CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: BHPP Psychology and skilled therapy rules

Rule Number(s):

5101:3-4-26 (Rescinded/New);

5101:3-8-01 (Rescinded); 5101:3-8-02 (Rescinded); 5101:3-8-03 (Rescinded);

5101:3-8-05 (Rescinded/New);

5101:3-8-30 (New); 5101:3-8-31 (New); 5101:3-8-32 (New);

5101:3-8-33 (New); 5101:3-8-34 (New);

5101:3-34-01 (Rescinded); 5101:3-34-01.1 (Rescinded);

5101:3-34-01.2 (Rescinded); 5101:3-34-01.3 (Rescinded)

Date: September 19, 2013

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded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.

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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.

The provision of skilled therapy services (physical therapy, occupational therapy, speech-language pathology services, and audiology services) in non-institutional settings is currently addressed in eight rules found in three separate chapters of the Ohio Administrative Code:

Rule 5101:3-4-26, "Covered physical medicine and rehabilitation services"
Rule 5101:3-8-01, "Eligible providers of limited practitioner services"
Rule 5101:3-8-02, "Covered physical therapy services and limitations"
Rule 5101:3-8-03, "Covered occupational therapy services and limitations"
Rule 5101:3-34-01, "Physical therapy, occupational therapy and speech-language pathology/audiology services: general provisions"
Rule 5101:3-34-01.1, "Physical therapy, occupational therapy and speech-language pathology/audiology services: definitions"
Rule 5101:3-34-01.2, "Physical therapy, occupational therapy and speech-language pathology/audiology services: coverage and limitations"
Rule 5101:3-34-01.3, "Physical therapy, occupational therapy and speech-language pathology/audiology services: reimbursement"

All eight of these rules are being rescinded and replaced by five new rules:

Rule 5101:3-8-30, "Skilled therapy: scope and definitions"
Rule 5101:3-8-31, "Skilled therapy: providers"
Rule 5101:3-8-32, "Skilled therapy: coverage"
Rule 5101:3-8-33, "Skilled therapy: documentation of services"
Rule 5101:3-8-34, "Skilled therapy: payment"

A new rule is being adopted to address physical medicine and rehabilitation services furnished by a physician or by a licensed individual under the supervision of a physician:

Rule 5101:3-4-26, "Physical medicine and rehabilitation services"

The current rule governing psychology services, which includes references to a rescinded rule, is being rescinded:

Rule 5101:3-8-05, "Covered psychology services and limitations"

It is being replaced by a new rule of the same number:

Rule 5101:3-8-05, "Psychology services provided by licensed psychologists"

All changes take effect for dates of service January 1, 2014, or after.

Several aspects of the consolidation of the skilled therapy rules are particularly noteworthy:

- The content of the rules has been reorganized and streamlined. As a result, there is no longer a need for Chapter 5101:3-34 of the Ohio Administrative Code.
- Unnecessary definitions have been removed.

- Parts of the current rules that duplicate provisions found elsewhere in the Ohio Administrative Code have been deleted.
- Speech-language pathologists and audiologists are now recognized as eligible providers who can submit claims to Medicaid on their own behalf. If they wish to do so, they may continue to receive payment for services that are reported on claims submitted through other providers, as the current rules require; the revised rules will give them an option they did not have before of becoming independent providers.
- The Medicaid requirement that therapy services be provided only by prescription is being eliminated, and all references to a "Medicaid-authorized prescriber" are being removed. Providers will continue to be bound by any licensing requirements that concern prescribing or prescriptions, but Medicaid will no longer superimpose additional prescription requirements not found in licensure law.
- For ease and consistency of administration, a defined benefit year replaces the rolling calendar year as the period within which service limits apply. The limit of thirty dates of service for any combination of physical therapy and occupational therapy is changed to thirty dates of service for each type of therapy.
- A payment-reduction provision is added that applies when more than one skilled therapy service of the same type is rendered by a non-institutional provider to an individual patient on the same date; under this provision, payment is made for the primary procedure at 100% and for each additional procedure at 50%.

There are several significant revisions in the new psychology services rule, 5101:3-8-05:

- Unnecessary references to past dates of service have been removed.
- The specification of procedure codes and modifiers has been discontinued. Descriptions of service are sufficient to indicate what is covered under Medicaid. (Descriptions are also not likely to change very much, even if code sets are revamped.) Providers are simply directed to report appropriate procedure codes and modifiers on claims, instructions for which are readily available from the department and other sources.
- Under the current rule, a doctoral-level clinical psychology intern may provide a psychology service if the licensed psychologist responsible for an individual's care furnishes direct supervision of the intern and has face-to-face contact with the individual during the visit (a phrase that has been interpreted to mean "each visit"). Psychologists have indicated that these supervision and contact requirements are overly stringent and exceed the relevant provisions set forth in the Ohio Revised Code. The new rule calls for general supervision, and face-to-face contact is required during the initial visit and no less often than once per quarter (or during each visit if visits are scheduled more than three months apart).

New rule 5101:3-4-26 maintains Medicaid coverage and payment policy for physical medicine and rehabilitation services, and it includes a reference to rules governing physical therapy, occupational therapy, speech-language pathology, and audiology.

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

The Ohio Department of Medicaid (ODM) is promulgating these rules under section 5111.02 of the Ohio Revised Code.

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.

Ohio Medicaid receives federal matching funds for coverage of medically necessary physical therapy, occupational therapy, speech-language pathology, and audiology services (addressed at 42 CFR 440.110); psychology services rendered by licensed psychologists (addressed at 42 CFR 440.60); and physician services (addressed at 42 CFR 440.50). Provisions in 42 CFR Part 447 Subpart B require each state Medicaid program to maintain documentation of the amounts it pays for supplies and services and to provide public notice of any significant proposed change in its methods and standards for establishing payment amounts. Any change that entails the addition, revision, or discontinuation of a Healthcare Common Procedure Coding System (HCPCS) code is governed by the Health Insurance Portability and Accountability Act (HIPAA).

