CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Behavioral Health Services-Other Licensed Professionals

Rule Number(s): 5160-8-05

Date: March 8, 2017

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- ✓ Rescinded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.

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.

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Rescind and new rule 5160-8-05, "Behavioral health services-other licensed professionals," sets forth coverage and payment provisions for behavioral health services provided by licensed professionals.

Rule 5160-8-05 recognizes the following practitioners:

- Certain professionals capable of rendering covered behavioral health services, their enrollment as Medicaid providers and the method of reimbursement:
    a. Physicians (MD/DO), advanced practice registered nurses (APRNs), and physician assistants (PAs)
    b. Licensed psychologists
    c. Licensed professional clinical counselors (LPCC), licensed independent social workers (LISW), licensed independent marriage and family therapists (LIMFT), licensed independent chemical dependency counselors (LICDC), and school psychologists licensed by the state board of psychology, (collectively termed "independent practitioners")

- Certain professionals capable of rendering covered behavioral health services with appropriate general supervision:
    a. Licensed professional counselors (LPC), licensed social workers (LSW), licensed marriage and family therapists (LMFT), and licensed chemical dependency counselors (LCDC) II and III (collectively termed "supervised practitioners")
    b. Doctoral-level psychology trainees and interns

- Certain professionals capable of rendering covered behavioral health services with appropriate direct supervision
    a. Registered counselor trainees, registered social work trainees, marriage and family therapist trainees, and chemical dependency counselor trainees

The proposed rescind and new rule adds school psychologists licensed by the state board of psychology as eligible Medicaid providers. They will be able to submit claims and receive payment for the Medicaid-covered services they provide.

The proposed rescind and new rule clarifies the level of supervision (general vs direct) that is required for each type of practitioner. This was done in collaboration with the Department's behavioral health redesign efforts to ensure standardization of supervision requirements across behavioral health providers.
In this clarification, doctoral psychology trainees and interns will now require general supervision as directed by the board of psychology. In response to board guidance, the requirement for an

independent supervisor to see the patient every visit has been removed in the rescinded and new rule.

This rule also allows the supervised trainees under direct supervision to be paid at the supervisor rate.

The proposed rule implements Ohio House Bill 483 that requires behavioral health services billed in nursing facilities to be billed by the practitioner rendering the service and not included in the nursing facility per diem calculations.

The proposed rule implements changes made in the Department's behavioral health redesign by accounting for services provided by employees of community behavioral health centers in the payment section of the rule.

The proposed rule removes place of service restrictions for psychotherapy and permits services to be provided in a school setting. The proposed rule lifts the benefit limit on therapeutic visits and expands the limits for psychological testing and diagnostic evaluation by applying the limit on the billing provider rather than the recipient. This rule adds a limitation on the service known as screening, brief intervention and referral to treatment (SBIRT) for substance abuse, as a provider should screen for substance use disorder once, then refer the patient to substance use disorder treatment if needed.

This rule references documentation requirements for providers certified by the Ohio Department of Mental Health and Addiction services (OhioMHAS), and clarifies ODM requirements for the use of checklists when documenting progress notes in the client's clinical record. All other documentation requirements remain the same.

The current and proposed version of the rule include the following payment amounts: 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 behavioral 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 behavioral health service (other than testing) rendered by an independent practitioner or a supervised practitioner, it is 85%. Payment made to licensed psychologists is 100% of the payment schedule amount, and payment made to supervised practitioners is 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, set limits on the types of entities that can receive Medicaid payment for these goods and services, and codify payment schedules or formulas to be accessed by providers and the general public. This rule supports the changes being made through Behavioral Health Redesign, an initiative developed by ODM, OhioMHAS, and the Governor's Office of Health Transformation (OHT).

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

The success of this rule will be measured by the extent to which payment is made for services rendered by independent practitioners, supervised practitioners and supervised trainees covered under this rule.

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.

ORGANIZATION	DATE AND MEDIUM OF INITIAL CONTACT	DETAILS OF CONTACT
Ohio Counselor, Social Worker, and Marriage and Family Therapist (CSWMFT) Board	In person and telephone consultations at various times in the past 12-18 months	The Ohio CSWMFT Board has been an active participant in this process. ODM has had many phone calls, meetings and emails with board leadership including a presentation on the BH Redesign at one of

