNDING CATEGORIES

Recovery Works recognizes a need for flexibility and creativity to administer individualized services based on treatment planning. As such, we have changed the way we allocate funding for services. Please remember, these are maximum allocations, and Direct Services Providers (DSPs) are expected to only utilize the services that are necessary for the participant's recovery. Funding allocations are broken down into seven (7) specific categories:

1. Re-Entry Funding
2. Community Funding
3. Recovery Residence Funding
4. Intensive Outpatient Treatment (IOT) Funding
5. Discretionary Funding
6. Residential Treatment Funding
7. After Care Funding

RE-ENTRY FUNDING SERVICES - $1,500 LIFETIME ALLOCATION

Re-Entry services are intended for individuals to use while in a correctional facility prior to being released into the community. This includes individuals residing in jails and/or Work Release facilities. While Recovery Works was not initially designed to provide services while individuals are incarcerated, we recognize a need for care while transitioning back into the community. Direct Service Provider's (DSP's) should seek to provide only the services the participant needs to help ensure transition back into society. As of October 1, 2019, there are no longer any "pilot" programs in Recovery Works (jail pilot, work release pilot, etc). We have allotted a funding stream for Re-Entry services to any agency that offers this service.

Direct Service Provider's (DSP's) must:

- Verify full eligibility and need for Recovery Works.
- Aim for as close to release as possible
- Utilize the services included on the Re-Entry Rate Sheet only.

Please note, all work release facilities must apply with Medicaid to determine their particular level for Freedom of Movement. If work release facilities opt not to apply for their designation, individuals within that facility are not eligible for Recovery Works until they are released from the facility. A copy of the facility designation is to be sent to Recovery Works by the individual work release facility. At no time should a participant participate in a class or service to satisfy a work release or jail requirement. The individual must participate in services based on the individualized treatment plan only. Clinically Managed Residential Services are excluded from Re-Entry Funding.

Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Works participants may not be charged additional amounts for services. This includes deposits, administrative fees, referral fees, etc. The only time a participant may be charged any additional funding, is when they are titrating down from Recovery Works funding, in an effort to become more self-sufficient. At this time only, the participant can be required to pay their portion of their stay. Direct Service Providers may not implement increased fees, copayments (except insurance copays or titration payments for Recovery Residences), or additional fees during this time. The participant is ONLY required to pay the titrated rate of what Recovery Works offers. All questions relating to this should be directed to Recovery Works staff.

COMMUNITY FUNDING - $2,500 MAXIMUM ALLOCATION

Community services are intended for individuals still involved with the criminal justice system, but no longer incarcerated (work release, jail, prison, etc.). DMHA Certified Treatment Providers are the only agencies able to utilize this service. Recovery Residences (excluding Level IV) cannot utilize this service.

Direct Service Provider's (DSP's) must:

- Verify full eligibility and need for Recovery Works.
- Ensure the individual is living within the community and not incarcerated (Not in WR facility)
- Connect the individual to insurance within ten (10) business days.
- Utilize the services included on the Community Rate Sheet only.
- Keep track of participant spending from beginning to end.
- Follow all other Recovery Works treatment policies and procedures.

The above funding is intended for gap services and should be utilized as the funding of last resort. When the individual obtains insurance, the participant should immediately begin utilizing said insurance for services. Rehabilitative services (Skills Training, Case Management, etc.) can be billed to Recovery Works while utilizing insurance services, however this should not be an intensive method of service or be the participant's primary method of service. Clinically Managed Residential Services are excluded in Community Funding.

Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Works participants may not be charged additional amounts for services. This includes deposits, administrative fees, referral fees, etc. The only time a participant may be charged any additional funding, is when they are titrating down from Recovery Works funding, in an effort to become more self-sufficient. At this time only, the participant can be required to pay their portion of their stay. Direct Service Providers may not implement increased fees, copayments (except insurance copays or titration payments for Recovery Residences), or additional fees during this time. The participant should ONLY be required to pay the titrated rate of what Recovery Works offers.

INTENSIVE OUTPATIENT FUNDING - $3,134.16 MAXIMUM ALLOCATION

Intensive Outpatient Treatment (IOT) is a treatment program that operates at least three (3) hours per day, at lease three (3) days per week, and is based on an Individualized Recovery Plan. IOT is planned and organized with Substance Use professionals and clinicians providing multiple treatment service components for rehabilitation of alcohol and other drug abuse or dependence in a group setting. IOT includes group therapy, interactive education groups, skills training, random drug screenings, and counseling. IOT is limited to forty (40) three (3) hour sessions; PA is required for consumers requiring additional units of service.

- 1 unit = $130.59
- All guidelines under the IOT service category must be adhered to.
- Providers are responsible for ensuring eligibility and adhering to the Recovery Works Policies and Procedures Manual (including insurance guidelines).
- Bulk billing is NOT allowed.

Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Works participants may not be charged additional amounts for services. This includes deposits, administrative fees, referral fees, etc. The only time a participant may be charged any additional funding, is when they are titrating down from Recovery Works funding, in an effort to become more self-sufficient. At this time only, the participant can be required to pay their portion of their stay. Direct Service Providers may not implement increased fees, copayments (except insurance copays or titration for Recovery Residences), or additional fees during this time. The participant should ONLY be required to pay the titrated rate of what Recovery Works offers.

RECOVERY RESIDENCE FUNDING - $8,000 MAXIMUM ALLOCATION

Recovery Residence Funding is intended for individuals residing in an Indiana Affiliation of Recovery Residence (DMHA Certifications Team) certified residence. All Recovery Residences must abide by the rules and regulations of DMHA Certifications Team and Recovery Works (excluding Medicaid requirements for Level II and III). Recovery Works recognizes three (3) levels of Recovery Residences, Level II, III, and IV.

Each residence has the option of two (2) main service allocations:

Room Only - $15/per day/per person

Room and Board - $20/per day/per person

In addition, Recovery Residences will be given a per diem to help offset the costs of rehabilitative services (Skill Training and Development, Case Management, Transportation, etc.). This per diem is in addition to what is billed above.

Per Diem allocations are as follows:

Level II - $6/per day/per person

Level III - $7/per day/per person

Level IV - $7/per day/per person

Recovery Residences who accept all forms of Medication Assisted Treatment (MAT) are able to bill at a higher per diem after attending the required MAT training (DMHA Contractor and Recovery Works). **Recovery Residences may bill the below per diem rates OR the above per diem rates, not both.**

Increased Per Diem allocations are as follows:

Level II - $9/per day/per person

Level III - $10/per day/per person

Level IV - $10/per day/per person

Recovery Residences Level II and III may not utilize community funding for services. Recovery Residence Level IV may utilize Community Funding for gap funding when necessary, however for individuals residing in the Recovery Residence, rehabilitative services are included in the per diem, therefore, double billing for services is prohibited.

RECOVERY RESIDENCE ADDITIONAL GUIDELINES:

- Recovery Works cannot be billed for “home passes” where the participant is not spending the night in the Recovery Residence.

- Recovery Residences cannot bill the participant for additional services in conjunction with Recovery Works. This includes deposits, administrative fees, etc. Recovery Residences agree to only bill the participant for Room Only or Room and Board, the Per Diem and clinical services (Level IV only) as required by the participant's treatment plan. The only exception to this is when the participant is titrating down from Recovery Works services.
- Participants may not be charged cash and/or billed to RW for overnight passes. If a participant is not in the recovery residence bed overnight, the participant is not eligible to be charged for services.
- Recovery Residences agree to send participants to a Recovery Works approved provider for services related to treatment. The exception to this rule is if participants are given a release form which states they are choosing to pay cash for services, despite having funding available to them. At no time may a provider mandate a participant to utilize a Direct Service Provider (DSP) who does not have Recovery Works certification or mandate a participant to pay out of pocket for services to the provider.

Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Works participants may not be charged additional amounts for services. This includes deposits, administrative fees, referral fees, etc. The only time a participant may be charged any additional funding, is when they are titrating down from Recovery Works funding, in an effort to become more self-sufficient. At this time only, the participant can be required to pay their portion of their stay. Direct Service Providers may not implement increased fees, copayments (except insurance copays or titration payments for Recovery Residences), or additional fees during this time. The participant should ONLY be required to pay the titrated rate of what Recovery Works offers.

RESIDENTIAL FUNDING SERVICES

Clinically Managed High Intensity ASAM 3.5 - $361.50/day (maximum fifteen (15) days)

Clinically Managed Low Intensity ASAM 3.1 - $126.46/day (maximum twenty-one (21) days)

All Clinically Managed services will require a Prior Authorization (PA) for services. Direct Services Providers (DSPs) are still expected to ensure the individual is connected and utilizing insurance. If insurance is utilized, and Recovery Works has paid in the interim, DSPs are responsible for ensuring a refund is sent to Recovery Works. If insurance approves a set number of days, the DSP will need to work with the insurance company to obtain more days if necessary. For extenuating circumstances, Recovery Works may be able to assist with additional days.

Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Works participants may not be charged additional amounts for services. This includes deposits, administrative fees, referral fees, etc. The only time a participant may be charged any additional funding, is when they are titrating down from Recovery Works funding, in an effort to become more self-sufficient. At this time only, the participant can be required to pay their portion of their stay. Direct Service Providers may not implement increased fees, copayments (except insurance copay or titration payments for Recovery Residences), or additional fees during this time. The participant should ONLY be required to pay the titrated rate of what Recovery Works offers.

DISCRETIONARY FUNDING - $250 MAXIMUM ALLOCATION

Effective April 1, 2020, Recovery Works will allot $250 per participant for discretionary funding and no more than $50 expended a month.
This funding can **ONLY** be used to pay for:

- Phone cards for participant cell phones/participant minutes on phone contracts.
- Birth Certificates
- Driver's License
- *US Postal Services (mailing may be necessary for insurance or COVID-19 non-contact purposes).
- Lockboxes for participant medication

Providers must document all services billed for the individual in the participant file. Please note, Recovery Works participants cannot be charged additional administrative fees, or any service fee that is not currently a billable service to Recovery Works. This discretionary fund is solely intended to assist the participant with obtaining the above necessary items to aid in a successful recovery. This fund is intended to provide temporary relief to participants.

This funding category should NOT be used all at one time, but rather assist in payment during times the participant is in need of assistance.

It is unacceptable to bill Recovery Works for the entire $250 in one bill.

Any questions regarding the above fund should be communicated with Recovery Works. Recovery Residences and treatment providers must work together, to ensure there is not a duplication of billing.

Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Works participants may not be charged additional amounts for services. This includes deposits, administrative fees, referral fees, etc. The only time a participant may be charged any additional funding, is when they are titrating down from Recovery Works funding, in an effort to become more self-sufficient. At this time only, the participant can be required to pay their portion of their stay. Direct Service Providers may not implement increased fees, copayments (except insurance copays or titration payments for Recovery Residences), or additional fees during this time. The participant is ONLY required to pay the titrated rate of what Recovery Works offers. All questions relating to this should be directed to Recovery Works staff.

AFTERCARE FUNDING - $1,500 MAXIMUM ALLOCATION

The Recovery Works Aftercare Funding is designed to assist participants who have exhausted all Community Funding and are in need of brief aftercare services due to relapse or emergency service connection.

Participants are eligible if:

- Participant has exhausted all Community and/or Recovery Residence Funding
- 90+ day separation since last date of all treatment services
- Participant voluntarily seeks services

Guidelines

- Providers may only bill for services on Aftercare Funding Rate Sheet
- Clinical individualized services are the primary focus of treatment
- Provider should complete a PA for participants who seek MAT to ensure participants have access to an adequate supply of treatment.
- Participants may not transition from one funding source directly into the next (IE, cannot utilize Community Funding then transition to Aftercare)
- Housing is excluded from Aftercare Funding

Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Works participants may not be charged additional amounts for services. This includes deposits, administrative fees, referral fees, etc. The only time a participant may be charged any additional funding, is when they are titrating down from Recovery Works funding, in an effort to become more self-sufficient. At this time only, the participant can be required to pay their portion of their stay. Direct Service Providers may not implement increased fees, copayments (except insurance copays or titration payments for Recovery Residences), or additional fees during this time. The participant is ONLY required to pay the titrated rate of what Recovery Works offers. All questions relating to this should be directed to Recovery Works staff.

SERVICE DEFINITIONS

AND

REIMBURSEMENT RATES

ONLY SERVICES DEFINED IN THIS MANUAL ARE BILLABLE TO RECOVERY WORKS. ANY DISCREPANCIES NEED WRITTEN APPROVAL FROM THE RECOVERY WORKS TEAM. RECOVERY WORKS IS A PAYER OF LAST RESORT. NO ADDITIONAL FEES MAY BE CHARGED TO RECOVERY WORKS PARTICIPANTS FOR SERVICES LISTED BELOW. ALL QUESTIONS REGARDING SERVICES SHOULD BE DIRECTED TO RECOVERY WORKS. ANY ASSUMPTIONS BY THE PROVIDER REGARDING SERVICES ARE AT THE PROVIDER EXPENSE.

ALL SERVICES ARE SUBJECT TO CHANGE. PLEASE REFER TO THE RATE SHEET APPENDIX TO REVIEW YOUR SPECIFIC RATE SHEET BASED ON THE FUNDING CATEGORY YOU ARE BILLING FROM. PLEASE CHECK THE WEBSITE REGULARLY FOR UPDATES. BULK BILLING FOR SERVICES IS NOT ACCEPTABLE FOR TREATMENT SERVICES. RECOVERY RESIDENCES MAY BILL IN SEVEN (7) DAY INCREMENTS ONLY. IF A PARTICIPANT HAS ACTIVE INSURANCE, ALL SERVICES MUST BE BILLED THROUGH THE PARTICIPANT'S INSURANCE. IF INSURANCE DENIES PAYMENT, THE DENIAL MAY BE SUBMITTED TO RECOVERY WORKS WITHIN SIXTY (60) DAYS OF RECEIPT FOR CONSIDERATION. PROVIDERS MUST UTILIZE ASAM CRITERIA WHEN ADMITTING PARTICIPANTS INTO THEIR PROGRAM.

AFTERCARE FUNDING - $1,500 MAXIMUM ALLOCATION

The Recovery Works Aftercare Funding is designed to assist participants who have exhausted all Community Funding and are in need of brief aftercare services due to relapse or emergency service connection.

Who may claim for this service:

- Providers who are eligible to bill from the Community Funding Category Only
- Providers must follow guidelines of specific billing service

Billing Guidelines – Service amount varies based on specific rate sheet

Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date and time of service
- Rendering Staff performing assessment.
- Name of Service performed
- Plans for long term connection to sobriety

ANSA Redetermination - $77.72/unit (unit = 1 Face to Face Reassessment)

The Adult Needs and Strengths Assessment (ANSA) must be completed at intake and every six (6) months. The redetermination requires face-to-face contact with the participant and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which results in a completed redetermination. A Direct Service Provider (DSP) that is NOT receiving reimbursement through MRO or another payer source may claim one (1) Recovery Works voucher for each ANSA done at the six (6) month follow-up for the participant. A DSP may not claim for the intake ANSA, as it is included in the initial assessment package.

Who may claim for this service: Licensed Professionals, Qualified Behavioral Health Providers, and Other Behavioral Health Providers who hold an active ANSA certification through the Praed Foundation.

Billing Guidelines:

Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date and time of assessment.
- Rendering Staff performing assessment.
- And a completed actual assessment.

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Participants must have an ANSA completed every six (6) months. Reminder: This service should only be billed to Recovery Works when no other funding is available.

Alcohol and Other Drug (AOD) Screening - $18.05/unit (unit = 1 screening)

This service should only be utilized in cases where AOD screening is clinically indicated as a means of removing barriers to recovery and/or triggers for relapse. At no time can AOD screening be billed to Recovery Works on behalf of the Criminal Justice Partner (CJP). This service should only be billed to Recovery Works when no other funding is available. Organizations providing AOD screenings are expected to provide collection and analysis of appropriate samples for the multi-substance drug testing. All tests must be at least a six-panel drug tests administered with or without an accompanying alcohol breath or blood test. In addition to the six-panel standard drug test, the participant must be tested for any substance they reported using at the time of intake. This means that the test will test for at least six (6) classes of drugs commonly abused in the organization's area of service, as well as any substance being used by the participant at intake. ETH tests for alcohol may also be billed under this category, only when it is accompanying at least a six-panel test for other drugs of abuse in the provider's service area. Organizations providing this service must have a policy in place that addresses and assures specimen validity by providing observed sample collection and maintains the chain-of-custody of the sample from collection to testing. Said policy and protocol must be established to be minimally invasive as possible while meeting the above measures of accuracy. The provider shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transferring, and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody. For those employing urine tests, diluted results must be reported on the result form. Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All specimens found to be "Adulterated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The referring location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

Who may claim for this service: Organizations meeting the standards above; must have current documentation of the administering provider's training by an outside AOD collection provider in the process and procedures of administration of the AOD screenings. Recovery Residence participants with less than three (3) years of treatment may not administer AOD screens.

Exclusions: AOD screening that is not clinically indicated to address needs or barriers identified on the participant's individual recovery plan.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date and time of sample collection
- Specific substances or classes of substances for which testing was performed
- Results of test

- Reason/type of test (ex: Random, Scheduled, Suspicion of use)
- Location/type of test (ex: On site/Instant test or Laboratory test)
- Rendering staff performing screen

Organizations can choose to include additional information at their discretion if minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences including return of funds paid for services and federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category. Participants may request that AOD screening vouchers be authorized to providers that have a random or cause based drug testing policy in case the participant is selected for a test. All tests should test for a multitude of chemicals, not less than seven (7), and not only the drugs of choice of the individual participant. If questions exist, it is the responsibility of the Direct Service Provider (DSP) to contact Recovery Works prior to billing.

