CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Behavioral Health Services and Medications

Rule Number(s): 5160-27-02, 5160-27-03, 5160-27-05, 5160-8-05

Date: January 12, 2018

Rule Type:

New ☐ **5-Year Review**

X Amended **Rescinded**

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

These rules were previously adopted as a component of the "Behavioral Health Redesign" initiative in 2017 and went in effect on 1/1/2018 for mental health and substance use disorder treatment services. Behavioral Health Redesign is a jointly sponsored project of the Ohio Department of Medicaid (ODM), the Ohio Department of Mental Health and Addiction Services

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(OhioMHAS), and the Governor's Office of Health Transformation (OHT). Extensive information about this initiative can be found at a dedicated internet site located at http://bh.medicaid.ohio.gov/ established by ODM and OhioMHAS to instruct and inform stakeholders.

Descriptions of the four OAC rules contained in this rule package are below. These rules were implemented on January 2, 2018 through an emergency filing. This BIA is for the permanent filing for these rules which are scheduled to be effective May 2, 2018. The proposed rules must be identical to the emergency filed rules.

Rule 5160-27-02 "Coverage and limitations of behavioral health services"
Describes, as applicable, any service provision limits and Medicaid coverage requirements, such as medical necessity, and options to exceed service provision limits through an approved prior authorization. The rule is being amended to delay the termination of health homes from December 31, 2017 to July 1, 2018. An appendix is added that states the eligibility criteria for health homes.

Rule 5160-27-03 "Reimbursement for community behavioral health services"
Describes the Medicaid reimbursement policies for the behavioral health services defined in Chapter 5160-27 of the Administrative Code. The rule is being amended to add a list of services for which Medicaid reimbursement will not be made to a provider when a Medicaid covered individual is also receiving a health home service.

Rule 5160-27-05 "Mental Health Intensive Home Based Service"
Describes a service and defines the criteria for receiving the service, as well as requirements that providers must meet in order to render the service. The rule is being amended to add the health home service as a service for which Medicaid reimbursement will not be made to a provider when a Medicaid covered individual is also receiving the intensive home based treatment service.

Rule 5160-8-05 "Behavioral health services-other licensed professionals" sets forth coverage and payment provisions for behavioral health services provided by licensed professionals. The rule is being amended to remove language regarding practitioner information required on a claim. Another change clarifies the benefit limit of a service.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Ohio Revised Code sections 5162.02, 5162.05, 5164.02

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to**

administer and enforce a federal law or to participate in a federal program?
If yes, please briefly explain the source and substance of the federal requirement.

Yes, these rules implement federal requirements but the amendments being made to these rules do not implement a federal requirement.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   The regulations in these rules do not exceed the provisions allowed under federal law.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The amendments to the four rules are in response to stakeholders' comments and ODM policy decisions, which require codification in Ohio Administrative Code rules.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   Success will be measured by providers being paid appropriately for services rendered and Medicaid eligible individuals being able to receive services. This includes appropriate billing of the health home service and continuing receipt, without disruption, of the service by eligible individuals.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   On November 15, 2017, ODM notified a stakeholder advisory group that rules were being revised. Standing membership in the group consists of the following:

   - Public Children Services Association of Ohio
   - Ohio Association of Health Plans
   - National Alliance on Mental Illness - Ohio
   - Ohio Psychological Association

- The Ohio Council of Behavioral Health & Family Service Providers and its member agencies
- The Ohio Association of County Behavioral Health Authorities and its member ADAMHS Boards
- Ohio Association of Child Caring Agencies and its member agencies
- Ohio Hospital Association and its members
- Ohio Children's Hospital Association and its members
- Northern Ohio Recovery Association
- Ohio Alliance of Recovery Providers
- Case Western Reserve University
- Mental Health & Addiction Advocacy Coalition
- Ohio Citizen Advocates for Addiction Recovery
- Vorys Health Care Advisors
- Ohio Family and Children First
- The following Medicaid managed care plans:
    - CareSource
    - United Healthcare
    - Aetna
    - Buckeye Health Plan
    - Molina
    - Paramount

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   The revisions reflected in this rule filing are a result of ODM discussions with stakeholders, which resulted in new policies that needed to be codified but, due to timing, could not be included in the previous final filing of these rules.

Stakeholders, specifically providers of health home services, requested that ODM delay the termination date of the services from December 31, 2017 to June 30, 2018. ODM agreed with this request, therefore rule language is being revised to implement the extension.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   Ohio Medicaid claims data was the main source of information used to guide the policy and budget models relevant to the proposed amendments.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    Alternative regulations were not applicable. ODM enforces requirements through the use of rules in the Ohio Administrative Code. The amendments to these four rules were previously implemented via an emergency filing effective January 2, 2018, and therefore need be replaced by these rules in order to ensure regulatory consistency and continued coverage and payment for specific behavioral health services.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    ODM did not consider a performance-based regulation because the nature of the regulations described in these rules do not lend themselves to a performance based standard.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    ODM partnered with OhioMHAS, Ohio's regulatory body for mental health and addiction treatment services, in the drafting of these proposed changes. Special attention was paid to ensure that the ODM and Ohio MHAS OAC rules are not duplicative.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    ODM's implementation of the regulations in these rules required changes to Medicaid's provider payment system, MITS. ODM staff, including provider support staff, have been

trained to assist providers. In addition, training materials for providers and stakeholders have been updated.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

The proposed revisions in these rules will impact Ohio Medicaid behavioral health providers that render the services associated with the revisions and seek Medicaid reimbursement for those services.

Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

The adverse impacts contained within these rules are federally mandated by the National Correct Coding Initiative (NCCI), program integrity requirements of the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and federally required third party liability and coordination of benefits with Medicare. The impact of these requirements are a result of current law and is not a result of the proposed language.

Information Technology and Billing System Updates

Participating Ohio Medicaid provider agencies are required to update their information technology and claims payment systems when needed to successfully submit claims for payment for services. The amendments being proposed to these rules do not affect the adverse impact of this requirement.

Coordination of Health Care Benefits/Third Party Liability

All Ohio behavioral health providers who are enrolled as Ohio Medicaid providers are required to ensure that Medicaid is the payer of last resort for health care services to patients with commercial or Medicare health insurance coverage. This requires agencies serving Medicare enrollees to enroll with the Medicare program. Additionally, agency employees who can render Medicare billable services must also enroll with Medicare. Finally, provider agency billing systems must be capable of submitting service claims for patients with third party coverage to the appropriate health care payer before they are submitted to Ohio Medicaid for cost sharing. This

requirement applies to all Medicaid providers. The amendments being proposed to these rules do not affect the adverse impact of this requirement.

