5160-27-02 **Coverage and limitations of medicaid community mental health services.**

(A) The following describes those services reimbursable as medicaid community mental health services when rendered by eligible medicaid providers as defined in rule ~~5101:3-27-01~~5160-27-01 of the Administrative Code. For the purposes of this rule, a twelve month period means the time period from July first of any given year to June thirtieth of the subsequent year.

(1) Behavioral health counseling and therapy services as defined in rule 5122-29-03 of the Administrative Code. A combined maximum of fifty-two hours of individual and group behavioral health counseling and therapy services are allowed per twelve month period. In accordance with the requirements of "Healthchek" (Ohio's early periodic screening, diagnosis, and treatment (EPSDT) benefit), children up to the age of twenty-one may receive services beyond established limits when medically necessary.

(2) Mental health assessment services as defined in rule 5122-29-04 of the Administrative Code. Psychological testing, when performed as a component of the mental health assessment, must be face-to-face. A provider billing for or receiving medicaid reimbursement for psychological testing as a component of a mental health assessment under this rule shall not bill for or be reimbursed for that same psychological testing under other medicaid programs.

(a) A maximum of two hours of psychiatric diagnostic interview services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to the age of twenty-one may receive services beyond established limits when medically necessary.

(b) A maximum of four hours of mental health assessment services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to the age of twenty-one may receive services beyond established limits when medically necessary.

(3) Pharmacologic management services as defined in rule 5122-29-05 of the Administrative Code. All psychiatric/mental health medical interventions billed through this service must be used to reduce, stabilize and/or eliminate psychiatric symptoms of the person served. A maximum of twenty-four hours of pharmacologic management services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to the age of twenty-one may receive services beyond established limits when medically necessary. Pharmacologic management services, as defined in this rule, are not covered during an inpatient stay in a hospital.

(4) Partial hospitalization services as defined in rule 5122-29-06 of the Administrative Code and meet the following requirements:

(a) Partial hospitalization services provided in social, recreational or education settings (internal or external to the partial hospitalization site) are allowable only if there are documented mental health interventions that address the specific individualized mental health treatment needs as identified in the individual service plan (ISP) of the person being served;

(b) Partial hospitalization services includes activity therapies, group activities, or other services and programs designed to enhance skills needed for living in the least restrictive environment are allowable.

(c) Unallowable partial hospitalization activities are listed in paragraph (H)(7) of this rule.

(5) Crisis intervention mental health services as defined in rule 5122-29-10 of the Administrative Code and meet the following requirements:

(a) Crisis intervention mental health service must be face-to-face interventions that are responding to emergent situations with the intended result of crisis stabilization or prevention of crisis escalation.

(b) Routine monitoring of clients in a crisis residential facility is not considered a crisis intervention mental health service.

(6) 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 ISP of the person served.

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

(c) A combined maximum of one-hundred and four hours of individual and group CPST services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to age of twenty-one may receive services beyond established limits when medically necessary and approved through the prior authorization process. Adults may receive services beyond established limits when medically necessary and approved through the prior authorization process.

(d) CPST services are not covered under this rule when provided to an adult or child 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.

(7) Eligibility for ~~Health~~health home services is determined as follows: ~~for persons with serious and persistent mental illness as defined in rule 5122-29-33 of the Administrative Code and reimbursed in accordance with rule 5101:3-27-05 of the Administrative Code. Services shall be covered only in geographical regions approved by the centers for medicare and medicaid services (CMS).~~

(a) 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 appendix B to this rule.

(b) Persons who do not meet the eligibility criteria in appendix B to this rule will continue to be eligible for health home services until July 1, 2015 if they meet the following criteria:

(i) 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

(ii) 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.

(c) Health home services shall be covered only in geographical regions approved by the centers for medicare and medicaid services (CMS).

(d) 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.

(B) All medicaid community mental health services are to be billed on a unit rate basis in accordance with definitions, standards and eligible providers of service requirements as set forth in Chapter ~~5101:3-27~~5160-27 of the Administrative Code.

(C) Medicaid community mental health services must be recommended by an individual who is qualified to supervise the specific service. The identification of individuals qualified to supervise each specific service is set forth in each applicable rule of Chapter 5122-29 of the Administrative Code and as defined in rule 5122-24-01 of the Administrative Code. Provisions set forth in rule 5122-25-06 of the Administrative Code do not affect the provisions of this paragraph.