		their board meetings. In addition, the leadership and the board at the Ohio CSWMFT Board was provided drafts of this rule and given several opportunities to comment. Many of their edits and suggestions have been incorporated into this rule.
Ohio Medicaid Managed Care Plans (MCPs) – Buckeye, CareSource, Molina, Paramount, UnitedHealthcare	In person and telephone consultations at various times in the past 12-18 months	The Ohio MCPs have been involved in the behavioral health redesign process for the past two years including attending bi-monthly stakeholder meetings, more frequent meetings about special policy topics and have been provided a draft of this rule with opportunity to comment prior to this BIA's submission.
Ohio Board of Psychology	In person and telephone consultations at various times in the past 12-18 months	The Ohio Board of Psychology has been an active participant in this process. ODM has conducted many phone calls, meetings and exchanged emails with board leadership. In addition, the Ohio Board of Psychology has been provided a draft of this rule with opportunity to comment prior to this BIA's submission. Several of their suggestions and edits have been incorporated into this rule.
Ohio Chemical Dependency Professionals Board	In person and telephone consultations at various times in the past 12-18 months	The Ohio Chemical Dependency Professionals Board has been an active participant in this process.

		ODM has conducted phone calls, exchanged emails, and met with board leadership and members. In addition, leadership at the Ohio Chemical Dependency Professionals Board was provided a draft of this rule and opportunity for comment prior to this BIA's submission.
Behavioral Health Stakeholder Working Group (Includes individual providers, provider associations, nonprofit organizations representing patients, and managed care plans.)	October 2014-Present, in person, e-mail, and phone.	Hundreds of stakeholders have participated in The Behavioral Health Stakeholder Working Group meetings related to the behavioral health redesign initiative including meetings on policy, rates, rules, and information technology. These stakeholders were provided a draft of this rule and an opportunity for comment prior to this submission. Many of their comments have been addressed and incorporated into this rule.
In addition to outreach to the aforementioned stakeholder groups, ODM and OhioMHAS also accomplished stakeholder outreach through the creation of a dedicated internet site for this initiative (bh.medicaid.ohio.gov) which includes a contact us link which is monitored by ODM and OhioMHAS staff. I addition to the website, ODM has established a dedicated mailbox (BH-enroll@medicaid.ohio.gov) to answer more detailed enrollment questions which is monitored daily by ODM staff. ODM and OhioMHAS held more than 25 regional training sessions, conducted surveys, and developed webinar training sessions. Staff have frequently had one on one phone calls and meetings with behavioral health agencies and associations.		
Stakeholders include but are not limited to: • The Joint Medicaid Oversight Committee of the Ohio General Assembly • 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
- 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?

Most of the suggestions and edits made by stakeholders have been incorporated into this rule including:

- School psychologists have been added as eligible providers;
- Supervision requirements have been clarified;
- Place of service restrictions have been removed for psychotherapy and services may be provided in schools;
- The 24 hour limitation on therapies has been removed;
- The documentation requirement to keep psychotherapy notes in the medical record has been removed;
- Doctoral psychology interns and trainees have been changed from direct to general supervision;
- The benefit limits for psychiatric diagnostic evaluation and testing is now associated with the billing provider rather the recipient.

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 projections were conducted by Mercer, a consulting firm as part of our behavioral health redesign budget modeling.

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?

ODM enforces requirements through the use of rules in the Ohio Administrative Code (OAC) and is specific to a particular subject. No other rules specifically address behavioral health services provided by licensed practitioners payable by ODM.

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 this rule will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the rule. They will therefore be automatically and consistently applied by the department's electronic claims payment system whenever an appropriate provider submits a payable claim for a covered service. To date, ODM and OhioMHAS have offered more than 20 regional training sessions, with additional trainings planned for March and April for stakeholders, with an emphasis on implementation training for behavioral health Providers. ODM and OhioMHAS will closely monitor the implementation of new regulations by reviewing patterns of Medicaid claims and utilization including anecdotal reports from key stakeholders. ODM is prepared to offer training and technical assistance as needed to the Medicaid behavioral health provider community to ensure successful and consistent implementation of the new regulations, as needed Providers may begin testing any new changes in May and ODM is establishing a dedicated group of staff to assist in any testing or claims issues prior to July. ODM and OhioMHAS are committed to providing a smooth transition period as providers switch to the new code set in July, 2017. As part of this effort, ODM and OhioMHAS will establish a Rapid Response team that will be available beginning in July, 2017 to provide technical assistance 6 days a week for any issues related to claims payment or processing time.

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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;

This rule affect physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), licensed psychologists, LPCs, LISWs, LIMFTs, school psychologists, LICDCs, LPCs, LSWs, LMFTs, LICDC II and III practitioners, registered counselor trainees, registered social work trainees, marriage and family therapist trainees, chemical dependency counselor trainees, doctoral psychology trainees and provider agencies that employ them, who are also ODM providers

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

This rule does not impose licensing fees or fines. The current rule indicates that no eligible provider may receive payment without a valid Medicaid provider agreement. If the newly eligible independent school psychologist wishes to enroll and be reimbursed by Ohio Medicaid, they will need to complete the online enrollment process which will require time and documentation. .