Federally Required Program Integrity Provisions
Provider agencies are required to register with Ohio Medicaid their employed or contracted physicians, nurse practitioners, physician assistants, psychologists, and counselors or social workers with independent scopes of practice. Practitioner registration will be accomplished by enrolling these practitioners in Ohio Medicaid as rendering practitioners. Once actively enrolled in Ohio Medicaid, provider agencies must ensure their practitioners are affiliated with their agencies in the Medicaid Information Technology System (MITS). The amendments being proposed to these rules do not affect the adverse impact of this requirement.

b. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The amendments being proposed to these rules do not affect the adverse impact otherwise contained in the rules. Quantifying any cost associated with the rules as a whole is difficult because of the significant variance of business design, number of service locations, agency workforce, client caseload, and business acumen among the impacted providers.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The amendments in the rules implement requests made by stakeholders and permit impacted providers to render services appropriately. Failure to adopt these rules could result in inappropriate provision and/or billing of services as well as a disruption in the delivery of behavioral health services to Medicaid eligible clients.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No, ODM is not able to make exemptions or provide alternative means for compliance for small businesses.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    This regulation does not apply to this rules package because it does not impose any fine or penalty for a paperwork violation.

18. **What resources are available to assist small businesses with compliance of the regulation?**

    All Medicaid providers in need of technical assistance can contact the Medicaid Provider Assistance telephone line at 1-800-686-1516. Behavioral health providers impacted by the revisions in the proposed rules have a unique email address available to them, BH-Enroll@medicaid.ohio.gov . Providers also have access to detailed information regarding Behavioral Health Redesign by visiting the dedicated internet site: bh.medicaid.ohio.gov. This web site allows visitors to submit questions which are monitored and responded to weekly by ODM and OhioMHAS staff. Providers have had, and will continue to have, access to webinars offered by ODM and OhioMHAS staff.

5160-8-05 **Behavioral health services-other licensed professionals.**

(A) Scope. This rule sets forth provisions governing payment for behavioral health services provided by certain licensed professionals in non-institutional settings.

(1) A behavioral health service performed in an inpatient or outpatient hospital setting is treated as a hospital service, rules for which are set forth in Chapter 5160-2 of the Administrative Code.

(2) Provisions governing payment for behavioral health services as the following service types are set forth in the indicated part of the Administrative Code:

(a) Cost-based clinic services, Chapter 5160-28; and

(b) Medicaid school program services, Chapter 5160-35.

(3) For services provided in a nursing facility, the cost for behavioral health services are paid directly to the provider of services and not through the nursing facility per diem rate.

(B) Definitions for the purposes of this rule.

(1) "Behavioral health service" is a service or procedure that is performed for the diagnosis and treatment of mental, behavioral, substance use, or emotional disorders by a licensed professional or under the supervision of a licensed professional. As it is used in this rule, the term includes neither psychiatry nor medication management.

(2) "Licensed psychologist" has the same meaning as in section 4732.01 of the Revised Code.

(3) "Independent practitioner" is a collective term used in this rule to designate the following persons who hold a valid license to practice in accordance with the indicated portion of the Revised Code:

(a) Licensed professional clinical counselor, section 4757.22;

(b) Licensed independent social worker, section 4757.27;

(c) Licensed independent marriage and family therapist, section 4757.30;

(d) Licensed independent chemical dependency counselor, rule 4758-4-01 of the Administrative Code; and

(e) School psychologist licensed by the state board of psychology has the same meaning as in rule 4732-3-01 of the Administrative Code and who is engaged in the "practice of school psychology" as that term is defined in section 4732.01 of the Revised Code.

(4) "Supervised practitioner" is a collective term used in this rule to designate the following persons who hold a valid license to practice under general ~~supervison~~ supervision in accordance with the indicated portion of the Revised Code:

(a) Licensed professional counselor, section 4757.23;

(b) Licensed social worker, section 4757.28;

(c) Licensed marriage and family therapist, section 4757.30;

(d) Licensed chemical dependency counselor II, rule 4758-4-01 of the Administrative Code; and

(e) Licensed chemical dependency counselor III, rule 4758-4-01 of the Administrative Code.;

(5) "Supervised trainee" is a collective term used in this rule to designate the following individuals who can operate under the general or direct supervision of a licensed practitioner:

(a) Registered counselor trainee, defined in rule 4757-13-09 of the Administrative Code;

(b) Registered social work trainee, defined in rule 4757-19-05 of the Administrative Code;

(c) Marriage and family therapist trainee, defined in rule 4757-25-08 of the Administrative Code;

(d) Chemical dependency counselor assistant, defined in rule 4758-4-01 of the Administrative Code; and

(e) Any individual registered with the Ohio board of psychology in compliance with requirements in rule 4732-13-04 of the Administrative Code, working under the supervision of a licensed psychologist, and assigned by the supervising psychologist a title appearing in rule 4732-13-03 of

the Administrative Code, such as “assistant,” “psychology assistant”, "psychology intern," "psychology fellow," or "psychology resident."

(6) "General supervision" is defined as the supervising practitioner being available by phone to provide assistance as needed.

(7) "Direct supervision" is defined as the supervising practitioner being immediately available and ~~interruptable~~ interruptible to provide assistance as needed.

(8) "Independent practice" is a business arrangement in which a professional is not subject to the administrative and professional control of an employer such as an institution, physician, or agency. In particular, a professional working from an office that is located within an entity is considered to be in independent practice when both of the following conditions are met:

(a) The part of the entity constituting the office of the professional is used solely for that purpose and is separately identifiable from the rest of the facility; and

(b) The professional maintains a private practice (i.e., offers services to the general public as well as to the customers, residents, or patients of the entity), and the practice is not owned, either in part or in total, by the entity.

(C) Provider requirements.

(1) A licensed psychologist or licensed independent practitioner must be enrolled in the medicaid program as an eligible provider, even if services are rendered under the supervision of another eligible provider.

(2) A licensed psychologist in independent practice or independent practitioner in independent practice who can participate in the medicare program either must do so or, if the practice is limited to pediatric treatment, must meet all requirements for medicare participation other than serving medicare beneficiaries.

(D) Coverage.

(1) Payment may be made for the following behavioral health services:

(a) Psychiatric diagnostic evaluation;

(b) Psychological and neuropsychological testing;

(c) Assessment and behavior change intervention:

(i) Alcohol or substance (other than tobacco) abuse, structured assessment and brief intervention, fifteen to thirty minutes;

(ii) Alcohol or substance (other than tobacco) abuse, structured assessment and intervention, greater than thirty minutes;

(d) Therapeutic services:

(i) Individual psychotherapy:

(a) Psychotherapy, thirty minutes with patient and/or family member;

(b) Psychotherapy, forty-five minutes with patient and/or family member;

(c) Psychotherapy, sixty minutes with patient and/or family member;

(d) Psychotherapy for crisis, first sixty minutes;

(e) Psychotherapy for crisis, each additional thirty minutes; and

(f) Interactive complexity (reported separately in addition to the primary procedure); and

(ii) Family psychotherapy for which the primary purpose is the treatment of the patient and not family members:

(a) Family psychotherapy without patient present; and

(b) Family psychotherapy with patient present;

(iii) Group psychotherapy:

(a) Group psychotherapy; and

(b) Multiple-family group psychotherapy;

(iv) Interactive complexity

(v) Prolonged service

(2) Payment may be made to the following eligible providers for a behavioral health service rendered as indicated:

(a) To a physician, group practice, clinic, or a community behavioral health center that meets the requirements found in rule 5160-27-01 of the Administrative Code, for a behavioral health service rendered by a licensed psychologist, or independent practitioner, employed by or under contract with the physician group practice, clinic or community behavioral health center;

(b) To a physician group practice, clinic, a community behavioral health center that meets the requirements found in rule 5160-27-01 of the Administrative Code, physician, advanced practice registered nurse, physician assistant, licensed psychologist in independent practice or independent practitioner in independent practice for a behavioral health service rendered by a supervised practitioner or supervised trainee under general supervision of the supervising practitioner who was, at a minimum, available by phone to provide assistance as needed.