Case Management - $14.53/unit (unit = ¼ hour)

Case Management consists of services that help participants gain access to needed medical, social, educational, and other services. This includes direct assistance in gaining access to services, coordination of care, oversight of the entire case, and linkage to appropriate services. Case Management does not include direct delivery of medical, clinical, or other direct services. Case Management is on behalf of the participant, not to the participant, and is management of the case, not the participant. Case Management must provide direct assistance in gaining access to needed medical, social, educational, and other services. Case Management includes referrals to services and activities or contacts necessary for continuity of care.
Case Management may include:

- ***Needs Assessment:*** Focusing on needs identification of the participant to determine the need for any medical, educational, social, or other services. This cannot be completed each session and should be conducted when necessary.

  Specific assessment activities may include:
  - Taking participant history
  - Identifying the needs of the participant
  - Completing the related documentation
  - Gathering information from other sources, such as family members or medical providers
- ***Referral/Linkage:*** Activities that help link the participant with medical, social, and educational providers, and/or other programs and services that are capable of providing needed rehabilitative services.
- ***Monitoring/Follow-up:*** Activities and contacts necessary to ensure continuity of care of the participant.

The activities and contacts may be with the following:

- Participant
- Family members
- Nonprofessional caregivers
- Providers
- Criminal Justice Providers
- Other entities

Monitoring and follow-up are necessary to help determine if services are being furnished in accordance with the participant's recovery plan, the adequacy of the services in the treatment plan, and changes in the needs or status of the participant. However, monitoring must not include simply talking to the individual, but must include action on the part of the case manager.

- ***Evaluation:*** The provider must periodically reevaluate the participant's progress toward achieving the participant's goals. Based on the provider's review, a determination would be made whether changes should be made. Time devoted to formal supervision of the case between provider and licensed supervisor are included activities and should be documented accordingly. The supervision must be documented appropriately and billed under one (1) provider only.

Clinicians may bill up to a maximum of thirty (30) minutes (2 units) of Case Management when completing Prior Authorizations (PAs). Please note, if the PA does not take thirty (30) minutes to complete, you may not bill for both units, you will need to bill for the time it took to complete up to thirty (30) minutes. When completing a Prior Authorization please note that answering all the questions completely is required and not an optional part of the process. It will expedite the approval process and reduce the likelihood of a denial if all the directions are followed. Should you need to select multiple services for a Prior Authorization, you will need to complete individual Prior Authorization forms for each service that you are requesting.

Who may claim for this service: Licensed Professionals, Qualified Behavioral Health Providers, Other Behavioral Health Providers

Exclusions: The actual or direct provision of medical services or treatment is excluded. Examples include, but are not limited to:

- Training in daily living skills.
- Training in work skills and social skills.
- Grooming and other personal services.
- Training in housekeeping, laundry, or cooking.
- Transportation services.
- Individual, group, or family therapy services.
- Crisis intervention services.
- Informal or brief interactions discussing client case.
- Services that go beyond assisting the participant in gaining access to needed services.

Examples include, but are not limited to:

  - Paying bills and/or balancing the recipient's checkbook
  - Traveling to and from appointments with recipients
  - Court-ordered reports
  - Assistance completing Medicaid application or redetermination documentation
- Meeting the participant for "talking session" as a case manager with the exception of the initial and continuity of care meetings.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file with the following:

- Date service was rendered.
- Start time and end time of service.
- Report of the participant's status on the identified outcome measures.
- Description of what happened in the session.
- How this interaction will assist the participant in moving forward in their recovery.
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact.
- Rendering staff name.

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Clinical Managed High-Intensity Residential Services - $361.65/unit (unit = 1 day); requires Prior Authorization – covers up to 15 days

Participants shall have a diagnosis of Substance Use Disorder as determined by the Diagnostic and Statistical Manual of Mental Disorders current edition. This service is equivalent to the American Society of Addiction Medicine (ASAM) Level 3.5. **Clinical Managed High-Intensity Residential Services** programs offer room, board, and interpersonal support to intoxicated individuals and individuals in substance use withdrawal.

All programs at this level rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of care. This service is delivered under a defined set of physician-approved policies and procedures or clinical protocols.

Clinically Managed High-Intensity Residential Services is restrictive on the participant and involves medications and/or close, regular monitoring, such as Medically Monitored Inpatient Detoxification. Participants using substances other than those outlined for medical

detoxification are typically put into this modality of treatment to be observed and monitored for stability before entering into a traditional residential treatment program. This program is monitored and supervised by a Medical Director.

Minimum service requirements:

- Length of stay in clinically managed high-intensity residential services shall be determined utilizing the American Society of Addiction Medicine (ASAM) level of care criteria and requires prior approval of DMHA.
- Clinically Managed High-Intensity Residential Services shall have separate living areas for women and men. Eligible participants shall have significant impairment in physiological, social, occupational, and/or psychological functioning due to substance use. Participants may have a co-occurring disorder, defined as concurrent diagnosis of mental illness, and shall receive treatment for substance use and co-occurring disorders concurrently.
- **Treatment services shall be based on individual need and diagnosis.** Criminal Justice Partners cannot make a determination of treatment; however, they can refer an individual to receive an assessment to determine treatment. Treatment services shall support participant self-sufficiency, decision making, empowerment, and disease self-management principles. Services include 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal.
- All services shall utilize evidence-based practices (EBP) and gender specific care. Evidence based practice is defined as programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results; show the greatest levels of effectiveness and have been replicated in different settings with different populations over time; and can include but are not limited to “treatment manuals.” Evidence based practices for substance abuse is supported by the Substance Abuse and Mental Health Administration (SAMHSA): National Registry of Evidence-based Programs and Practices (NREPP).
- Provider shall have individualized, holistic, and comprehensive recovery/discharge plans for all participants utilizing community resources, recovery support services, and clinical interventions in the community of the participants’ primary residence.
- All Clinically Managed High-Intensity Residential Services shall be designed to practice and utilize recovery-oriented environment, philosophy, and practices to include participant empowerment, self-sufficiency, and recovery options as defined by the participant.
- Ability to refer to hospital providing 24-hour medical backup.
- Use of Clinically Managed High-Intensity Residential Service time as preparation for referral to another level of care.
- Recognition of the chronic nature of disease of substance dependence and the fact that some participants will require multiple admissions.

Who can claim for this service: DMHA Certified Service Provider Agencies; Free-Standing Psychiatric Inpatient Treatment Facilities shall be certified and in compliance with the Indiana Administrative Code, 440 IAC 1 5. Residential Care Providers shall be certified and in compliance with the Indiana Administrative Code, 440 IAC 6.

Exclusions: Provider shall voucher for admission day in clinically managed high-intensity residential service but **not** day of discharge. Services are all inclusive. On the day of admission, the provider may voucher for the enrollment fee and administration fee only. No additional services shall be billed during the duration of the participant's Recovery Works stay.

Billing Guidelines: Organizations billing for reimbursement of this service must receive a Prior Authorization (PA) and be able to document approval of the PA from state staff.

In addition, be able to document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences including return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category. Providers must make every effort to bill insurance for the individual's stay. If the insurance company approves the stay after Recovery Works has been billed, the provider will reimburse Recovery Works for the covered service. If additional days are necessary, providers must advocate with the insurance company for additional days (if the stay was covered by insurance).

Clinically Managed Low-Intensity Residential Services (Treatment Bundle) - $126.46/unit (unit = 1 day); requires Prior Authorization – covers up to 21 days

Participant shall have a diagnosis of Substance Use Disorder as determined by the Diagnostic and Statistical Manual of Mental Disorders current edition. This service is equivalent to the American Society of Addiction Medicine (ASAM) Level 3.1. Clinically Managed Low-Intensity Residential Services program offers room, board, and interpersonal support to individuals in substance use recovery. Clinically Managed Low-Intensity Residential Services provide an ongoing therapeutic environment for participants requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional

functioning; promoting personal responsibility; reintegrating the individual into the world of work, education, and family life; and building adaptive skills that may not have been achieved or have been diminished during the participant's active addiction. Services may be offered in an appropriately licensed facility located in a community setting, such as a halfway house, group home, or other supportive living environment. Clinically Managed Low-Intensity Residential Services is provided by a health care institution other than a hospital or a nursing care institution which provides resident beds or residential units, supervisory care services, personal care service, directed care services or health related services for persons who do not need a higher level of service according to ASAM criteria.
All programs at this level rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of care. This service is delivered under a defined set of physician-approved policies and procedures or clinical protocols.

The purpose of Clinically Managed Low-Intensity Residential Services is to support, stabilize and rehabilitate individuals so they can return to independent community living. Clinically Managed Low-Intensity Residential Services provide a structured environment on a 24-hour basis.