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

These rules do not exceed federal requirements.

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)?**

Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment methodologies or fee schedules for the use of providers and the general public.

Medicaid is adopting the multiple-procedure payment-reduction provision for skilled therapy used by Medicare in recognition of the fact that—regardless of setting—there is no appreciable difference in overhead expense whether one procedure is performed or several procedures are performed in a single treatment session. Therefore, when multiple procedures are performed by the same provider for the same person on the same date, payment for overhead expense should be included for only one of the procedures and deducted for the others.

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

These rules essentially involve internal operating procedures and place no requirements on providers. The success of these rules will be measured by (1) the extent to which payment is reduced for multiple therapy procedures performed during the same treatment session and (2) the extent to which speech-language pathologists and audiologists are able to submit claims that are correctly paid.

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.

The proposed changes to rule 5101:3-8-05 that allow general supervision rather than direct supervision of a psychology intern and the easing of the requirements for face-to-face contact by the supervising psychologist with the patient are being made at the recommendation of psychologists objecting that current supervision and contact requirements are overly stringent and exceed the relevant Ohio Revised Code provisions.

The proposed multiple-procedure payment-reduction provision for skilled therapy was presented as part of the Executive Budget for SFY2014 and SFY2015 and posted on the Office of Health Transformation website at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=3I8MukSy-Uw%3d&tabid=156. Director Greg Moody (Office of Health Transformation) and members of the Health Transformation team described them on February 14, 2013, in testimony before the House Finance and Appropriations Committee. Director John McCarthy (Ohio Department of Medicaid) presented them in testimony on February 28, 2013, before the Health and Human Services Subcommittee of the House Finance and Appropriations Committee and on April 24, 2013, before the Medicaid Finance Subcommittee of the Senate Finance Committee.

In order to solicit public comment on multiple-procedure payment reduction and on other provisions not stemming from the budget, the department will submit the proposed Administrative Code rules to the Clearance process.

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

The proposed multiple-procedure payment-reduction provision for skilled therapy was not modified in nor eliminated from Am. Sub. H.B. 59 during the legislative process. Accordingly, those legislative provisions will be implemented through the administrative rules.

Drafts of those rules are currently in Clearance. All comments received will be carefully reviewed to determine whether modifications are necessary to the rules before they are formally filed with the Joint Committee on Agency Rule Review (JCARR). Any suggestions made by stakeholders will be sent to the CSI Ohio office, along with the responses given and a description of any changes made as a result of those suggestions.

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?

Utilization and expenditure data drawn from ODM's Decision Support System were used in projecting the fiscal impact of the proposed changes.

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?

No alternatives were considered, because multiple-procedure payment-reduction was a requirement set forth in the biennial budget.

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.

Because these rules place no requirements on providers, the concept of performance-based regulation does not apply.

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

Rules involving Medicaid providers are located exclusively in division 5101:3 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to which type of provider and item or service. In this instance, there was no duplication.

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.

The proposed multiple-procedure payment-reduction policy will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the applicable rule. They will therefore be automatically and consistently applied by the department's electronic claim-payment system whenever an appropriate provider submits a claim for an applicable service.

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;

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

c. 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.

a. Changes in these rules affect professional providers of skilled therapy services rendered in non-institutional settings and, to a very small degree, psychologists.

b. These rules impose no license fees or fines. They require no additional record-keeping or reporting.

In fact, the amount of documentation that must be maintained by skilled therapy providers will be substantially reduced. For example, under the current rules, after a "Medicaid-authorized prescriber" writes a prescription for therapy, the skilled therapy provider must perform a clinical evaluation and assessment and submit a plan of care and treatment to the prescriber for approval; the skilled therapy provider must then send the prescriber a patient progress summary at the end of the treatment period. Most of this paperwork transmission is rendered unnecessary by the fact that under current Ohio law, some skilled therapists may initiate treatment without needing to obtain separate authorization from another practitioner. Therefore, although there is still a need for an evaluation and a treatment plan, there is no need for the skilled therapy provider to turn these documents into reports, and such a requirement has been omitted in the new rules.

Moreover, in response to objections from psychologists that parts of the current rule concerning interns exceed provisions of the Ohio Revised Code, we have relaxed the supervision requirement both qualitatively and quantitatively.

Most of the reporting requirements laid out in these rules are essentially billing instructions that enable providers to submit claims successfully. They are not directives to submit a claim but rather descriptions of the information to be included if a provider should submit a claim. Similarly, specifications concerning procedure codes or modifiers provide guidance rather than impose obligation.

c. Under these revised rules, speech-language pathologists and audiologists may enroll as Medicaid providers, but they are not required to do so; taking on the burden of going through the enrollment process and subsequently submitting claims is entirely voluntary. If they wish to do so, they may continue to receive payment for services that are reported on claims submitted through other providers, as the current rules require; the revised rules will give them an option they did not have before of becoming independent providers. In all other respects, the changes in these rules should have no adverse operational impact, either on individual providers or in the aggregate. On the contrary, providers should find that doing business with Medicaid will be much less onerous.

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

None of the changes in these rules requires a provider to do anything. Any effort undertaken by providers to enroll in Medicaid or to update their billing systems will be the result of business decisions rather than regulatory mandate.

Regulatory Flexibility

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

These rules do not require any compliance action on the part of providers other than to submit claims when they want Medicaid payment.

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?

These rules impose no sanctions on providers.

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

Providers that submit claims through an electronic clearinghouse (a “trading partner”) can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.