(c) To a physician group practice, clinic, a community behavioral health center that meets the requirements found in rule 5160-27-01 of the Administrative Code, physician, advanced practice registered nurse, physician assistant, licensed psychologist in independent practice or independent practitioner in independent practice for a behavioral health service rendered by a supervised trainee under direct supervision if the following conditions are met:

(i) The professional responsible for the patient's care has in person, face-to-face contact with the patient during the initial visit and face to face contact not less often than once per quarter (or during each visit if visits are scheduled more than three months apart)

(ii) The professional responsible for the patient's care reviews and updates the patient's medical record at least once after each treatment visit.

(d) To a physician, advanced practice registered nurse, physician assistant, licensed psychologist in independent practice, or independent practitioner in independent practice for a behavioral health service personally rendered by that health care professional;

(3) The following coverage limits, which may be exceeded only with prior authorization from the ODM designated entity, are established for behavioral health services provided to a medicaid recipient.

(a) For diagnostic evaluation, one encounter, per code, per billing provider, per recipient, per calendar year, not on the same date of service as a therapeutic visit;

(b) For psychological testing a maximum of ~~eight~~ twelve hours per recipient, per calendar year; and

(c) For neuropsychological testing, a maximum of eight hours per recipient, per calendar year;

(d) For screening, brief intervention and referral to treatment for substance use disorder, one of each code, per billing provider, per recipient, per calendar year.

(E) Constraints.

(1) Every behavioral health service reported on a claim must be within the scope of practice of the licensed professional, with appropriate certification and/or training for the service, who renders or supervises it and must be performed in accordance with any supervision requirements established in law, regulation, statute, or rule.

~~(2) Neither a supervised practitioner nor a supervised trainee can be reported on a claim as the rendering provider.~~

~~(3)~~(2) No payment will be made under this rule for the following activities:

(a) Services that are rendered by an unlicensed individual other than a supervised trainee;

(b) Activities, testing, or diagnosis conducted for purposes specifically related to education;

(c) Services that are unrelated to the treatment of a specific behavioral health diagnosis but serve primarily to enhance skills or to provide general information, examples of which are given in the following non-exhaustive list:

(i) Encounter groups, workshops, marathon sessions, or retreats;

(ii) Sensitivity training;

(iii) Sexual competency training;

(iv) Recreational therapy (e.g., art, play, dance, music);

(v) Services intended primarily for social interaction, diversion, or sensory stimulation; and

(vi) The teaching or monitoring of activities of daily living (such as grooming and personal hygiene);

(d) Psychotherapy services if the patient cannot establish a relationship with the provider because of a cognitive deficit;

(e) Family therapy for the purpose of training family members or caregivers in the management of the patient; and

(f) Self-administered or self-scored tests of cognitive function.

(F) Documentation of services.

(1) The patient's medical record must substantiate the medical necessity of services performed, and each record is expected to bear the signature and indicate the discipline of the professional who recorded it.

(a) All relevant diagnoses pertaining to medical or physical conditions as well as to behavioral health;

(b) A treatment plan which must be completed within five sessions or one month of admission, whichever is longer and must specify mutually agreed upon treatment goals, track responses to ongoing treatment, and present a prognosis that documents that the plan has been reviewed with the patient and, as appropriate, with family members, parents, legal guardians or custodians or significant others;.

(c) The inability or refusal of the patient to participate in treatment planning or services must be documented and the reason given.

(d) Test results, if applicable, with interpretation;

(e) Evidence that the patient has sufficient cognitive capacity to benefit from treatment; and

(f) Discharge summaries which include date of admission, date of last service, outcome of the service and recommendations and referrals made to the patient.

(2) The following items must be included as progress note documentation and shall be completed at a minimum on a per provision basis, or on a daily or weekly basis:

(a) The type, description, date, time of day, duration, location and, if documenting weekly services, the frequency of treatment, with dates of service;

(b) A description of the patient's current symptoms and changes in functional impairment;

(c) Changes in medications taken by or prescribed for the patient when applicable;

(d) The amount of time spent by the provider face-to-face with the patient;

(e) The amount of time spent by the provider in interpreting and reporting on procedures represented by "Central Nervous System Testing" codes, when applicable;

(f) Progress notes shall include assessment of the patient's progress or lack of progress and a brief description of the progress made, if any, significant changes in symptoms, functioning, or events in the life of the patient and recommendation for modifications to the treatment plan, if applicable; and

(g) Evidence of clinical supervision, as required,

(G) Claim payment.

The payment amount for a behavioral health service is the lesser of the provider's submitted charge or the applicable percentage of the amount specified in the appendix to rule 5160-27-03 of the Administrative Code:

(1) For testing, one hundred per cent;

(2) For a behavioral health service other than testing, the percentage differs according to the provider who rendered it:

(a) For a service rendered by a physician, an advanced practice registered nurse, a physician assistant, or a licensed psychologist, it is one hundred per cent; and

(b) For a service rendered by ~~an~~ a licensed practitioner or a supervised practitioner, it is eighty-five per cent.

(c) For a service rendered by a supervised trainee/assistant under direct supervision, the rate of their supervising practitioner.

(d) For a service rendered by a supervised trainee/assistant under general supervision, it is eighty-five per cent of the rate of their supervising practitioner.

Effective:

Five Year Review (FYR) Dates: 4/30/2023

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02, 5164.03
Prior Effective Dates:	02/17/1991, 11/01/2001, 07/01/2002, 08/17/2003, 10/01/2003, 01/01/2004, 12/30/2005 (Emer.), 03/27/2006, 01/01/2008, 12/31/2012 (Emer.), 03/28/2013, 01/01/2014, 02/01/2016, 06/30/2016 (Emer.), 10/29/2016, 01/01/2018, 01/02/2018 (Emer.)

5160-27-02 **Coverage and limitations of behavioral health services.**

(A) This rule sets forth coverage and limitations for behavioral health services rendered to medicaid recipients by behavioral health provider agencies who meet all requirements found in agency 5160 of the Administrative Code unless otherwise specified.

(1) All claims for behavioral health services submitted to the Ohio department of medicaid (ODM) must include an ICD-10 diagnosis of mental illness or substance use disorder. The list of recognized ~~diagnosis~~ diagnoses can be accessed at www.medicaid.ohio.gov.

(2) Medicaid reimbursable behavioral health services are limited to medically necessary services defined in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code. Providers shall follow the requirements in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code regarding services that cannot be billed in combination with other services.

(B) The following services have limitations on the amount, scope or duration of service that can be rendered to a recipient within a certain timeframe. These limits can be exceeded with prior authorization from ODM or its designee.