Minimum service requirements:

- Eligible participants shall have significant impairment in physiological, social, occupational, and/or psychological functioning due to substance use. Participants may have a co-occurring disorder, defined as concurrent diagnosis of mental illness, and shall receive treatment for substance use and co-occurring disorders concurrently.
- Treatment services shall be based on individual need and diagnosis. Treatment services shall support participant self-sufficiency, decision making, empowerment, and disease self-management principles. Services include 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal.
- Length of stay in Clinically Managed Low-Intensity Residential Services shall be determined utilizing the American Society of Addiction Medicine (ASAM) level of care criteria and requires prior approval of DMHA. Clinically Managed Low-Intensity Residential Services shall have separate living areas for women and men. All services shall utilize evidence-based practices (EBP) and gender specific care. Evidence-based practice is defined as programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results; show the greatest levels of effectiveness and have been replicated in different settings with different populations over time; and can include but are not limited to "treatment manuals." Evidence-based practices for substance use is supported by the Substance Abuse and Mental Health Administration (SAMHSA). National Registry of Evidence-based Programs and Practices (NREPP). The provider shall have individualized, holistic, and comprehensive recovery/discharge plans for all participants utilizing community

resources, recovery support services, and clinical interventions in the community of the participants' primary residence.

- All Clinically Managed Low-Intensity Residential Services shall be designed to practice and utilize recovery-oriented environment, philosophy, and practices to include participant empowerment, self-sufficiency, and recovery options as defined by the participant.
- Ability to refer to hospital providing 24-hour medical backup.
- Use of Clinically Managed Low-Intensity Residential Services as preparation for referral to another level of care.
- Recognition of the chronic nature of the disease of substance dependence and the fact that some participants will require multiple admissions.
- Facilitates application of recovery skills, relapse prevention, and emotional coping skills.
- 24-hour structure and support provide residents with the opportunity to develop and practice interpersonal/group living skills, reintegrate into the community/family, and begin or resume employment and/or academic pursuits.
- Treatment Bundle must include a minimum of five (5) hours of planned, clinical services of professionally directed treatment per week; the specific services and supports must be listed on the individualized plan and include a projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter and type of personnel that will be furnishing the services.
- Clinical services must be individualized for each participant; services available for the treatment bundle should include, at a minimum:
    - Case Management
    - Individual, family, and group Skills Training and Development
    - Individual, family, and group Counseling
    - Alcohol and Other Drug Screening
    - Peer Recovery Support Services
    - Medication monitoring/review; and/or access to medications
- When possible, all services should be billed through the participant's insurance. If insurance denies payment, the actual denial may be submitted to Recovery Works for consideration. Please ensure providers are utilizing ASAM criteria when admitting participants.

Who may claim for this service: DMHA Certified Service Provider Agencies; Free-Standing Psychiatric Inpatient Treatment Facilities shall be certified and in compliance with the Indiana Administrative Code, 440 IAC 1 5. Residential Care Providers shall be certified an in compliance with Indiana Administrative Code, 440 IAC 6.

Exclusions: Provider shall voucher for admission day in Clinically Managed Low-Intensity Residential Service but **not** day of discharge. Services are all inclusive. On the day of admission,

the provider may voucher for the enrollment fee and administration fee only. No additional services shall be billed during the duration of the participant's Recovery Works stay.

Billing Guidelines: Organizations billing for reimbursement of this service must receive a Prior Authorization (PA) and be able to document approval of the PA from state staff.

In addition, be able to document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences including return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category. Providers must make every effort to bill insurance for the individual's stay. If the insurance company approves the stay after Recovery Works has been billed, the provider will reimburse Recovery Works for the covered service. If additional days are necessary, providers must advocate with the insurance company for additional days (if the stay was covered by insurance).

Comprehensive Mental Health and Substance Use Assessment - $130/unit (unit = 1 assessment)

Designated Recovery Works Providers agree, upon acceptance of the referral, to begin the treatment process with a Comprehensive Mental Health and Substance Use Disorder Assessment. The assessment must include a DSM 5 or ICD 10 Diagnosis of Mental Health, Substance Use Disorder, or Co-Occurring; clear medical necessity for ongoing treatment; and the participant's statement of his/her individualized treatment goal. Organizations providing clinical assessment are expected to provide each participant with an in-depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of an evidence-based peer-reviewed standardized assessment tool in general use for mental health populations in the State of Indiana. The ANSA must be paired with the clinical interview. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinician with the participant.

When documenting a claim for Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcome of the assessment (including ANSA)

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: None. ALL assessments must be completed in conjunction with the ANSA.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file of the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcome of Assessment (including ANSA results) (i.e., Treatment Plan)
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Comprehensive Mental Health and Substance Use Disorder Assessment - $205/unit (unit = 1 assessment) – CRIMINAL JUSTICE INSTITUTION

Designated Recovery Works Providers agree, upon acceptance of the referral, to begin treatment process with a Comprehensive Mental Health and Substance Use Disorder Assessment. The assessment must include a DSM 5 or ICD 10 Diagnosis of Mental Health, Substance Use Disorder, or Co-Occurring; clear medical necessity for ongoing treatment; and the participant's statement of his/her individualized treatment goal. Organizations providing clinical assessment are expected to provide each participant with an in-depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of and evidence-based peer-reviewed standardized assessment tool in general use for mental health populations in the State of Indiana. The ANSA must be paired with the clinical interview. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinician with the participant.

When documenting a claim fir Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcomes of the assessment (including ANSA)

In order to claim for this service, the assessment must be performed face-to-face inside of a Criminal Justice Institution. An institution is defined as "a place where an organization takes care of people for a usually long period of time" (Merriam-Webster Dictionary). Providers entering these institutions would most likely need additional security clearances; may receive professional visitor status; may receive additional security screenings; may or may not be allowed laptops/WIFI for assessments. When Recovery Works speaks about Criminal Justice Institutions, we are speaking to facilities in which your participant cannot leave (DOC Facilities/Prison, County Jail, some Community Correction/Work Release Facilities).

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: None. ALL assessments must be in conjunction with the ANSA.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcomes of Assessment (including ANSA results) (i.e., Treatment Plan)
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Comprehensive Mental Health and Substance Use Disorder Assessment - $100/unit (unit = 1 assessment) – TELEHEALTH

Designated Recovery Works Providers agree, upon acceptance of the referral, to begin the treatment process with a Comprehensive Mental Health and Substance Use Disorder Assessment. The assessment must include a DSM 5 or ICD 10 Diagnosis of Mental Health, Substance Use Disorder, or Co-Occurring; clear medical necessity for ongoing treatment; and the participant's statement of his/her individualized treatment goal. Organizations providing clinical assessment are expected to provide each participant with an in-depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of an evidence-based peer-reviewed standardized assessment

tool in general use for mental health populations in the State of Indiana. The ANSA must be paired with the clinical interview. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinician with the participant.
When documenting a claim for Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcomes of the assessment (including ANSA)

Tele-health is the use of a telecommunication system to provide services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Tele-health is the delivery of acute mental health or substance use care, including diagnosis or treatment, by means of a secure, two-way real-time interactive audio and video by a health care provider in a remote location to an individual needing care at a referring site, known as the Originating Site.

Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio, and video. The information or data exchanged can occur in real-time (synchronous) through interactive video or multimedia collaborative environments or in near real-time (asynchronous) through “store and forward” applications.

Service Sites

The originating site is the facility in which the participant is located. The distant site is the facility from which the provider furnishes the TMH (Tele-Mental Health) service. All distant sites must be approved Recovery Works providers.

Special Considerations

When ongoing services are provided, the participant should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the distant physician should coordinate with the patient’s primary care physician.

Documentation Standards

- Documentation must be maintained at the distant and originating locations to substantiate the services provided.
- Documentation must indicate the services were rendered via TMH.
- Documentation must clearly indicate the location of the distant and originating sites.
- All documentation guidelines for services rendered via TMH apply.
- Documentation is subject to post-payment review.
- Providers must have written protocols for circumstances when the participant must have a face-to-face visit with the consulting provider. The participant should always be given the choice between a traditional clinical encounter versus a telemedicine visit.

Appropriate consent from the participant must be obtained by the originating site and maintained at the distant and originating sites.

Who may claim for this service: Licensed Professionals, including and LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: None. ALL assessments must be done with an ANSA. Telemedicine is not the use of the following: (1) *Telephone transmitter for trans-telephonic monitoring; or* (2) *Telephone or any other means of communication for consultation from one provider to another.*

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcomes of Assessment (including ANSA results) (i.e., Treatment Plan)
- Rendering Staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Enrollment Administrative Fee - $50.00/unit (unit = 1 enrollment assessment)

Upon completing a comprehensive mental health and substance use disorder assessment along with the ANSA on a referred participant, Designated Recovery Works agencies may claim one (1) Enrollment Administrative Fee unit per participant. This unit should be claimed at the same time as the assessment.

Who may claim for this service: Licensed Professionals, including and LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: Must be claimed with an initial assessment.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file or in WITS the following:

- Date and time of assessment
- Rendering Staff performing assessment

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and

including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Health Care Coordination Services - $8.55/unit (unit = ¼ hour)

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Who may claim for this service: DMHA/ISDH Certified Community Health Workers and/or Certified Recovery Specialist (CHW/CRS).

