CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Mental Health Services

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS:

5160-4-29 (To be rescinded), 5160-8-05 (To be rescinded), 5160-8-05 (New)

Date: August 19, 2015

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- ☑ Rescinded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.

   Two rules of the Ohio Administrative Code concern mental health services provided in non-institutional settings. The provisions of these rules are being streamlined, updated, and combined into a single new rule. The two existing rules are being rescinded.

   Existing rule 5160-8-05, "Psychology services provided by licensed psychologists," sets forth coverage and payment provisions for psychology services provided by licensed psychologists.

   Existing rule 5160-4-29, "Services provided for the diagnosis and treatment of mental and emotional disorders," sets forth coverage and payment provisions for mental health services provided by physicians, licensed social workers, professional counselors, and professional clinical counselors.

   New rule 5160-8-05, "Mental health services," sets forth coverage and payment provisions for mental health services provided in non-institutional settings.

   Changes:

   Existing rules 5160-4-29 and 5160-8-05 recognize certain professionals capable of rendering covered mental health services, under appropriate supervision as necessary:
   - Physicians
   - Licensed psychologists
   - Professional clinical counselors
   - Professional counselors
   - Clinical social workers
   - Licensed social workers
   - Doctoral-level psychology interns

   New rule 5160-8-05 identifies not only these professionals (some of them by updated title) but also other individuals capable of rendering covered mental health services:
   - Physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs)
   - Licensed psychologists
   - Licensed professional clinical counselors, independent social workers, and independent marriage and family therapists (collectively termed "independent practitioners")
   - Licensed professional counselors, social workers, and marriage and family therapists (collectively termed "supervised practitioners")

- Registered counselor trainees, registered social work trainees, marriage and family therapist trainees, and doctoral psychology trainees (collectively termed "supervised trainees")

The new rule recognizes licensed professional clinical counselors, independent social workers, and independent marriage and family therapists as eligible Medicaid providers with their own provider types; they will be able to submit claims and receive payment for Medicaid services they provide. An existing provision that in effect compels licensed psychologists to enroll in Medicaid as eligible providers, even if their services are rendered under the supervision of an eligible provider, is extended to independent practitioners.

An existing provision that requires licensed psychologists in independent practice to participate in Medicare if they can do so (or, if the practice is limited to pediatric treatment, to meet all requirements for Medicare participation other than serving Medicare beneficiaries) is extended to independent practitioners in independent practice.

The list of covered services is expanded to include assessment and behavior change intervention and psychotherapy for crisis.

Specific provisions concerning supervision are replaced by a statement that every mental health service reported on a claim must be performed in accordance with any supervision requirements established in law, regulation, statute, or rule.

The payment structure for some mental health services is being modified. The maximum payment amount for psychological or neuropsychological testing is 100% of the amount specified in the published payment schedule (Appendix DD to rule 5160-1-60 of the Administrative Code), regardless of provider. For a mental health service (other than testing) rendered by a physician, APRN, PA, or licensed psychologist, the maximum payment amount is 100% of the payment schedule amount; for a mental health service (other than testing) rendered by an independent practitioner or a supervised practitioner, it is 85%. Payment made to licensed psychologists is thus increasing from 85% to 100% of the payment schedule amount, and payment made to supervised practitioners is increasing from 50% to 85%.

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

   Section 5164.02 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.

   No.

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 schedules or formulas for use by providers and the general public.

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

   The success of new rule 5160-8-05 will be measured by the extent to which payment is made for services rendered by licensed professional clinical counselors, independent social workers, and independent marriage and family therapists (collectively termed "independent practitioners"); licensed professional counselors, social workers, and marriage and family therapists (collectively termed "supervised practitioners"); and registered counselor trainees, registered social work trainees, marriage and family therapist trainees, and doctoral psychology trainees (collectively termed "supervised trainees"), under appropriate supervision when applicable.

