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-level 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 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 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.

(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 5160-1-27 of the Administrative Code ODM reserves the right to 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 appendix DD of 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 CMH/ALCRX tab of 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) Place of service 99 is defined as "community," and 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 (6)(b)(i) or (6)(b)(iii) of rule 5160-27-01 of the Administrative Code.

(I) The medications and services listed in 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 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 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-level 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, 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:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5162.02, 5162.05, 5164.02
Rule Amplifies:	5164.02, 5164.03, 5164.15, 5164.76, 5164.88