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What are the specific plans for next step, including the participants actionable items, include date, time, and type of next contact
- Rendering staff name

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

HIP Power Account Contribution - $1/unit (unit = 1 dollar); requires Prior Authorization for claims exceeding $165 maximum – contribution amount varies

The Division of Mental Health and Addiction is able to contribute to a beneficiary's POWER account contribution. Funds cannot be used toward co-pays. Recovery Works funds can be used to pay the POWER account contribution for any participant in our program who expresses need, as long as the individual qualifies for, and is enrolled in, Recovery Works. All, or a portion, of the annual contribution amount may be requested in the Prior Authorization; however, a plan for the participant to make future contributions into the POWER account should accompany the Prior Authorization request.

Who may claim for this service: Designated Recovery Works Agencies

Exclusions: There are no limits on the amounts third parties can contribute to a beneficiary's POWER account except that the contribution must be used to offset the beneficiary's required contribution only – not the state's.

Billing Guideline: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Intensive Outpatient Treatment - $130.59/unit (unit = 3-hour group)

Intensive Outpatient Treatment (IOT) is a treatment program that operates at least three (3) hours per day, at least three (3) days per week, and is based on the Individualized Recovery Plan. IOT is planned and organized with Substance Use professionals and clinicians providing multiple treatment service components for rehabilitation of alcohol and other drug abuse or dependence in a group setting. IOT includes group therapy, interactive education groups, skills training, random drug screenings, and counseling. IOT is limited to forty (40) three (3) hour sessions; Prior Authorization (PA) is required for consumers requiring additional units of service. IOT may be provided for eligible participants with a substance-related disorder and:

- Minimal or manageable medical conditions.
- Minimal or manageable withdrawal risk.
- Emotion, behavioral, and cognitive conditions that will not prevent the consumer from benefiting from this level of care.

IOT program standards include the following components:

- Regularly scheduled sessions, within a structured program, that are at least three (3) consecutive hours per day, and at least three (3) days per week.
- Referral to 12-step programs, peers, and other community supports (12-step programs are not Recovery Works billable).

- Education on Substance Use disorders.
- Skills training in communication, anger management, stress management, and relapse prevention.
- Individual, group, and family therapy (provided by a licensed professional or QBHP only).
- IOT must be offered as a distinct service.
- IOT must be individualized and a service necessary for the individual participant.
- Access to additional support services (e.g., peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated treatment, referral to other community supports) as needed.
- The participant is the focus of the service.
- Documentation must support how the service benefits the participant, including when the service is in a group setting. Individual contribution to the session is not optional documentation.
- Services must demonstrate progress toward, or achievement of consumer identified treatment goals. Service goals must be rehabilitative in nature.
- Up to twenty (20) minutes of break time is allowed during each three (3) consecutive hour session.
- THIS SERVICE IS BILLED AS ONE (1) UNIT PER THREE (3) HOURS with a MAXIMUM OF THREE (3) UNITS BILLED PER WEEK ONLY.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers; Other Behavioral Health Providers. A licensed professional is responsible for the overall management of the clinical program. At least one (1) of the Direct Service Providers must be a LAC or a LCAC.

Exclusions:

- Consumers with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Consumers at imminent risk of harm to self or others.
- IOT will not be reimbursed for consumers receiving Group Substance Use Counseling on the same day.
- IOT sessions that consist of education services only are not reimbursable. Skills sessions cannot be billed or utilized as IOT services.
- Any service that is less than three (3) hours, three (3) times a week may not be billed as IOT.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service

- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Medication for Treatment of Mental Health and/or Substance Use Disorders – Requires Prior Authorization for claims exceeding the Community Funding maximum; Actual pharmacy expense will be reimbursed for medication; (unit = $1); must maintain receipts in record
Who can claim for this service: Psychiatrist; Licensed Physician; AHCP. For MAT prescribers must be data waived under Indiana and Federal law.
Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff – individual who dispensed medication to participant

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Medication Assisted Treatment (OTP Treatment Bundles) – Requires Prior Authorization for services beyond Initial Intake and ten (10) subsequent days of dosing/services; Methadone Assisted Treatment Bundle - $16.05/unit (unit = 1 day)
Organizations providing Medication Assisted Treatment are expected to provide pharmacotherapies approved by the Food and Drug Administration (FDA) for the treatment of Opioid use disorders and be recognized by the Division of Mental Health and Addiction to offer this service.

All recognized protocols eligible for billing under a treatment bundle must include the statutorily required services for medication assisted opiate treatment, as well as must include:

- Full medical physical included at initial intake
- Full DMHA approved bio-psychosocial assessment at initial intake
- Ongoing medical supervision
- Supervised medication distribution
- Regular counseling
- Regular multi-panel AOD testing, both scheduled and random
- Ongoing referrals for other needed treatment and recovery support services
- Screening and/or referral for the treatment of co-occurring mental health needs

All of these services are to be provided as one (1) bundled service for the purpose of Recovery Works vouchers. Recovery Works vouchers will only pay for Medication Assisted Treatment in support of individual participant's recovery activities as listed in his/her individualized recovery plan.

Who can claim for this service: Indiana Opioid Treatment Programs who meet the DMHA Certification Requirements under Indiana Code 440 Article 10. Prescribers must meet licensure requirements and be data waived under Indiana and Federal law.

Billing Guidelines: Organizations billing for reimbursement of this service must receive a Prior Authorization (PA) and be able to document approval of the PA from state staff.

In addition, be able to document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service.

Medication Assisted Treatment Assessment - $112.78 unit (unit = 1 assessment)

Organizations providing clinical assessment are expected to provide each participant with an in-depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of an evidence-based peer-reviewed standardized assessment tool in general use for mental health populations in the State of Indiana. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinicians with the participant.
The assessment may also include:

- Drug testing
- Specimen collection and handling
- Hepatitis A, B, and C testing, as needed
- Pregnancy testing, as needed
- Tuberculous testing, as needed
- Syphilis testing, as needed
- Complete blood count, as needed
- Other blood testing, as needed

When documenting a claim for Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcomes of the assessment

Who may claim for this service: Licensed Physician; AHCP; Psychiatrist

Exclusions: None.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcomes of Assessment (including ANSA results) (i.e., Treatment Plan)
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Medication Review - $23.88/unit (unit = ¼ hour)

Psychiatric Assessment consist of a face-to-face activity that is designed to provide psychiatric assessment, consultation, and medication services to participants. Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional, behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a participant's treatment.

Monitoring a participant's medical and other health issues that are either directly related to the mental health or substance-related disorder, or to the treatment of the disorder (for example: diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, and seizures).

To be a billable activity, consultation must be goal-oriented, focused on addressing barriers to fulfilling the participant's recovery plan, and documented in the clinical record in a way that reflects the complexity of the interaction.

Who may claim for this service: Licensed Physician; AHCP; Psychiatrist

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Medication Training and Support – Individual - $18.62/unit (unit = ¼ hour); Group - $3.35/unit (unit = ¼ hour); Individual/Family - $18.62/unit (unit = ¼ hour); Family Group - $3.35/unit (unit = ¼ hour)

Medication Training and Support involves face-to-face contact with the participant and/or family or nonprofessional caregivers in an individual setting for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non-face-to-face activities. Face-to-face contact in an individual setting with the participant and/or family or nonprofessional caregivers that includes monitoring self-administration of prescribed medications and monitoring side effects. When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available under the Clinic Option.

Who may claim for this service: The following providers may provide Medication Training and Support within the scope of practice as defined by federal and state law: Licensed physician, AHCP, RN, LPN, MA who has graduated from a two (2) year clinical program.

Exclusions:

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding participant self-administration of medications is not reimbursable under Medication Training and Support but may be billed as Skills Training and Development.
- Medication Training and Support may not be provided for professional caregivers.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Mental Health Counseling – Individual - $28.65/unit (unit = ¼ hour)

Mental Health Counseling is a planned and organized service with the participant, where mental health professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. The participant is the focus of Mental Health Counseling. Documentation must support how Mental Health Counseling benefits the participant, including when the participant is not present. Mental Health Counseling requires face-to-face contact with the participant. Mental Health Counseling consists of regularly scheduled sessions.

- Mental Health Counseling may include:
    - Education on mental health disorders; however, Mental Health Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Mental Health Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
      (Batterer's Intervention Program and similar programming is not a covered service under Recovery Works).
- Mental Health Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Mental Health Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Mental Health Counseling must be individualized, and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and

including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Mental Health Counseling – Family/Individual- $28.65/unit (unit = ¼ hour); Family Group - $7.16/unit (unit = ¼ hour)

Mental Health Counseling is a planned and organized service with the participant and/or family members (as defined by participant), or nonprofessional caregivers, where Mental Health professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. The participant is the focus of Mental Health Counseling. Documentation must support how Mental Health Counseling benefits the participant, including when the participant is not present. Mental Health Counseling requires face-to-face contact with the participant and/or family members. Mental Health Counseling consists of regularly scheduled sessions.