   The recognition of licensed professional clinical counselors, independent social workers, and independent marriage and family therapists as their own provider types with the ability to submit claims and receive payment for Medicaid services will enhance access by expanding the number of available mental health professionals in the Medicaid program. The increase in reimbursement rates for psychologists counselors, social workers and marriage and family therapists will increase the number of mental health professionals willing to treat Medicaid consumers.

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.

SW = social worker, C = counselor, MFT = marriage and family therapist, ISAC = independent substance abuse counselor, ILCDC = independent licensed chemical dependency counselor

ORGANIZATION	DATE AND MEDIUM OF INITIAL CONTACT	TOPICS OF INTEREST OR CONCERN
National Association of Social Workers Ohio Chapter	08/17/2013, meeting	Medicare and Medicaid fees for psychologists, SWs, and Cs; authorization of SWs, Cs, and MFTs as direct providers; work supervision and clinical supervision; practice settings and organization; differences between independent and supervised SWs; payment for supervision; program limits on covered services, Medicaid managed care plans; enrollment; claim submission; utilization and fiscal impact
Ohio Counselor, Social Worker, and Marriage and Family Therapist Board	08/27/2013, e-mail	Medicare and Medicaid fees for psychologists, SWs, and Cs; authorization of SWs, Cs, and MFTs as direct providers; work supervision and clinical supervision; practice settings and organization; clarification of licensure requirements; providing assistance in establishing fiscal impact
Ohio Association of Marriage and Family Therapy	08/30/2013, e-mail	Medicare and Medicaid fees for psychologists, SWs, and Cs; authorization of SWs, Cs, and MFTs as direct providers; work supervision and clinical supervision; practice settings and organization; differences between independent and supervised SWs

ORGANIZATION	DATE AND MEDIUM OF INITIAL CONTACT	TOPICS OF INTEREST OR CONCERN
Ohio Medicaid Managed Care Plans (MCPs) – Buckeye, CareSource, Molina, Paramount, UnitedHealthcare	09/08/2013, survey, with follow-up contact	Current coverage of services and enrollment of providers by MCPs; payment and other program considerations for SWs, Cs, and MFTs
Ohio Counseling Association	09/12/2013, e-mail	Medicare and Medicaid fees for psychologists, SWs, and Cs; authorization of SWs, Cs, and MFTs as direct providers; work supervision and clinical supervision; practice settings and organization; differences between independent and supervised SWs; payment for supervision; program limits on covered services, Medicaid managed care plans; enrollment; claim submission; utilization and fiscal impact
Ohio Psychological Association	08/15/2014, e-mail	Medicare and Medicaid fees for psychologists, SWs, and Cs; authorization of SWs, Cs, and MFTs as direct providers; supervision; definition and coverage of services rendered by trainees, students, or unlicensed staff members
Ohio Board of Psychology	03/09/2015, e-mail	Authorization of SWs, Cs, and MFTs as direct providers; Medicare and Medicaid fees for psychologists, SWs, and Cs; supervision by psychologists; potential impact of policy change on psychologists; coverage and requirements established by Medicare and other payers; coverage and rule language for "doctoral level psychology intern"
Ohio Chemical Dependency Professionals Board	04/21/2015, e-mail	Selection of new direct providers; omission of ISACs and ILCDCs

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

   Most of the suggestions made by stakeholders have been incorporated into the rule, particularly changes involving terminology (e.g., the definition of "doctoral level psychology intern"). ODM is currently working with the Ohio Chemical Dependency Professionals Board and chemical dependency professionals to extend provider status to licensed independent chemical dependency counselors.

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 Quality 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?**

    Each Medicaid rule in the Ohio Administrative Code is specific to a particular subject or aspect of a subject. No other rules specifically address mental health services provided in non-institutional settings.

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.**

    The concept of performance-based regulation does not apply to these services.

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

    Rules involving Medicaid providers are housed exclusively within agency 5160 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 policies set forth in these rules will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the new 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:

These rules affect physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), licensed psychologists, licensed professional clinical counselors, independent social workers, independent marriage and family therapists, licensed professional counselors, social workers, marriage and family therapists, registered counselor trainees, registered social work trainees, marriage and family therapist trainees, and doctoral psychology trainees.