(1) Screening, brief intervention and referral to treatment (SBIRT) as defined by the ~~american~~ American medical association's current procedural terminology book. Limitation for this service is one per code, per recipient, per billing provider, per calendar year.

(2) Assertive community treatment (ACT) as defined in rule 5160-27-04 of the Administrative Code is available on or after the date as determined by prior authorization approval.

(3) Intensive home based treatment (IHBT) as defined in rule 5160-27-05 of the Administrative Code is available on or after the date as determined by prior authorization approval.

(4) Community psychiatric supportive treatment (CPST) services as defined in rule 5122-29-17 of the Administrative Code and meet the following requirements:

(a) All CPST services provided in social, recreational, vocational, or educational settings are allowable only if they are documented mental health service interventions addressing the specific individualized mental

health treatment needs as identified in the recipient's individualized service plan.

(b) A billable unit of service for CPST may include either face-to-face or telephone contact between the mental health professional and the recipient or an individual essential to the mental health treatment of the recipient.

(c) CPST services are not covered under this rule when provided in a hospital setting, except for the purpose of coordinating admission to the inpatient hospital or facilitating discharge to the community following inpatient treatment for an acute episode of care.

(d) Medicaid reimbursement of CPST services is described in rule 5160-27-03 of the Administrative Code.

(5) Psychiatric diagnostic evaluation and psychiatric diagnostic evaluation with medical services are each limited to one encounter per recipient, per billing provider, per calendar year.

(C) The following services delivered to recipients with substance use disorders have limitations on the amount, scope or duration of service that can be rendered to a recipient within a certain timeframe. These limits can be exceeded with prior authorization from the ODM designated entity.

(1) Substance use disorder assessment as referenced in rule 5160-27-09 of the Administrative Code is limited to two hours per recipient, per billing provider, per calendar year.

(2) Substance use disorder urine drug screening as referenced in rule 5160-27-09 of the Administrative Code, is limited to one per day, per recipient.

(3) Substance use disorder peer recovery support as referenced in rules 5160-27-09 and 5160-43-04 of the Administrative Code is limited to four hours per day per recipient.

(4) Substance use disorder partial hospitalization as described in rule 5160-27-09 of the Administrative Code is available on or after the date as determined by prior authorization approval. The prior authorization request must substantiate that the recipient meets the partial hospitalization level of care of twenty or more hours of service per week. In accordance with rule 5160-1-27 of the Administrative Code ODM ~~reserves the right to~~ may retrospectively review the case that the number of hours of service delivered matches the approved level of care.

(5) Substance use disorder residential level of care as described in rule 5160-27-09 of the Administrative Code is available for up to thirty consecutive days without prior authorization per medicaid recipient for the first and second admission, during the same calendar year. If the stay continues beyond thirty days of the first or second stay, prior authorization is required to support the medical necessity of continued stay. If medical necessity is not substantiated and not approved by the ODM designated entity, only the initial thirty consecutive days will be reimbursed. Third and subsequent admissions during the same calendar year must be prior authorized by the ODM designated entity from the date of admission.

(D) The medications listed in the appendix to rule 5160-27-03 or appendix DD to rule 5160-1-60 of the Administrative Code are covered by ODM when rendered and billed by an eligible provider as described in rule 5160-27-01 of the Administrative Code. The medication must be administered by a qualified practitioner acting within their professional scope of practice.

(E) Laboratory services, vaccines, and medications administered in a prescriber office may be administered in accordance with rule 5160-1-60 of the Administrative Code.

(F) Medical and evaluation and management services stated in the appendix to rule 5160-27-03 of the Administrative Code or appendix DD to rule 5160-1-60 of the Administrative Code are covered by ODM when rendered by a practitioner as described in paragraphs (A)(3) and (A)(4) of rule 5160-27-01 of the Administrative Code and operating within their scope of practice.

(G) CMS place of service code set descriptions may be found at www.cms.gov. The department further defines place of service 99 as "community," and this place of service may only be used when a more specific place of service is not available. Place of service 99 shall not be used to provide services to a recipient of any age if the recipient is being held in a public institution as defined in 42 C.F.R. 435.1010 (October 1, 2016).

(H) The activities that comprise or are included in the aforementioned medicaid reimbursable behavioral health services must be intended to achieve identified treatment plan goals or objectives. Providers shall maintain treatment records and progress notes as specified in rules 5160-01-27 and 5160-8-05 of the Administrative Code. A treatment plan for mental health services may only be developed by a practitioner who, at a minimum, meets the therapeutic behavioral services practitioner requirements found in paragraphs (A)(2)(a)(i) and (A)(2)(a)(ii) of rule 5160-27-08 of the Administrative Code. A treatment plan for substance use disorder services may only be developed by a practitioner who, at a minimum meets the practitioner

requirements found in paragraph (A)(6)(b)(i) or (A)(6)(b)(iii) of rule 5160-27-01 of the Administrative Code.

(I) The medications and services listed in the appendix to rule 5160-27-03 of the Administrative Code or the opiate treatment service section of appendix DD to rule 5160-1-60 of the Administrative Code are reimbursed by the department when rendered and billed by an opiate treatment program as described in Chapter 5122-40 of the Administrative Code and licensed as such by the Ohio department of mental health and addiction services and/or federally certified as such as stated in 42 CFR 8.11 (October 1, 2016). Reimbursement rates are determined by the methodology described in paragraph (E) of rule 5160-4-12 of the Administrative Code or as listed in the appendix to rule 5160-27-03 of the Administrative Code or as listed in appendix DD to rule 5160-1-60 of the Administrative Code.

(J) When permitted, provision of any service addressed in Chapter 5160-27 of the Administrative Code by interactive videoconferencing ~~as defined in rule 5122-24-01 of the Administrative Code,~~ must comply with the appropriate interactive videoconferencing requirement(s) found in ~~Chapter 5122-29~~ rule 5122-29-31 of the Administrative Code.

(K) The services described in this chapter shall not substitute or supplant natural supports and do not include any of the following:

(1) Educational, vocational, or job training services.

(2) Room and board.

(3) Habilitation services including but not limited to financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature.

(4) Services to recipients who are being held in a public institution as defined in 42 C.F.R. 435.1010 (October 1, 2016);

(5) Services to individuals residing in institutions for mental diseases as described in 42 C.F.R. 435.1010 (October 1, 2016);

(6) Recreational and social activities, including but not limited to art, music, and equine therapies;

(7) Services that are covered elsewhere in agency 5160 of the Administrative Code; and

(8) Transportation for the recipient or family.

(L) Health home services as described in rule 5122-29-33 of the Administrative Code shall be available until ~~December 31, 2017,~~July 1, 2018, at which time the service shall be terminated. Until that date eligibility for health home services is determined as follows:

(1) Health home enrollment is restricted to persons with serious and persistent mental illness as defined in rule 5122-29-33 of the Administrative Code and in accordance with additional eligibility criteria defined by the Ohio department of medicaid in collaboration with the Ohio department of mental health and addiction services as stated in the eligibility criteria document created on May 16, 2014 and available at www.medicaid.ohio.gov.