- Family Mental Health Counseling may include the following:
    - Education on mental health disorders; however, Mental Health Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Mental Health Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
      (Batterer's Intervention Program and similar programming is not a covered service under Recovery Works).
- Mental Health Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Mental Health Counseling must be provided in an age-appropriate setting for a participant younger than eighteen (18) years of age receiving services.
- Mental Health Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Mental Health Counseling must be individualized, and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals, including and LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session

- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Mental Health Counseling – Group - $7.16/unit (unit = ¼ hour)

Mental Health Counseling is planned and organized service with the participant, where mental health professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. The participant is the focus of Mental Health Counseling. Documentation must support how Mental Health Counseling benefits the participant, including when the participant is not present. Mental Health Counseling requires face-to-face contact with the participant. Mental Health Counseling consists of regularly scheduled sessions.

- Mental Health Counseling may include:
    - Education on mental health disorders; however, Mental Health Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Mental Health Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
      (Batterer's Intervention Program and similar programming is not a covered service under Recovery Works).
- Mental Health Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Mental Health Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Mental Health Counseling must be individualized, and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service

- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Peer Recovery Services - $8.55/unit (unit = ¼ hour)

Peer Recovery Services are **individual face-to-face** services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Organizations providing Peer Recovery Services are required to have personnel on staff that have completed and passed the Addition Peer Recovery Coach training or the Certified Recovery Specialist-Substance Abuse (CRS-SA). These are the **ONLY** Peer Recovery Services certifications that are accepted by Recovery Works.

Who may claim for this service: Peer Recovery Services must be provided by individuals meeting DMHA training and competency standards for CRS or Recovery Coach. Individuals providing Peer Recovery Services must be under supervision of a licensed professional or QBHP.

Exclusions: Peer Recovery Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed.

- **Interventions targeted to groups are not billable as Peer Recovery Services.**
- Activities that may be billed under Skills Training and Development or Case Management services are not billable as Peer Recovery Services.
- Peer Recovery Services are not reimbursable for children under the age of sixteen (16).
- Peer Recovery Services that occur in a group setting are not reimbursable. **Peer Recovery Services are individual service support only.**

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery

- What is the specific plan for next steps, including the participants actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Psychiatric Evaluation - $26.14/unit (unit = ¼ hour)

Psychiatric Assessment consist of a face-to-face activity that is designed to provide psychiatric assessment, consultation, and medication services to participants. Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional, behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a participant's treatment.

Monitoring a participant's medical and other health issues that are either directly related to the mental health or substance-related disorder, or to the treatment of the disorder (for example: diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, and seizures).

To be a billable activity, consultation must be goal-oriented, focused on addressing barriers to fulfilling the participant's recovery plan, and documented in the clinical record in a way that reflects the complexity of the interaction.

Who may claim for this service: Licensed Physician; AHCP; Psychiatrist

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other

Recovery Residency - $15 room only/unit; $20 room and board/unit (unit = 1 day)

Organizations providing Recovery Residency are expected to provide participants with residential housing that is supportive of the participant's recovery and free of relapse triggers. Organizations must be certified by the Indiana Affiliation of Recovery Residences (DMHA Certifications Team) and a Recovery Works designated agency. Information on the DMHA Certifications Team certification can be found at www.INARR.org. Application for Recovery Works can be found at www.RecoveryWorks.fssa.IN.gov. Residences must provide a safe, clean, and sober environment for adults with mental health and/or substance use disorders. Additionally, they must comply with all DMHA Certifications Team standards. Organizations may also help families in locating and securing affordable and safe housing, as needed. Additionally, assistance may include accessing a housing referral service, relocation, tenant/landlord counseling, repair mediation, and other approved housing needs. It is required that the housing provider will develop with the participant a plan to move toward more stable housing. This plan will be established through an evaluation that the provider conducts, have measurable goals and a projected timeline for completion of goals. Recovery Works vouchers will only pay for Housing in support of an individual participant's recovery activities as listed in their individual recovery plan and budget.

Recovery Works will pay for up to $8,000 for Traditional Housing Assistance. We expect Recovery Residences to have a "plan of stay" for the participant that includes titrating the individual down off Recovery Works.

> *For example, upon the fourth (4th) month, the expectation is that the participant will begin paying a portion and titrating down from Recovery Works funding and transitioned to a more permanent living space. Another example of how this may work is that Recovery Works will pay for three (3) full months, on the fourth (4th) month, Recovery Works will pay for three (3) weeks, and the participant will pay for one (1) week. On month five (5), Recovery Works will pay for two (2) weeks, and the participant will pay for two (2), etc. Recovery Works staff expects that this conversation will be held with the participant at the beginning of their stay and be part of their housing plan.*

Direct Service Providers (DSPs) should NOT rely on WITS to track client expenditures. Total housing coverage varies based on service definition and per diem rates. DSPs should track length and stay, as well as obtain a monetary amount upon the individual arriving at the home. An inquiry can be submitted to Recovery Works at the initial intake to determine number of days remaining.

Room Only ($15/unit) Requirements:

Recovery Residence wishing to provide room only, must have a kitchen with all necessary cooking tools and eating utensils available to residents. Cooking utensils include, but not limited to: a refrigerator, food storage units (such as cabinets/shelves), cooking pots, cooking pans, cooking utensils (such as spatulas, spoons, ladle, knives, potato masher, grater, peeler, tongs,

whisk, can opener, oven mitts, measuring spoons/cups, etc.), stove top, oven, etc. Eating utensils include, but are not limited to: a table, forks, spoons, knives, plates, bowls, cups, etc.

Room only providers must provide:

- A bed
- 60 square feet of living space per resident
- A place to store personal items
- One (1) toilet for every four (4) individuals
- One (1) bath/shower for every six (6) individuals
- Common space
- Medication rules, including free administration of drugs by qualified personnel (Recovery Works participants may not be charged a fee for administering medication)
- TB testing

Room and Board ($20/unit) Requirements:

DMHA Certifications Team Certified Recovery Residences wishing to provide room and board services must provide all of their services listed above under Room Only definition, and: one (1) prepared meal per day, and resources for two (2) additional meals. The prepared meal must be prepared with purchased items, using agency funds. The resources for the additional two (2) meals can be donated resources.

Recovery Works will pay for up to $8,000 for Traditional Housing Assistance. We expect Recovery Residences to have a "plan of stay" for the participant that includes titrating the individual down off Recovery Works.

> *For example, upon the fourth (4th) month, the expectation is that the participant will begin paying a portion and titrating down from Recovery Works funding and transitioned to a more permanent living space. Another example of how this may work is the Recovery Works will pay for three (3) full months, on the fourth (4th) month, Recovery Works will pay for three (3) weeks, and the participant will pay for one (1) week. On month five (5), Recovery Works will pay for two (2) weeks, and the participant will pay for two (2), etc.*

Recovery Works staff expects that this conversation will be held with the participant at the beginning of their stay and be part of their housing plan. Direct Service Providers (DSPs) should NOT rely on WITS to track client expenditures. Total housing coverage varies based on service definition and per diem rates. DSPs should track length and stay, as well as obtain a monetary amount upon the individual arriving at the home. An inquiry can be submitted to Recovery Works at the initial intake to determine number of days remaining.

Please NOTE, the above $8,000 should NOT be used in its entirety when it is not necessary. Recovery Residences should work with the participant to have a plan of action to help them

become more self-sufficient, and to preserve funding in the event of a relapse or unexpected life event. Each individual situation is different and should be reflected in the participant file(s). Recovery Works reserves the right to implement mandatory titration schedules for providers who do not have an acceptable titration schedule available.

Who may claim for this service: Agencies that have been DMHA Certifications Team certified and have become a Recovery Works designated agency. Level IV Recovery Residences must also be DMHA Certified as an outpatient addiction provider.

Exclusions: Providers wishing to bill for room and board days of service may not use donated food for the one (1) prepared meal.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date(s) service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened during the client's days of residence
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- If billing for one (1) week at a time, MUST include EACH day that residency was provided in the Encounter Notes section of the Encounter
- Rendering staff – house manager

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including prosecution from local, state, and federal entities. Services that are properly funded under other programs are not to be funded under this service category.

Skills Training and Development – Individual - $26.14/unit (unit = ¼ hour); Group - $4.71/unit (unit = ¼ hour); Individual/Family - $26.14/unit (unit = ¼ hour); Family Group - $4.71/unit (unit = ¼ hour)

Skills Training and Development – Individual (26.14 per ¼ hour) – Only the participant and rendering staff are included in the session.

Skills Training and Development – Group (4.71 per ¼ hour) – Participant and one (1) or more individuals (non-family) are present for services at one (1) time.

Skills Training and Development – Family (26.14 per ¼ hour) – Participant and one (1) or more family members are present.

Skills Training and Development – Family Group ($4.71 per ¼ hour) – Participant is not present for service. The provider is meeting with the family to help provide a necessary skill or training pertinent to the participant's recovery. *(i.e., Family wants to understand how to calm their family member down when he has episodes pertinent to mental health. The provider may want to meet with the family separately, to ensure they are fully trained and understand their role in the process).*

Please NOTE – Skills Training and Development is NOT an intensive service category and should not be utilized as a substitution to clinical services. If an individual is in need of intensive services, we encourage the Direct Service Provider (DSP) to work with the insurance company and advocate for an MRO package or rehabilitative package (private insurance).