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

This rule imposes no license fees or fines. The existing rule and new rule indicate that no eligible provider may receive payment without a valid Medicaid provider agreement. Both the existing rules and the new rule specify that participating practitioners must hold a current license, and, when appropriate, medical necessity must be documented for certain services over the specified program limits.

New rule 5160-8-05 specifies that the patient's file must substantiate the medical necessity of services performed and that each record is expected to bear the signature and indicate the discipline of the professional who entered it. It sets forth a list of items that requires the types of information to be included. This requirement is consistent with professional standards, and it is imposed for program integrity purposes.

c. Quantify the expected adverse impact from the regulation.

The requirements for holding a Medicaid provider agreement and licensure are means of identifying providers by credentials they already possess; these provisions impose no additional requirements. Documentation of medical necessity consists of spending a few minutes making or transferring notations in a medical file. The time involved in documentation is less than 15 minutes, an estimate based on ODM's knowledge of the type and quantity of information needed and an understanding of provider office operations and staffing. The median hourly wage for the mental health professionals mentioned in this rule is $20.57 to $34.55 according to the Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services and the United States Bureau of Labor and Statistics; adding 30% for fringe benefits brings these

figures to between $26.64 and $44.91. So the cost associated with documenting medical necessity can be up to between $6.60 and $11.22 depending on which mental health professional is completing the documentation.

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

The requirements for holding a Medicaid provider agreement, licensure and to document services in a patient's file is imposed for program integrity purposes.

Regulatory Flexibility

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

No alternate means of compliance is available, and no exception can be made on the basis of an entity's size.

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?

Information on the documentation requirements for medical records is readily available on the Centers for Medicare and Medicaid Services (CMS) website.

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

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau, at noninstitutional_policy@medicaid.ohio.gov.

TO BE RESCINDED

5160-4-29 **Services provided for the diagnosis and treatment of mental and emotional disorders.**

(A) Definitions.

(1) For the purpose of this rule, "direct supervision and general supervision" by a physician are defined in rule 5101:3-4-02 of the Administrative Code.

(2) "Clinical social worker (CSW)" is defined in rule 5101:3-16-01 of the Administrative Code.

(3) "Licensed social worker" is defined in section 4757.28 of the Revised Code;

(4) "Professional counselor" is as defined in rule 4757-3-01 of the Administrative Code; and

(5) "Professional clinical counselor" is as defined in rule 4757-3-01 of the Administrative Code.

(6) "Non-physician" as used in this rule means either a clinical social worker, licensed social worker, professional counselor, professional clinical counselor, or clinical psychologist.

(B) Covered clinical psychiatric diagnostic services, evaluative procedures and therapeutic procedures personally provided by a physician are directly reimbursable to the physician, regardless of the place of service.

(C) Services for the diagnosis and treatment of mental and emotional disorders are covered as physician services when the services are performed by a licensed social worker, professional counselor, or professional clinical counselor who is employed by or under contract with the physician or clinic as long as the services provided are within the licensed social worker's professional counselor's, or professional clinical counselor's scope of practice as defined in Chapter 4757. of the Revised Code and:

(1) The services performed by a clinical social worker are provided under the general supervision of a physician;

(2) The services performed by a licensed social worker who does not meet the

requirements of a clinical social worker are provided;

(a) Under the direct supervision of a physician; or

(b) Under the general supervision of a physician and the direct supervision of a clinical social worker.

(3) The services performed by a professional counselor are provided under the direct supervision of a physician as described in rule 5101:3-4-02 of the Administrative Code;

(4) The services performed by a professional clinical counselor are provided under the general supervision of a physician as described in rule 5101:3-4-02 of the Administrative Code.