(2) Persons who do not meet the eligibility criteria stated in the eligibility criteria document will continue to be eligible for health home services if they meet the following criteria:

(a) They are enrolled in a health home located in Adams, Butler, Lawrence, Lucas, or Scioto counties for an effective date prior to July 1, 2014, and

(b) The health home in which they were enrolled prior to July 1, 2014, delivered a health home service to the person during the month of June 2014.

(3) Health home services must be provided only in geographical regions approved by the centers for medicare and medicaid services (CMS).

(4) When a health home enrollee or the parent or guardian requests to disenroll from the health home, the health home must process the disenrollment within three business days. The request for disenrollment, including the date the request was made, must be recorded in the client record.

(5) Health home services must be provided in accordance with rule 5122-29-33 of the Administrative Code. Health home services performed after the development of the single, person-centered, integrated care plan must be directly linked to the goals and actions documented in the single, person-centered integrated care plan. Health home services shall be documented as necessary to establish medical necessity as defined in Chapter 5160-1 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates: 4/30/2023

Certification

Date

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Statutory Authority:	5164.02, 5162.05, 5162.02
Rule Amplifies:	5164.02, 5164.88, 5164.76, 5164.15, 5164.03
Prior Effective Dates:	01/01/2018, 01/02/2018 (Emer.)

Ohio Department of Medicaid
Health Home SPMI/SED Enrollee Identification Methodology
Using Updated Mental Health Diagnosis Codes
May 16, 2014

To be enrolled in an Ohio Mental Health -Health Home, a Medicaid consumer must meet at least ONE of the four pathways during the research time period* [1]

1. Medicaid Mental Health Claims History

A. Four or more visits with one or more of the following Mental Health codes (data provided by OhioMHAS):

Zl831, 90862 (1/1/2013 forward)	Pharmacological Management
Z1833, H0004	Counseling & Therapy (lnd)
Z1834, H0004	Counseling & Therapy (Grp)
ZI837, S9484	Crisis Intervention
Z1838, S0201	Partial Hospitalization
Z1840, H0036	Community Psychiatric Support Tx (lnd)
Z1841, H0036	Community Psychiatric Support Tx (Grp)
S0281	Mental Health -Health Home

AND

B. One or more Medicaid claims containing a primary or secondary mental health diagnoses listed in "**Attachment 1*- Health Home Mental Health Diagnosis Codes**."

2. High Mental Health pharmaceutical use defined as:

A. Received 12 or more prescriptions during the research time period from the following drug classes or lists

i. Psychotherapy medications, Tranquilizers, Antipsychotics;
ii. Antimanic Agents;
iii. Anticonvulsant, Benzodiazepine;
iv Anticonvulsant, Misc;
v. Any drug listed on **Attachment 2* Health Home Mental Health Pharmaceuticals**
vi If the client is age 18 or younger, any drug listed on Attachment 3* **Additional Health Home Mental Health Pharmaceuticals for Consumers 18 and Younger**

[1] The research time period will be updated regularly based on updated Medicaid claims data. As of April 2014, the research time period will be Jan 1– Dec 31, 2013.

• Attachments 1, 2 and 3 referenced above are available on the web site of Ohio Department of Mental Health Addiction Services at the following link: http://mha.ohio.gov/Default.aspx?tabid=601

OR

B. Received any office administered antipsychotic medication ("J code injectable")

AND In addition to 2A OR 2B, the enrollee must have BOTH:

C. One or more Medicaid claims containing a primary or secondary mental health diagnoses listed in "Appendix A: Health Home Mental Health Diagnosis Codes."

AND

D. Meets the cost threshold of greater than or equal to the average total Medicaid cost of the SPMI/SED overall population ($10,471 for SPMI; $5,653 for SED)

3. History of Hospital Inpatient Admission

A. Has had at least one inpatient hospital admission during the research period for any primary diagnosis

AND

B. Has had one or more Medicaid claims containing a primary or secondary mental health diagnoses listed in "Appendix A: Health Home Mental Health Diagnosis Codes."

AND

C. Has had Medicaid claims during the research period of at least the average total cost of SPMIISED overall population ($10,471 for SPMI; $5,653 for SED)

4. History of Emergency Room Use

A. Has had 4 or more visits to a hospital emergency department

AND

B. One or more Medicaid claims containing a primary or secondary mental health diagnoses listed in " Appendix A: Health Home Mental Health Diagnosis Codes."

AND

C. Has Medicaid claims during the research period of at least the average total cost of the SPMI/SED overall population ($10,471 for SPMI; $5,653 for SED)

5160-27-03 **Reimbursement for community behavioral health services.**

(A) This rule sets forth the reimbursement requirements and rates for behavioral health services as described in Chapter 5160-27 of the Administrative Code and applies to providers as described in rule 5160-27-01 of the Administrative Code.

(B) Providers rendering community behavioral health services shall abide by all applicable requirements stated in rules 5160-01-02 and 5160-27-01 of the Administrative Code.

(C) Records related to services reimbursed under this rule are subject to review in accordance with 42 C.F.R. 456.3 (October 1, 2016) and rule 5160-01-27 of the Administrative Code.

(D) Medicaid reimbursement rates for services and practitioners described in Chapter 5160-27 of the Administrative Code are listed in the appendix to this rule. Ohio medicaid shall reimburse the provider the lower of either their usual and customary charges or the reimbursement amount described in the appendix to this rule.

(1) The reimbursement rate for physicians, as described in paragraph (A)(3) of rule 5160-27-01 of the Administrative Code, is one hundred per cent of the medicaid maximum rate stated in the appendix to this rule.

(2) The reimbursement rate for clinical nurse specialists, certified nurse practitioners, and physician assistants, as described in paragraph (A)(3) of rule 5160-27-01 of the Administrative Code, is eighty-five per cent of the medicaid maximum rate stated in the appendix to this rule.

(3) The reimbursement rate for practitioners described in paragraph (A)(5) of rule 5160-27-01 of the Administrative Code is the reimbursement rate percentage described in rule 5160-8-05 of the Administrative Code (medicaid maximum rate stated in the appendix to this rule). The reimbursement rates for services not defined in rule 5160-8-05 of the Administrative Code are stated in the appendix to this rule.

(4) The reimbursement rates for practitioners ~~decribed~~ described in rule 5160-27-01 of the Administrative Code and not ~~otherwised~~ otherwise addressed in paragraph (D) of this rule, are stated in the appendix to this rule.

(E) The medicaid reimbursement rate for any of the following services provided for more than ninety minutes by the same billing provider, to the same recipient, on the same calendar day will be fifty per cent of the rate listed in appendix to this rule.

(1) Community psychiatric supportive treatment as described in rule 5122-29-17 of the Administrative Code.

(2) Therapeutic behavioral service as described in rule 5160-27-08 of the Administrative Code when delivered in an office setting.

(3) Psychosocial rehabilitation as described in rule 5160-27-08 of the Administrative Code when delivered in an office setting.

(4) Substance use disorder targeted case management as described in rule 5160-27-10 of the Administrative Code.