Skills Training and Development involves face-to-face contact with the participant and/or family or nonprofessional caregivers that result in the participant's development of skills (for example: self-care, daily life management, or problem-solving skills), in an individual setting or group setting directed toward eliminating psychosocial barriers. Development of skills is provided through structured interventions for attaining goals identified in the recovery plan and the monitoring of the participant's progress in achieving those skills. Participants are expected to show benefit from Skills Training and Development, with the understanding that improvement may be incremental. Skills Training and Development must result in demonstrated movement toward, or achievement of, the participant's treatment goals identified in the recovery plan. Skills Training and Development includes monitoring the impact of training acquisition (i.e., structured opportunities for participant to demonstrate skills acquisition and improved functioning as a result). Skills Training and Development aims to restore participant's abilities essential to independent living (i.e., self-care and daily life management skills). Provide skills training specific to illness self-management.

May include, but not limited to the following types of services:

- Skills training in food planning and preparation, money management, and maintenance of living environment.
- Training in appropriate use of community services.
- Medication-related education and training by nonmedical staff.
- Training in skills needed to locate and maintain a home; renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, locating and interviewing prospective roommates, and understanding renter's rights and responsibilities.
- Social skills training necessary for functioning in a work and/or community environment.

The participant is the focus of Skills Training and Development. Documentation must support how the service benefits the participant, including when the participant is not present. Skills Training and Development goals are rehabilitative in nature and time limited.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers; Other Behavioral Health Providers

Exclusions:

- Skills Training and Development that is habilitative in nature is not reimbursable.
- Skill-building activities not medically necessary to address the mental health and/or substance use disorder are not reimbursable.
- Activities purely for recreation or diversion are not reimbursable (see case management referrals and linkages).
- Job coaching is not reimbursable (see supportive employment services definition).
- Academic tutoring is not reimbursable (see case management referrals and linkages).
- Individual Skills Training and Development services are not reimbursable if delivered on the same day as AIRS or CAIRS.
- Skills Training and Development may not be provided to professional caregivers.
- Skills Training and Development cannot be used to build or employ participants within the provider organization.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Substance Use Disorder Counseling – Individual - $14.58/unit (unit= ¼ hour)

Substance Use Disorder Counseling is a planned and organized service with the participant, where Substance Use professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. Substance Use Disorder Counseling is designed to be a less intensive alternative to Intensive Outpatient Treatment. The participant is the focus of Substance Use Disorder Counseling. Documentation must support how Substance Use Disorder Counseling benefits the participant. Substance Use Disorder Counseling requires

face-to-face contact with the participant. Substance Use Disorder Counseling consists of regularly scheduled sessions.

- Substance Use Disorder Counseling may include the following:
    - Education on Substance Use Disorders; however, Substance Use Disorders Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, mood de-escalation, stress management, and relapse prevention; however, Substance Use Disorder Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
- Substance Use Disorder Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Substance Use Disorder Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Substance Use Disorder Counseling must be individualized, and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers

Exclusions:

- Participants with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Participants at imminent risk of harm to self or others are not eligible for this service.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Substance Use Disorder Counseling – Family - $14.58/unit (unit = ¼ hour); Family Group - $3.65/unit (unit = ¼ hour) – Involves the participant and at least one (1) family member

Substance Use Disorder Counseling – Family is a planned and organized service with the participant and/or family members, or nonprofessional caregivers, where Substance Use professionals and clinicians provide counseling intervention that works toward the goals identified in his/her IRPB. Substance Use Disorder Counseling is designed to be a less intensive alternative to IOT. The participant is the focus of Substance Use Disorder Counseling. Documentation must support how Substance Use Disorder Counseling benefits the participant, including when the participant is not present. Substance Use Disorder Counseling requires face-to-face contact with the participant and/or family members. Substance Use Disorder Counseling consists of regularly scheduled sessions.

- Substance Use Disorder Counseling may include the following:
    - Education on Substance Use Disorders; however, Substance Use Disorder Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Substance Use Disorder Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
- Substance Use Disorder Counseling must demonstrate progress toward, and achievement of participant treatment goals identified in the IRPB.
- Substance Use Disorder Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Substance Use Disorder Counseling must be individualized, and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers

Exclusions:

- Participants with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Participants at imminent risk of harm to self or others are not eligible for this service.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery

- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Substance Use Disorder Counseling – Group - $3.65/unit (unit = ¼ hour) – Participant plus one (1) other individual (non-family related)

Substance Use Disorder Counseling is a planned and organized service with the participant, where Substance Use professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. Substance Use Disorder Counseling is designed to be a less intensive alternative to Intensive Outpatient Treatment. The participant is the focus of Substance Use Disorder Counseling. Documentation must support how Substance Use Disorder Counseling benefits the participant. Substance Use Disorder Counseling requires face-to-face contact with the participant. Substance Use Disorder Counseling consists of regularly scheduled sessions.

- Substance Use Disorder Counseling may include the following:
    - Education on Substance Use Disorders; however, Substance Use Disorder Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, mood de-escalation, stress management, and relapse prevention; however, Substance Use Disorder Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
- Substance Use Disorder Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Substance Use Disorder Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Substance Use Disorder Counseling must be individualized, and person centered.
- Referral to available community-based support services is expected.
- Group setting should be no larger than 12 participants.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers

Exclusions:

- Participants with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Participant at imminent risk of harm to self or others are not eligible for this service.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the service up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Supported Employment Services - $9.17/unit (unit = ¼ hour)

Supported Employment means competitive work in integrated work settings, or employment in integrated work settings, in which individuals are working toward competitive work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities

- for whom competitive employment has not traditionally occurred; or
- for whom competitive employment has been interrupted or intermittent as a result of a significant disability; and
- who, because of the nature and severity of their disability, need intensive supported employment services for the period, and any extension, described in paragraph (36) (C) and extended services after the transition described in paragraph (13) (C) in order to perform such work
- such term includes transitional employment for persons who are individuals with the most significant disabilities due to mental illness.

Supported Employment Services are intended to be a placement and support program designed for adult individuals with a mental impairment for whom competitive employment has been interrupted or unattainable as a result of their disability. Due to the nature and extent of their disabilities, these individuals may benefit from placement, support, and ongoing services in order to maintain employment. Participants are provided concentrated placement, support, and ongoing services in order to gain and maintain employer and community relationships. Supported Employment Services emphasize a holistic approach to enhance the participant's strengths, talents, and abilities in order to match the needs and requirements of the business, while remaining mindful of the individual's chosen vocational goal. Supported Employment

Services should assist participants with accessing resources for job applicants, including phones, internet service, resume writing support, interview tips and practice, as well as appropriate dress and presentation guidance for the workplace.

The essential components of supported employment are:

- competitive employment (e.g., at least minimum wage)
- duties integrated with other employees who are not disabled
- ongoing supports to assist the individual to keep his or her job long term

Supported Employment Services are any services described in an individualized plan for employment necessary to assist an individual with a mental health and/or substance use disorder, which prevents them from otherwise obtaining employment, in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual, including—

- An assessment for determining eligibility and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology.
- Counseling and guidance, including information and support services to assist an individual in exercising informed choice consistent with the provisions of section 722 (d) of 29 U.S. CODE § 722.
- Referral and other services to secure needed services from other agencies through agreements developed under section 721 (a)(11) of 29 U.S. CODE § 722.
- Job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services.
- Vocational and other training services, including the provision of personal and vocational adjustment services, books, tools, and other training materials, except that no training services provided at an institution of higher education shall be paid for with these funds.
- Maintenance for additional costs incurred while participating in an assessment for determining eligibility and vocational rehabilitation needs or while receiving services under an individualized plan for employment.
- Transportation, including adequate training in the use of public transportation vehicles and systems, that is provided in connection with the provision of any other service described in this section and needed by the individual to achieve an employment outcome.
- On-the-job or other related personal assistance services provided while an individual is receiving other services described in this section.
- Occupational licenses, tools, equipment, and initial stocks and supplies.

- Technical assistance and other consultation services to conduct market analyses, develop business plans, and otherwise provide resources, to the extent such resources are authorized to be provided through the statewide workforce investment system, to eligible individuals who are pursing self-employment or telecommuting or establishing a small business operation as an employment outcome.
- Specific post-employment services necessary to assist an individual with a disability to retain, regain, or advance in employment.

Who can claim for this service: Licensed Professionals; Qualified Behavioral Health Providers; Other Behavioral Health Providers

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category. Please note, supported employment cannot be utilized to build or support the service provider organization.