OAC 5160-8-05 specifies that the patient's medical record 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 as required by all Medicaid enrolled providers and practitioners, and is being imposed for program integrity purposes. The clarification of supervision requirements will assure that proper supervision is maintained, and at the level expected under licensing board requirements. The addition of requirements for provider agencies certified by the OhioMHAS simply keeps the required documentation consistent with existing certification requirements.

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.

The requirements for holding a Medicaid provider agreement and licensure are means of identifying providers by credentials they already possess and impose no additional requirements. Documentation of medical necessity consists of spending a few minutes

making or transferring notations in a medical record. 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 behavioral health professionals mentioned in this rule ranges between $20.57 to $34.55 according to the Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services (ODJFS) and the United States Bureau of Labor and Statistics. Including an additional 30% for fringe benefits brings these figures to between $26.64 and $44.91. Therefore, the cost associated with documenting medical necessity may fall between $6.60 and $11.22 depending on which type of behavioral health professional is completing the documentation. This will vary widely based on provider agency size, current staffing, and services provided.

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, for verifying professional licensure and documenting services in a patient's medical record 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 ODM provider's agency 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. Additionally, the website bh.medicaid.ohio.gov provides detailed resources for Ohio Medicaid's Behavioral Health Redesign of which the requirements in this rule are a part. Staff from ODM and the OhioMHAS have conducted regional training sessions concerning behavioral health redesign for providers and stakeholders over the past two years and will continue to do so

ODM's 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 Policy Management and Development section of ODM's policy bureau, at BH-Enroll@medicaid.ohio.gov.

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5160-8-05 ~~Mental~~ Behavioral health services-other licensed professionals.

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

(1) A ~~mental~~ 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) 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)~~ (2) Provisions governing payment for ~~mental~~ 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) "~~Mental~~ 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~~ independent social worker, section 4757.27; ~~and~~

(c) ~~Independent~~ 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 in accordance with the indicated portion of the Revised Code:

(a) Licensed professional counselor, section 4757.23;

(b) Licensed ~~Social~~ social worker, section 4757.28; ~~and~~

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

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

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

(f) 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."

(5) "Supervised trainee" is a collective term used in this rule to designate the following individuals who can operate under the 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; and

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

~~(e) 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 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 ~~mental~~ behavioral health services:

(a) ~~Diagnostic~~ Psychiatric diagnostic evaluation, one unit of each;

(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; and

(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).~~

(iii) Group psychotherapy

(a) Group psychotherapy; and

(b) Multiple-family group psychotherapy;

(iv) 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~~ behavioral health service rendered as indicated:

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

~~(b)~~ (d) To a physician, advanced practice registered nurse, physician assistant, licensed psychologist in independent practice, or independent practitioner in independent practice for a ~~mental~~ behavioral 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 reviews 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 from the ODM designated entity, are established for ~~mental~~ behavioral health services provided to a medicaid recipient. ~~an individual in a non-institutional setting~~:

(a) For diagnostic evaluation, one ~~date of service per benefit year~~ 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 ~~or neuropsychological testing,~~ a maximum of ~~eight~~ twelve hours, per recipient, per calendar year ~~per benefit 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.

~~(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~~ behavioral health service reported on a claim must be within the scope of practice of the licensed professional, with appropriate ~~certificationa~~ 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) No payment will be made under this rule for the following ~~items~~ activities:

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

~~(d)~~ (c) Services that are unrelated to the treatment of a specific ~~mental~~ behavioral health diagnosis ~~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)~~ (d) Psychotherapy services if the patient cannot establish a relationship with the provider because of a cognitive deficit;

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

~~(g)~~ (f) 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;~~ 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. The following items must be included as documentation at a minimum on a daily or weekly basis after provision of the service:

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

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

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

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

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

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

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

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

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

(j) Summaries of psychotherapy sessions and progress notes.

(2) For the purpose of medicaid reimbursement, progress notes must include a narrative of the recipient's progress. In addition, the provider may support progress notes with a checklist as found in a standard electronic health record platform.

~~(2)~~ (3) For other licensed practitioners employed by community mental health or substance use disorder agencies practitioners must follow documentation standards as found in rules 5122-27-03, 5122-27-04, 5122-27-05 of the Administrative Code and paragraph (F)(2) of this rule.

~~(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~~ behavioral 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~~ 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 ~~independent~~ practitioner ~~or a supervised practitioner,~~ it is

eighty-five per cent.

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