(F) Providers identified in rule 5160-27-01 of the Administrative Code must identify the rendering practitioner as follows:

(1) For practitioners who are eligible to enroll with Ohio medicaid and who meet the requirements of Chapter 5160-27 of the Administrative Code, list their national provider identifier number in the rendering field on the claim, or

(2) For licensed practitioners who do not have an independent professional scope or for practitioners that are unlicensed, include the modifier that accurately describes their credentials.

(G) Medicaid reimbursement is contingent upon providers maintaining complete and accurate documentation as required by Chapter 5160-27 of the Administrative Code.

(H) Medicaid behavioral health claims submitted for reimbursement must comply with the requirements of the national correct coding initiative of the centers for medicare and medicaid services.

(I) Behavioral health services that are reimbursable by medicare shall be billed first to medicare in accordance with rule 5160-1-05 of the Administrative Code. Failure to do so may result in denial of the medicaid claim.

(J) Behavioral health services that are reimbursable by a third party health care insurer shall be billed first to the third party health care insurer in accordance with rule 5160-1-08 of the Administrative Code. Failure to do so may result in denial of the medicaid claim.

(K) Health home services for persons with serious and persistent mental illness, as defined in rule 5122-29-33 of the Administrative Code, are reimbursed using a monthly case rate specific to the health home service providers located in Ohio counties Adams, Butler, Lawrence, Lucas, and Scioto, and shall be calculated as follows:

(1) Annual costs must be compiled in accordance with appropriate uniform cost report principles.

(2) Calculation of the monthly case rate is as follows:

(a) Divide the annual cost as developed in accordance with paragraph (K)(1) of this rule by the caseload, then

(b) Divide the result of the calculation in paragraph (K)(2)(a) of this rule by twelve.

(3) The monthly case rates calculated using the methodology in paragraphs (K)(1) and (K)(2) of this rule ~~shall be~~ were reduced by ten percent beginning July 1, 2014.

(4) Reimbursement for health home services is considered payment in full for all components of the service as defined in rule 5122-29-33 of the Administrative Code, including service components that may otherwise be reimbursable as: ~~CPST.~~

(a) CPST,

(b) Therapeutic behavioral service (with the exception of therapeutic behavioral service crisis from a provider other than the health home provider) as defined in rule 5160-27-08 of the Administrative Code,

(c) Psychosocial rehabilitation as defined in rule 5160-27-08 of the Administrative Code,

(d) Assertive community treatment as defined in rule 5160-27-04 of the Administrative Code,

(e) Intensive home based treatment as defined in rule 5160-27-05 of the Administrative Code,

(f) Screening, brief intervention, and referral to treatment service.

(L) Health home service providers located in Butler and Lucas counties that render health home services to individuals enrolled in a "MyCare Ohio" plan, as specified in rule 5160-58-01 of the Administrative Code, shall bill the "MyCare Ohio" plan for the monthly case rate outlined in paragraph (K) of this rule.

Effective:

Five Year Review (FYR) Dates: 4/30/2023

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Certification

_____

Date

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5160-27-03

APPENDIX A

The following rates are effective for dates of service on or after January 1, 2018.

Community Mental Health Center and ALCRX Medicaid Fee Schedule

STATUS CODE:
1 -- Initial maximum payment amount
2 -- Change in maximum payment amount as of the Effective Date
3 -- Discontinued coverage