(D) Medicaid community mental health services must be performed by an individual who is qualified to perform the specific service. The identification of individuals qualified to perform each specific service is set forth in each applicable rule of Chapter 5122-29 of the Administrative Code and as defined in rule 5122-24-01 of the Administrative Code. Provisions set forth in rule 5122-25-06 of the Administrative Code do not affect the provisions of this paragraph.

(E) With the exception of the limitations in paragraphs (C) and (D) of this rule, the provisions set forth in rule 5122-25-06 of the Administrative Code apply.

(F) For the purposes of medicaid community mental health services, a billable unit of service is defined as the following:

(1) A face-to-face contact between a client and a professional authorized to provide medicaid reimbursable services as described in this rule; or

(2) A face-to-face contact with family members, parent, guardian and/or significant others as defined in rule 5122-24-01 of the Administrative Code for children or adolescents receiving behavioral health counseling and therapy, pharmacologic management, mental health assessment, or crisis intervention mental health services, when the purpose of the contact is directed to the exclusive benefit of the medicaid eligible beneficiary; or

(3) A face-to-face contact with family members or significant others of adults receiving crisis intervention mental health services, when the purpose of the contact is directed to the exclusive benefit of the medicaid eligible beneficiary; or

(4) Community psychiatric supportive treatment interventions provided to individuals other than the client as allowed in paragraphs (A)(6)(b) and (A)(6)(c) of this rule; or

(5) Services rendered via interactive video conferencing as described in paragraph (I) of this rule, and in rules 5122-29-03, 5122-29-04, 5122-29-05 and 5122-29-17 of the Administrative Code.

(6) Health home services 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.

(G) All medicaid community mental health services contacts, other than health home services, must be documented in the individual client record (ICR) of the person served and satisfy the requirements in rule 5122-27-06 of the Administrative Code. Health home services shall be documented as necessary to establish medical necessity as defined in Chapter ~~5101:3-1~~5160-1 of the Administrative Code.

(H) Non-covered medicaid community mental health services include:

(1) Community meetings or group sessions that are not designed to provide specific mental health treatment services to clients. Examples of such activities include, but are not limited to, orientation sessions for new clients, mental health presentations to community groups (high school classes, parent teacher associations, etc.), and informal presentations about the community mental health program.

(2) Monitoring clients while they are sleeping.

(3) Observing clients when not performing a therapeutic intervention (e.g., when client is watching television, resting, eating, etc.)

(4) Transportation in and of itself.

(5) Unallowable vocational job training activities include, but are not limited to, job shadowing, job coaching, teaching computer skills, math skills, or other trade skills.

(6) Services which are considered mental health residential treatment facility

services as set forth in Chapter 5122-30 of the Administrative Code.

(7) Unallowable partial hospitalization activities include, but are not limited to, crafts, general non-therapeutic art projects, recreational outings purely for recreational purposes, exercise groups, etc.

(I) Services rendered via interactive video conferencing technology must be provided in accordance with rules established by Ohio department of mental health (ODMH). All services rendered via interactive video conferencing technology must also meet the following conditions:

(1) The services rendered via interactive video conferencing technology are consistent with rules 5122-29-03, 5122-29-04, 5122-29-05 and 5122-29-17 of the Administrative Code; and

(2) The documentation requirements of the interactive video conferencing technology contacts remain the same as the face-to-face contacts; and

(3) The purpose of the interactive video conferencing technology contact is not the scheduling of appointments.

(J) The medications listed in appendix A to this rule are covered by the department when rendered and billed by an eligible provider as described in rule ~~5101: 3-27-01~~5160-27-01 of the Administrative Code. The medication must be administered by a qualified provider acting within the provider's professional scope of practice.

Effective:

R.C. 119.032 review dates: 01/01/2017

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02, 5164.03, 5164.15, 5164.76, 5164.88
Prior Effective Dates:	4/30/82(Temp), 8/1/82, 7/1/84, 1/1/86, 3/19/87, 7/1/91, 11/1/93, 6/30/95(Emer.), 9/28/95, 7/15/01, 6/1/07, 7/1/08, 11/1/11(Emer.), 1/30/12