Telepsychiatry - $23.88/unit (unit = ¼ hour); requires Prior Authorization

Telepsychiatry is the use of a telecommunication system to provide psychiatric services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Telepsychiatry is the delivery of acute mental health or substance abuse care, including diagnosis or treatment, by means of a secure, two-way real-time interactive audio and video by a health care provider in a remote location to an individual needing care at a referring site, known as the Originating Site. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real-time (synchronous) through interactive video or multimedia collaborative environments or in near real-time (asynchronous) through "store and forward" applications.

Service Sites: The originating site is the facility in which the participant is located. The distant site is the facility from which the provider furnishes the TMH service. All services sites **must** be approved Recovery Works providers.

Special Considerations: When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the hub physician should coordinate with the patient's primary care physician.

Documentation Standards:

- Documentation must be maintained at hub and spoken locations to substantiate service provided.
- Documentation must indicate the services were rendered via TMH.
- Documentation must clearly indicate the location of the hub and spoke sites.
- All documentation guidelines for services rendered via TMH apply.
- Documentation is subject to post-payment review.
- Providers must have written protocols for circumstances when the member must have a hands-on visit with the consulting provider. The member should always be given the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the spoke site and maintained at the hub and spoke sites.

Who can claim for this service: Designated Recovery Works Agencies with Prior Authorization who follow federal and state digital health information security guidelines. Providers include Licensed Physician, Psychiatrist, AHCP.

Exclusions: Telemedicine is not the use of the following: (1) *Telephone transmitter for transtelephonic monitoring; or* (2) *Telephone or any other means of communication for consultation from one provider to another.*

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud

and can result in consequences from the return of funds paid for the services up to and including federal prosecution. Additionally, services properly funded under other Recovery Works service categories are not to be funded under this service category.

Transportation Agency Vehicle - $10.00/unit (unit = round trip); Public Transport – Actual Expense

Organizations providing Transportation Services are expected to provide individual participants with transportation to and from recovery related activities in the form that has the most appropriate and cost-effective manner. Transportation assistance can be provided in one (1) of the following two (2) ways: Properly registered and insured agency owned vehicle and public transportation (bus passes/tokens). A trip is defined as transporting a Recovery Works participant from the initial point of pick-up to the drop point at destination. Transportation must be the least expensive type of transportation available that meets the recovery needs of the participant. Providers must bill for all transport services provided to the same participant on the same date of service on one (1) encounter If the participant is traveling to multiple destinations in succession, the provider may not bill for a trip between each point of destination.

The following offers explanations of this concept:

- **Example 1:** A vehicle picks up participant at home and transports participant to psychiatrist's office. This is a one-way trip (1 unit).
- **Example 2:** A vehicle picks up participant from home and transports to psychiatrist's office. The provider leaves, and later the same vehicle picks participant up from psychiatrist's office and transports participant back to participant's home. The is considered a round trip (1 unit).
- **Example 3:** A vehicle picks participant up from psychiatrist's office and transports participant to laboratory for blood draw, waits outside laboratory for participant, and then transports participant home. This is a one-way trip (1 unit), as a stop along the way is not considered a separate trip.
- **Example 4:** A vehicle picks up Participant A at participant's home and begins to transport Participant A to recovery center. Along the way, a stop is made to pick up Participant B at a Recovery home and both Participant A and Participant B are transported to recovery center. The stop at Recovery home is not considered a separate trip and the transportation of Participant A from home to the recovery center is considered a one-way trip. If they were then picked up and returned to their recovery centers/homes, it would still be a round trip (1 unit).

When entering the encounter, for billing purposes, provider must list the initial point of pick-up and any destinations in the Note section of the encounter. Recovery Works will only reimburse the per trip unit, not mileage. Agencies providing transportation via agency owned vehicles must have on file: photocopies of Driver's Licenses, Vehicle Registration, and Auto Insurance Coverage.

Exclusions: Uber, Lyft, cab or personal vehicles are not public/agency transportation. In addition, Recovery Works cannot be billed for taking participants to and from work.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact
- A plan for continued transportation services to help participant become self-sufficient

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Voucher Management System/
Web Infrastructure for Treatment Services

WITS WEBSITE

Web Infrastructure for Treatment Services (WITS) is the electronic voucher management system where Designated Service Providers (DSPs) will go to access participant information and billing. WITS also contains a section for announcements. This section will hold announcements as posted by Recovery Works administrative staff regarding training, upcoming events, changes, WITS outages, etc. The announcements on WITS will typically be dually posted on Recovery Works public website; however, this will not always be the case. The WITS site may be accessed via the Recovery Works website.

VOUCHER MANAGEMENT

The initial Recovery Works Designated Service Provider (DSP) will determine voucher availability for services. No other Provider can duplicate or supersede this function. Other Recovery Works Providers will only be paid for Recovery Works services provided to participants with an active and current Recovery Works voucher at the time the service is provided and with an active Memorandum Of Understanding (MOU) with the initial DSP.

VOUCHER REIMBURSEMENT

Providers agree to accept reimbursement for services at the rate specified in the latest version of the Recovery Works Rate Sheet as updated from time to time by DMHA and posted on the Recovery Works website here: www.RecoveryWorks.fssa.in.gov. Providers should not ask participants to make additional payment for the portion of their care that is paid for by Recovery Works. When billing for services, providers have two (2) options: they may bill daily or weekly. When billing weekly, providers MUST list out EACH day of service in the encounter notes.

Additionally, in order to claim for a service, the service must have already been rendered. You may not bill for anticipated future services.

Vouchers MUST be built for thirty (30) calendar days or less and MUST start within ten (10) calendar days of when a DSP begins serving a participant. Encounters MUST be released within ten (10) business days of when a voucher ends.

Agencies are not allowed to contact Recovery Works to request an extension for billing unless it meets the following circumstances:

- In the case of insurance denials, in which the agency will need to provide a copy of the denial with a valid reason for denial, as determined by the Recovery Works team.
- In the case of login issues—if Recovery Works does not reset logins promptly, which results in providers being unable to complete billing, a late billing phrase may be provided

WITS ACCESS

To add or remove agency personnel from the WITS system, or change their WITS access level, the agency staff member with oversight of Recovery Works service provision must submit a ticket to JIRA with the WITS Access Spreadsheet attached. When removing access, the individual's account will be locked. It is required that agencies send the Recovery Works team an updated WITS Access Spreadsheet whenever additions or removals need to be completed. This includes additions of new rendering providers. All personnel of the Direct Service Provider (DSP) who administer services directly to Recovery Works participants must be entered into WITS as rendering staff. See page 24 for more detail. Accounts inactive for 180 days or more will be automatically locked.

JIRA ACCESS

To request assistance for WITS related tasks, such as voucher adjustments or account resets, a ticket must be submitted to JIRA.
Users can access JIRA at https://dmha.fssa.in.gov/helpdesk/?div=dmha.

- Once on the website, enter your email and click the "create ticket" button.
- Enter all required fields. For the related application section, please choose WITS—Recovery Works (if it automatically does not choose that for you).
- In the summary box, enter what you would normally put as the subject line of an email.
- For the description, you can enter the body of the email, which would include what you are requesting (ex: add units, reject encounter, WITS access, insurance denials, etc.).

Please remember to provide all information. If all information is not present, the ticket will be closed, and you will be asked to complete a ticket with the requested information.

RECOVERY WORKS BILLING CYCLE

The Recovery Works adjudication process begins automatically within WITS on Friday afternoon at 12:00pm. On Saturday morning, all claims that were accepted, move forward to be processed and paid. Any claims that the system had questions about move to a pending status. Those claims with pending status are reviewed by Recovery Works staff by 4:00pm on Wednesday the following week. If the claims are approved, they move on to be processed for payment.
Once a claim is approved and is processed for payment, it is sent to the Auditor's Office. We send payments to Auditor's Office every Thursday afternoon. Once the Auditor's Office receives the payments, they have a billing cycle of thirty-five (35) days. Therefore, you can expect payment approximately thirty-five (35) days after the posted date in WITS.

Example:

- Encounter is released Tuesday, November 27.
- Next, the payment is batched in WITS on Friday, December 2.
- Then, the payment is approved in WITS on Saturday, December 3.

- The payment is then sent to the auditor's office on Thursday, December 8.
- Lastly, the agency receives payment on January 26.

PUSHING TO WITS

Every Recovery Works participant who visits a treatment provider (or Level 4 Recovery Residence) needs to be pushed from DARMHA into WITS, even if the provider does not foresee them using Recovery Works funding. The only way for Recovery Works staff to count enrollments is through WITS. This is especially crucial if the participant is a Medicaid participant, as this is the only way that Recovery Works will know how to count that individual as enrolled for the program and to assist our agencies with their Medicaid Match.

CHOOSING A REFERRAL SOURCE

- When creating an episode for a participant, it will ask the provider to indicate the referral source.
- It automatically fills in the box with "Criminal Justice Provider," however please click on the drop-down box, where it will give more specific referral sources to choose from.
- Please use the more specific option in the drop-down box, instead of leaving it as "Criminal Justice Provider."
- If the referral source used is not indicated in that drop-down box, please let Recovery Works staff know by emailing them at Recovery.Works@fssa.IN.gov.