(D) A licensed social worker, a clinical social worker, professional counselor or professional clinical counselor may not be directly reimbursed for services provided under the medicaid program. Services of a licensed social worker, clinical social worker, professional counselor or professional clinical counselor may only be billed by and reimbursed to the employing or contracting physician or clinic only when the following provisions are met:

(1) The supervision requirements listed in paragraph (C) of this rule have been met; and

(2) The physician provides supervision which, at a minimum, includes the following:

(a) Discussion about the progress of the patient toward specified goals;

(b) Updating treatment plans as needed; and

(c) Periodic participation in therapy sessions.

Countersigning the therapist's signature is insufficient evidence of active supervision.

(E) Physicians or clinics may not be reimbursed for services provided by a licensed social worker clinical social worker, professional counselor or professional clinical counselor if the services are provided to patients in the inpatient hospital setting, in the outpatient hospital setting, or to resident of a LTCF.

(1) Services provided by a licensed social worker CSW, professional counselor or professional clinical counselor to patients in the inpatient or outpatient hospital setting are covered as hospital services in accordance with Chapter 5101:3-2 of the Administrative Code and may not be reimbursed separately.

(2) Services provided by a licensed social worker CSW, professional counselor or professional clinical counselor to residents of a long-term care facility are covered only as long-term care facility services in accordance with Chapter 5101:3-3 of the Administrative Code.

(F) The following services are noncovered under the medicaid program:

(1) Services provided in facilities regulated by the state board of education;

(2) Sensitivity training, encounter groups or workshops;

(3) Sexual competency training;

(4) Marathons and retreats for mental disorders; and

(5) Educational activities, testing and diagnosis;

(6) Monitoring activities of daily living;

(7) Recreational therapy (art, play, dance, or music);

(8) Teaching grooming skills;

(9) Services primarily for social interaction, diversion, or sensory stimulation;

(10) Psychotherapy services are not covered if the patient's cognitive deficit is too severe to establish a relationship with the psychotherapist; and

(11) Family therapy psychotherapy involving training of family members or care givers if the purpose is the management of the patient.

(G) For reimbursement for services provided by , non-physicians meeting the criteria in paragraph (C) of this rule, the services must be billed using the following codes and modifiers:

(1) Billable codes and services:

(a) For individual therapy, bill the standard individual therapy codes specified in paragraphs (D)(1)(a)(i) to (D)(1)(a)(ii) and (D)(1)(a)(iv) of rule 5101:3-8-05 of the Administrative Code;

(b) For group therapy, bill the standard codes specified in paragraphs (D)(1)(b)(i) to (D)(1)(b)(iv) of rule 5101:3-8-05 of the Administrative Code.

(2) Modifiers to signify the level of educational training of a non-physician providing therapy services:

(a) If the non-physician providing the service is a clinical social worker, bill the appropriate code modified by "AJ" to signify that a clinical social worker provided the service.

(b) If the non-physician providing the service is a clinical psychologist, bill the appropriate code modified by "AH" to signify that a clinical psychologist provided the service.

(c) If the non-physician providing the service holds a doctoral degree and is not a clinical psychologist, bill the appropriate code modified by "HP" to signify a doctoral level trained professional.

(d) If the non-physician providing the service holds a master's degree and is not a clinical social worker, bill the appropriate code modified by "HO" to indicate a masters degree level trained professional.

(e) If the non-physician providing the service holds a bachelor's degree only, bill the appropriate code , modified by "HN " to signify that a bachelor's level clinical staff person provided the service.

(3) Reimbursement for therapy provided by a non-physician will be reimbursed at the following levels:

(a) For services provided by a clinical psychologist, services will be reimbursed as stated in paragraph (D)(1) of rule 5101:3-8-05 of the Administrative Code.

(b) For individual therapy provided by non-physicians except as described in paragraph (G)(3)(a) of this rule, services will be reimbursed at the lesser of the provider's billed charge or fifty per cent of the medicaid maximum for the individual therapy code.