HCPCS CODE	Modifier	DESCRIPTION	EFFECTIVE DATE	STATUS CODE	CURRENT MAXIMUM PAYMENT AMOUNT	CURRENT MAXIMUM PAYMENT AMOUNT Office	CURRENT MAXIMUM PAYMENT AMOUNT Home/Community	PREVIOUS MAXIMUM PAYMENT AMOUNT
90785		Psytx complex interactive	01/01/2018	1	13.81			
90791		Psych diagnostic evaluation	01/01/2018	1	130.72			
90792		Psych diag eval w/med srvcs	01/01/2018	1	144.35			
90832		Psytx pt&/family 30 minutes	01/01/2018	1	63.11			
90833		Psytx pt&/fam w/e&m 30 min	01/01/2018	1	65.37			
90834		Psytx pt&/family 45 minutes	01/01/2018	1	82.05			
90836		Psytx pt&/fam w/e&m 45 min	01/01/2018	1	83.03			
90837		Psytx pt&/family 60 minutes	01/01/2018	1	120.36			
90838		Psytx pt&/fam w/e&m 60 min	01/01/2018	1	109.53			
90839		Psytx crisis initial 60 min	01/01/2018	1	132.08			
90840		Psytx crisis ea addl 30 min	01/01/2018	1	63.04			
90846		Family psychotherapy (w/o patient)	01/01/2018	1	102.28			
90847		Family psychotherapy (with patient)	01/01/2018	1	100.72			
90849		Multiple-family group psychotherapy	01/01/2018	1	31.28			
90853		Group psychotherapy (other than multiple-family group)	01/01/2018	1	25.45			
93000		Electrocardiogram, complete	01/01/2018	1	15.90			
93005		Electrocardiogram, tracing	01/01/2018	1	6.90			
93010		Electrocardiogram report	01/01/2018	1	7.90			
96101		Psycho testing by psych/phys	01/01/2018	1	59.26			
96111		Developmental testing with interpretation & report	01/01/2018	1	56.11			
96116		Neurobehavioral status exam	01/01/2018	1	64.10			
96118		Neuropsych tst by psych/phys	01/01/2018	1	78.31			
96372		Ther/proph/diag inj, sc/im	01/01/2018	1	21.39			
99201		Office/outpatient visit, new	01/01/2018	1	49.38			
99202		Office/outpatient visit, new	01/01/2018	1	84.67			
99203		Office/outpatient visit, new	01/01/2018	1	122.93			
99204		Office/outpatient visit, new	01/01/2018	1	188.51			
99205		Office/outpatient visit, new	01/01/2018	1	236.92			
99211		Office/outpatient visit, est	01/01/2018	1	22.31			
99212		Pre-natal Office/outpatient visit, est	01/01/2018	1	48.97			
99213		Office/outpatient visit, est	01/01/2018	1	82.85			
99214		Office/outpatient visit, est	01/01/2018	1	122.27			
99215		Office/outpatient visit, est	01/01/2018	1	165.15			
99341		Home visit, new patient	01/01/2018	1	63.65			
99342		Home visit, new patient	01/01/2018	1	91.90			
99343		Home visit, new patient	01/01/2018	1	150.80			
99344		Home visit, new patient	01/01/2018	1	210.78			
99345		Home visit, new patient	01/01/2018	1	255.57			
99347		Home visit, established patient	01/01/2018	1	64.00			
99348		Home visit, established patient	01/01/2018	1	97.38			
99349		Home visit, established patient	01/01/2018	1	148.16			
99350		Home visit, established patient	01/01/2018	1	205.79			
99354		Prolonged service, office	01/01/2018	1	89.90			
99355		Prolonged service, office	01/01/2018	1	89.24			
G0396		Alc/Sub. Abuse test inter. 15-30 min	01/01/2018	1	25.05			
G0397		Alc/Sub. Abuse test inter. over 30 min	01/01/2018	1	47.68			
H0001		Alcohol and/or drug assessment (not incident to a licensed practitioner's assessment)	01/01/2018	1	77.22			
H0004		BH counseling and therapy, per 15 minutes (unlicensed)	01/01/2018	1	19.31			
H0004		BH counseling and therapy, per 15 minutes (licensed)	01/1/2018 to 6/30/2018	1	22.50			
H0004	HQ	BH counseling and therapy, group per 15 minutes (licensed)	01/1/2018 to 6/30/2018	1	9.87			
H0005		Alcohol and/or drug services; group counseling (unlicensed)	01/01/2018	1	$6.44			
H0005	HK	Alcohol and/or drug services; group counseling (licensed)	01/01/2018	1	$7.21			
H0005	AF	Alcohol and/or drug services; group counseling (physician)	01/01/2018	1	8.48			
H0006		Alcohol and/or drug services; case management	01/01/2018	1	19.54			
H0010		Alcohol and/or drug services; sub acute detoxification (residential addiction program inpatient)	01/01/2018	1	256.33			
H0011		Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)	01/01/2018	1	392.86			
H0012		Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)	01/01/2018	1	360.36			
H0014		Alcohol and/or drug services; ambulatory detoxification RN	01/01/2018	1	127.68			
H0014		Alcohol and/or drug services; ambulatory detoxification LPN	01/01/2018	1	90.16			
H0015		Alcohol and/or drug services; intensive outpatient (unlicensed)	01/01/2018	1	$103.04			
H0015	HK	Alcohol and/or drug services; intensive outpatient (licensed)	01/01/2018	1	149.88			
H0015	TG	SUD Partial Hospitalization (unlicensed)	01/01/2018	1	$154.56			
H0015	HK,TG	SUD Partial Hospitalization (licensed)	01/01/2018	1	224.82			
H0036		Community Psychiatric Supportive Treatment (CPST), per 15 minutes	01/01/2018	1	19.54			
H0036	HQ	Community Psychiatric Supportive Treatment (CPST), per 15 minutes group	01/01/2018	1	8.99			
H0038		SUD Peer Recovery Support	01/01/2018	1	15.51			
H0038	HQ	SUD Peer Recovery Support Group	01/01/2018	1	1.94			
H0040	AM	Assertive community treatment program, per diem, medium team (physician)	01/01/2018	1	615.64			
H0040	SA/UC	Assertive community treatment program, per diem, medium team (CNS,CNP,PA)	01/01/2018	1	352.75			
H0040	HO	Assertive community treatment program, per diem, medium team (Masters, licensed, RN, LPN)	01/01/2018	1	251.91			
H0040	HN	Assertive community treatment program, per diem, medium team (Bachelors)	01/01/2018	1	199.70			
H0040	HM	Assertive community treatment program, per diem, medium team (Peer)	01/01/2018	1	159.24			
H0048		Alcohol and/or other drug testing; collection and handling only, specimens other than blood	01/01/2018	1	14.48			
H2012	HQ, UK	TBS Group Services, hourly (QMHS plus 3)	01/01/2018	1	18.54			
H2012	HQ, HN	TBS Group Services, hourly (Bachelors)	01/01/2018	1	18.54			
H2012	HQ, HO	TBS Group Services, hourly (Masters)	01/01/2018	1	21.05			
H2012	HQ, HK	TBS Group Services, hourly (Licensed)	01/01/2018	1	$28.10			
H2015		IHBT per 15 minutes	01/01/2018	1	33.26			
H2017		Psychosocial rehabilitation service (LPN)	01/01/2018	1		22.54	29.13	
H2017		Psychosocial rehabilitation service	01/01/2018	1		15.84	20.32	
H2019	UK	TBS, per 15 minutes (QMHS plus 3)	01/01/2018	1		19.96	25.46	
H2019	HN	TBS, per 15 minutes (Bachelors)	01/01/2018	1		19.96	25.46	
H2019	HO	TBS, per 15 minutes (Masters)	01/01/2018	1		22.47	28.59	
H2019		TBS, per 15 minutes (RN)	01/01/2018	1		31.92	41.00	
H2019	HQ, UK	TBS, per 15 minutes (QMHS plus 3; Group)	01/01/2018	1	4.99			
H2019	HQ,HN	TBS, per 15 minutes (Bacherlors; Group)	01/01/2018	1	4.99			
H2019	HQ, HO	TBS, per 15 minutes; (Masters; Group)	01/01/2018	1	5.62			
H2019	HQ	TBS, per 15 minutes; (RN; Group)	01/01/2018	1	7.98			
H2020	UK	TBS Group Services Per Diem (QMHS plus 3)	01/01/2018	1	$104.55			
H2020	HN	TBS Group Services Per Diem (Bachelors)	01/01/2018	1	$104.55			
H2020	HO	TBS Group Services Per Diem (Masters)	01/01/2018	1	$117.05			
H2020	HK	TBS Group Services Per Diem (Licensed)	01/01/2018	1	$140.51			
H2034		Alcohol and/or drug abuse halfway house services, per diem.	01/01/2018	1	152.57			
H2036		Alcohol and/or other drug treatment program, per diem.	01/01/2018	1	213.70			
H2036	TG	Alcohol and/or other drug treatment program, per diem.	01/01/2018	1	303.49			
T1002		Alcohol And/Or Drug Services; RN	01/01/2018	1		31.92	41.00	
T1002	HQ	Alcohol And/Or Drug Services; RN Group	01/01/2018	1	7.98			
T1003		Alcohol And/Or Drug Services; LPN	01/01/2018	1		22.54	29.13	
H0023		SRS Supported Employment; Initial	01/01/2018	1	19.53			
H0025		SRS Supported Employment; Subsequent	01/01/2018	1	19.53			
H0038		SRS Peer Recovery Support	01/01/2018	1	15.51			
H0038	HQ	SRS Peer Recovery Support; Group	01/01/2018	1	1.94			

5160-27-05 **Mental health intensive home based treatment service.**

(A) For the purposes of medicaid reimbursement, intensive home based treatment (IHBT), is the service and activities as set forth by the Ohio department of mental health and addiction services in paragraphs (A) to (C) of rule 5122-29-28 of the Administrative Code.

(B) To be eligible for IHBT, a medicaid recipient must meet the following:

(1) The requirements as established in paragraph (E) of rule 5122-29-28 of the Administrative Code; and

(2) Score the following on the life functioning domain, child behavioral/emotional needs, and child risk behaviors dimensions of the child and adolescent needs and strengths (CANS) assessment tool available at www.medicaid.ohio.gov:

(a) A rating of "three" on one of the following life function domain items or a rating of at least "two" on two of the following life functioning domain items, and;

(i) Family;

(ii) Legal;

(iii) Social functioning;

(iv) Living situation;

(v) School behavior; or

(vi) School attendance.

(b) A rating of "two" or higher on one or more of the following items within the child behavioral/emotional needs criteria, or:

(i) Psychosis;

(ii) Impulse/hyperactivity;

(iii) Depression;

(iv) Anxiety;

(v) Oppositional;

(vi) Conduct;

(vii) Adjustment to trauma;

(viii) Anger control; or

(ix) Substance use.