(c) For group therapy services provided by non-physicians except as described in paragraph (G)(3)(a) of this rule, services will be reimbursed at the lesser or the provider's billed charge or fifty per cent of the medicaid maximum for the group therapy code.

(H) The patient's medical record must substantiate the nature of the services billed including:

(1) The medical necessity of the services billed;

(2) A treatment plan which is signed and dated by the physician prior to initiating therapy. The treatment plan shall include but is not limited to:

(a) Relevant medical and psychiatric diagnoses;

(b) Treatment goals;

(c) Type, duration, frequency of therapy services;

(d) Response to treatment on an on-going basis;

(e) Prognosis; and

(f) Evidence of sufficient cognitive ability to benefit from therapy.

(3) Any medications prescribed;

(4) Information regarding the patient's symptoms, functional impairment, type, duration, and frequency of treatment including dates of treatment sessions;

(5) The face-to-face time period spent with the patient;

(6) Test results, if applicable.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	02/17/1991, 11/01/2001, 10/01/2003, 12/31/2012 (Emer), 03/28/2013

TO BE RESCINDED

5160-8-05 **Psychology services provided by licensed psychologists.**

(A) Scope. This rule sets forth provisions governing payment for psychology services provided by licensed psychologists in non-institutional settings. Provisions governing payment for psychology services as the following service types are set forth in the indicated part of the Administrative Code:

(1) Hospital services, Chapter 5160-2;

(2) Nursing facility services, Chapter 5160-3;

(3) Physician services, Chapter 5160-4;

(4) Clinic services rendered by the following providers:

(a) Fee-for-service ambulatory health care clinics, Chapter 5160-13;

(b) Rural health clinics, Chapter 5160-16;

(c) Federally qualified health centers, Chapter 5160-28; or

(d) Outpatient health facilities, Chapter 5160-29;

(5) Medicaid school program services, Chapter 5160-35; and

(6) Intermediate care facility services, Chapter 5123:2-7.

(B) The following definitions apply to this rule:

(1) "Psychologist" is a person who holds a valid license as a psychologist under Chapter 4732. of the Revised Code.

(2) "Independent psychologist" is a psychologist who is not subject to the administrative and professional control of an employer such as an institution, physician, or agency. A psychologist practicing in an office that is located within an entity is considered to be independent when both of the following conditions are met:

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

(b) The psychologist 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.

(3) "General supervision" has the same meaning as in rule 5160-4-02 of the Administrative Code.

(C) Providers.

(1) Independent psychologists either must participate in the medicare program or, if they limit their practice to pediatric treatment and do not serve medicare beneficiaries, must meet all other requirements for medicare participation.

(2) Rendering providers. The following eligible providers may render a psychology service:

(a) A psychologist; or

(b) A doctoral-level psychology intern completing a required internship, if the following conditions are met:

(i) The service is provided under the general supervision of the psychologist responsible for the patient's care;

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

(iii) The psychologist responsible for the patient's care keeps on file official documentation of the internship, including the beginning and ending dates; and

(iv) The psychologist responsible for the patient's care includes in the patient's medical record documentation that appropriate service

was provided under general supervision, that the psychologist checked and updated the medical record at least once a week, and that all requirements for payment were met.

(3) Billing ("pay-to") providers. The following eligible providers may receive medicaid payment for submitting a claim for a psychology service on behalf of a rendering provider:

(a) An independent psychologist;

(b) A professional medical group;

(c) A hospital;

(d) A fee-for-service ambulatory health care clinic;

(e) A rural health clinic;

(f) A federally qualified health center; or

(g) An outpatient health facility.

(D) Coverage.

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

(a) Psychological and neuropsychological testing;

(b) Therapeutic services:

(i) Individual psychotherapy provided in the office, outpatient clinic, outpatient hospital, or home:

(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; and

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

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

(a) Family psychotherapy without patient present;

(b) Family psychotherapy with patient present;

(c) Group psychotherapy;

(d) Multiple-family group psychotherapy; and

(e) Interactive complexity (reported separately in addition to the primary procedure, only when specific communication barriers complicate the delivery of service); and

(c) Diagnostic evaluation, one unit.

(2) The following payment limitations apply to psychology services provided to an individual in a non-hospital setting:

(a) For psychological testing, a maximum of eight hours per twelve-month period;

(b) For diagnostic evaluation, one date of service per twelve-month period, not on the same date of service as a therapeutic visit; and

(c) For therapeutic visits, a maximum of twenty-four dates of service per twelve-month period if a diagnostic evaluation is performed, twenty-five if no diagnostic evaluation is performed.

(3) The following psychology-related items and services are not covered by medicaid:

(a) Services that are not medically necessary in accordance with Chapter 5160-1 of the Administrative Code;

(b) Services rendered by an by unlicensed individual, even if the services are provided under the personal supervision of a psychologist;

(c) Services rendered by licensed psychologist who lacks a current medicaid provider agreement, even if the services are provided under the personal supervision of a psychologist who has a current medicaid provider agreement;

(d) Psychology-related services listed as non-covered in rule 5160-4-29 of the Administrative Code;

(e) Services unrelated to the treatment of a specific medical complaint;

(f) Services determined by a third-party payer not to be medically necessary;

(g) Any psychology service for which payment is denied by medicare;

(h) The outpatient psychiatric exclusion from medicare payments;

(i) Self-administered or self-scored tests of cognitive function; and

(j) Biofeedback therapy.

(E) Documentation of services. The patient's file must substantiate the medical necessity of services performed. Each record should include the signature and professional discipline of the provider. The following items illustrate the types of information to be included:

(1) A description of the patient's symptoms and functional impairment;

(2) Relevant medical and psychiatric diagnoses;

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

(4) A treatment plan that specifies treatment goals, tracks responses to ongoing treatment; and presents a prognosis;

(5) The type, duration, and frequency of treatment, with dates of service;

(6) Medications taken by or prescribed for the patient;

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

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

(9) Test results, if applicable, with interpretation; and

(10) Summaries of and notes on psychotherapy sessions.

(F) Claim payment.

(1) Providers must report appropriate procedure codes and modifiers on claims.

(2) The maximum fee for a psychology service performed by a psychologist is the lesser of the provider's submitted charge or eighty-five per cent of the amount for the service specified in appendix DD to rule 5160-1-60 of the Administrative Code.

(3) A psychology service performed during a hospital stay is treated as a hospital service.

(4) Payment for a psychology service rendered to a resident of a nursing facility (NF) is made to the NF through the facility per diem. An independent psychologist who renders a psychology service to a NF resident must seek payment from the NF.

(5) A psychologist may be reported on a claim as the billing provider only if the psychologist is independent. If a psychologist is a member of a professional medical group or is employed by a hospital or clinic, then the medical group, hospital, or clinic must be reported as the billing provider.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	07/01/2002, 08/17/2003, 01/01/2004, 12/30/2005 (Emer), 03/27/2006, 01/01/2008, 12/31/2012 (Emer), 03/28/2013, 01/01/2014

5160-8-05 **Mental health services.**

(A) Scope. Effective for dates of service on and after January 1, 2016, this rule sets forth provisions governing payment for mental health services provided by certain licensed professionals in non-institutional settings.

(1) A mental 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) Payment for certain mental health services rendered to a resident of a long-term care facility (LTCF) is made to the LTCF through the facility per diem in accordance with Chapter 5160-3 or Chapter 5123:2-7 of the Administrative Code. A provider who renders such a mental health service must seek payment from the LTCF.

(3) Provisions governing payment for mental 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.

(B) Definitions for the purposes of this rule.

(1) "Mental health service" is a service or procedure that is performed for the diagnosis and treatment of mental, behavioral, 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) Independent social worker, section 4757.27; and

(c) Independent marriage and family therapist, section 4757.30.

(4) "Supervised 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 counselor, section 4757.23;

(b) Social worker, section 4757.28; and

(c) Marriage and family therapist, section 4757.30.