(c) A rating of "two" or higher on one or more of the following items within the child risk behaviors criteria:

(i) Suicide risk;

(ii) Self-mutilation;

(iii) Other self-harm;

(iv) Danger to others;

(v) Sexual aggression;

(vi) Runaway;

(vii) Delinquency;

(viii) Judgment;

(ix) Fire setting; or

(x) Social behavior.

(3) The recipient must have at least one adult family member or other adult individual who is a part of the recipient's home who authorizes IHBT services to be provided, and actively participates in the provision of IHBT. "Home" has the same meaning as in rule 5122-29-28 of the Administrative Code.

(C) Prior authorization of IHBT services.

(1) The provider must submit a request for prior authorization and receive approval from the Ohio department of medicaid designated entity before ODM will reimburse for IHBT services. The maximum amount of IHBT service which may be prior authorized at any one time is seventy-two hours.

(2) The provider agency may request additional IHBT service to be prior authorized by the ODM designated entity.

(D) Disenrollment from IHBT

(1) A recipient or their guardian may request to end receipt of IHBT services at their discretion. The IHBT provider will notify ODM or its designee of the disenrollment. Failure to timely notify ODM or its designee may result in claims denial for other mental health services.

(2) Disenrollment of a recipient from IHBT is necessary to ensure that the recipient may obtain medicaid reimbursed behavioral health services from a provider other than the IHBT team. Upon disenrollment of an IHBT recipient, the IHBT team shall document the circumstances regarding disenrollment in the recipient's treatment plan. The provider must inform the ODM designated entity of disenrollment within three business days of the discharge date. Either the provider or the ODM designated entity shall deactivate the authorization for the IHBT service. Failure to timely disenroll the recipient from IHBT may result in claims denial for other mental health or substance use disorder services.

(E) A provider of IHBT must meet all of the following criteria:

(1) Meets the ~~eligibility~~ requirements found in paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code; and

(2) Employment of one or more IHBT practitioners licensed by the counselor, social worker, and marriage and family therapist board or Ohio board of psychology working within their scope of practice, and

(3) Have documentation of completion, within the previous twelve months, of an on site fidelity review performed by an ODM designated entity. Information concerning fidelity standards and requirements is available at www.medicaid.ohio.gov; and

(4) Receive a minimum rating of three on the following items on the IHBT fidelity rating tool (dated September 23, 2016); ~~and~~

(a) Intensity of service;

(b) Strength-based assessment and treatment planning;

(c) Comprehensive system collaboration and service coordination;

(d) Cultural responsiveness;

(e) Professional training and development;

(f) Treatment partnerships and youth and family engagement;

(g) Team composition;

(h) Accessible and flexible services and scheduling:

(i) Must meet items listed in paragraphs (E)(4)(b) and (E)(4)(c) of this rule; and

(ii) Meet one additional item.

(i) Treatment durations and continuity of care: items listed in paragraphs (E)(4)(b), (E)(4)(c), and (E)(4)(d) of this rule must be met.

(5) Receive a minimum rating of four on the following items on the IHBT fidelity rating tool (dated September 23, 2016); ~~and~~

(a) Location of service;

(b) Caseload;

(c) Crisis response and availability;

(d) Safety planning;

(e) Outcomes monitoring and quality improvement;

(f) Fidelity monitoring.

(6) Receive a minimum rating of five on the following items on the IHBT fidelity rating tool (dated September 23, 2016); ~~and~~

(a) Comprehensive and integrated behavioral health treatment approach;

(b) Supervisory support and availability.

(7) ~~An IHBT provider must have~~ Have documented evidence of fidelity compliance prior to submitting any prior authorization requests for ~~recipients of~~ IHBT services.

(F) ODM reserves the right to suspend or terminate the payment of IHBT services and to require subsequent review of an IHBT practitioner's fidelity rating if ODM has reason to believe that the IHBT practitioner's fidelity to the model may be in question. ODM

may, at its discretion, suspend the payment of IHBT claims from the provider agency employing the IHBT practitioner until such time as ODM receives documentation from its independent validation entity that the practitioner does meet the minimum fidelity criteria described in paragraph (E) of this rule.

(G) All IHBT services must be rendered in person by an IHBT practitioner to the recipient or his/her family members who are participating in the treatment. While IHBT practitioner services rendered via telephone or video conference are not prohibited, they are not considered in person services and therefore do not qualify as a billable Medicaid-covered IHBT service.

(H) Documentation requirements.

(1) Documentation in the recipient's client record of the services provided by the IHBT practitioner must meet the requirements stated in paragraph (H) of this rule as well as those stated in rules 5160-1-27 and 5160-8-05 of the Administrative Code.

(2) The IHBT practitioner must develop a specific treatment plan for each recipient receiving IHBT. The treatment plan must, at a minimum, meet the requirements stated in rule 5160-8-05 of the Administrative Code as well as the following:

(a) The treatment plan shall be individualized based on the recipient's needs, strengths, and preferences and shall set measurable long-term and short-term goals and specify approaches and interventions necessary for the recipient to achieve the individual goals. The treatment plan shall also identify who will carry out the approaches and interventions.

(b) The treatment plan shall address, at a minimum, the following key areas:

(i) Behavioral health symptom reduction.

(ii) Risk reduction and safety planning.

(iii) Family and interpersonal relationship.

(iv) Functioning in relevant life domains.

(c) The treatment plan shall be reviewed and updated by an IHBT practitioner with the recipient or guardian whenever there is a significant change in condition or at least every three months. The treatment plan update shall include a summary of the recipient's progress, goal attainment, effectiveness of the intervention and the recipient's satisfaction with the IHBT practitioner's intervention(s).

(d) The treatment plan, and all subsequent revisions of it, shall be reviewed and signed by the recipient and the adult as described in paragraph (B)(3) of this rule, and the IHBT practitioner.

(I) The following activities are not reimbursable as part of IHBT:

(1) Time spent doing, attending, or participating in recreational activities.

(2) Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.

(3) Respite care.

(4) Transportation for the beneficiary or family.

(5) Any art, movement, dance, or drama therapies.

(6) Services provided to teach academic subjects or as a substitute for educational personnel including, but not limited to, a teacher, teacher's aide, or an academic tutor.

(J) Medicaid payment will not be made for any of the following services or treatments while the recipient is enrolled in IHBT services:

(1) Assessments, screenings, and diagnostic evaluations.

(2) Mental health day treatment.

(3) Individual, group, or family psychotherapy and counseling.

(4) Therapeutic behavioral services.

(5) Community psychiatric supportive treatment.

(6) Psychosocial rehabilitation.

(7) Substance use disorder residential treatment services.

(8) Assertive community treatment.

(9) Crisis intervention provided by the provider agency employing the IHBT practitioner.

(10) Health home services.

(K) Substance use disorder (SUD) targeted case management requires prior authorization from the ODM designated entity while a recipient is enrolled in IHBT.

(L) The medicaid payment rate for IHBT is stated in appendix DD to rule 5160-1-60 of the Administrative Code. Payment for services provided by authorized IHBT teams is only available for dates of services on or after January 1, 2018.

Effective:

Five Year Review (FYR) Dates: 4/30/2023

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Certification

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Date

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