(5) "Supervised trainee" is a collective term used in this rule to designate the following individuals:

(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; and

(d) Doctoral psychology trainee, a person who is enrolled in or has earned a degree from a doctoral psychology program meeting requirements set forth in section 4732.10 of the Revised Code, is working under the supervision of a licensed psychologist, and has been assigned by the supervising psychologist a title appearing in rule 4732-13-03 of the Administrative Code, such as "psychology intern," "psychology fellow," or "psychology resident."

(6) "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 independent practitioner must be enrolled in the

medicaid program as an eligible provider, even if services are rendered under the supervision of an 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 mental health services:

(a) Diagnostic evaluation, one unit;

(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;

(iii) Smoking and tobacco use cessation counseling, intermediate, greater than three minutes up to ten minutes; and

(iv) Smoking and tobacco use cessation counseling, intensive, greater than ten minutes; and

(d) Therapeutic services:

(i) Individual psychotherapy provided in the office, outpatient clinic, or home:

(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 or group psychotherapy for which the primary purpose is the treatment of the patient and not family members:

(a) Family psychotherapy without patient present;

(b) Family psychotherapy with patient present;

(c) Group psychotherapy;

(d) Multiple-family group psychotherapy; and

(e) Interactive complexity (reported separately in addition to the primary procedure, only when specific communication barriers complicate the delivery of service).

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

(a) To a physician, group practice, or clinic for a mental health service rendered by a licensed psychologist, independent practitioner, or supervised practitioner employed by or under contract with the physician, group practice, or clinic;

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

(c) To a physician, advanced practice registered nurse, physician assistant, licensed psychologist in independent practice, or independent practitioner in independent practice for a mental health service rendered by a supervised practitioner under the supervision of that health care professional; or

(d) To a licensed psychologist in independent practice or independent practitioner in independent practice for a mental health service rendered by a supervised trainee if the following conditions are met:

(i) The professional responsible for the patient's care has face-to-face contact with the patient at the following intervals:

(a) A licensed psychologist, during the initial visit and not less often than once per quarter (or during each visit if visits are scheduled more than three months apart); and

(b) A independent practitioner, during each visit; and

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

(3) The following coverage limits, which may be exceeded only with prior authorization, are established for mental health services provided to an individual in a non-institutional setting:

(a) For diagnostic evaluation, one date of service per benefit year, not on the same date of service as a therapeutic visit;

(b) For psychological or neuropsychological testing, a maximum of eight hours per benefit year; and

(c) For therapeutic visits, a maximum of twenty-four dates of service per benefit year if a diagnostic evaluation is performed, twenty-five if no diagnostic evaluation is performed.

(E) Constraints.

(1) Every mental health service reported on a claim must be within the scope of practice of the licensed professional 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) No payment will be made under this rule for the following items:

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

(b) Services that are provided in facilities regulated by the state board of education;

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

(d) Services that are unrelated to the treatment of a specific mental health

complaint 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);

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

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

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

(F) Documentation of services.

The patient's file 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 entered it. The following items must be included as documentation if applicable:

(1) A description of the patient's symptoms and functional impairment;

(2) All relevant diagnoses pertaining to medical or physical conditions as well as to mental health;

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

(4) A treatment plan that specifies treatment goals, tracks responses to ongoing treatment, and presents a prognosis;

(5) The type, duration, and frequency of treatment, with dates of service;

(6) Medications taken by or prescribed for the patient;

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

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

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

(10) Summaries of psychotherapy sessions; and

(11) Any psychotherapy notes that are kept.

(G) Claim payment.

The payment amount for a mental health service is the lesser of the provider's submitted charge or the applicable percentage of the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code:

(1) For testing, it is one hundred per cent;

(2) For a mental 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 independent practitioner or a supervised practitioner, it is eighty-five per cent.

Replaces: 5160-4-29, 5160-8-05

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Five Year Review (FYR) Dates:

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Certification

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