



Common Sense Initiative

Mike DeWine, Governor

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Business Impact Analysis

Agency, Board, or Commission Name: Department of Medicaid

Rule Contact Name and Contact Information: Tommi Potter Rules@Medicaid.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Behavioral Health Policy FYRR

Rule Number(s): 5160-8-05, 5160-27-01, 5160-27-02, 5160-27-04, 5160-27-06, 5160-27-08, 5160-27-09, 5160-27-10, 5160-27-14

Date of Submission for CSI Review: 10/5/2026

Public Comment Period End Date: 10/13/2026

Rule Type/Number of Rules:

New/ 5 rules

No Change/ rules (FYR?)

Amended/ 4 rules (FYR? Y)

Rescinded/ 1 rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

Which adverse impact(s) to businesses has the agency determined the rule(s) create?

The rule(s):

- a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**
- b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**
- c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**
- d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**

Please include the key provisions of the regulation as well as any proposed amendments.

5160-8-05: Provides definitions and general Medicaid coverage and payment policy for behavioral health services. Revisions include policy and payment clarifications.

5160-27-01: Defines the eligible providers of Medicaid covered behavioral health services. Revisions include updating a sister agency name and correcting a typo.

5160-27-02: Coverage and limitations of behavioral health services. States services that might be subject to provision limits and how such limits can be bypassed. The CPST service is removed from the rule and existing policy is clarified.

5160-27-04 (Rescind): Mental health assertive community treatment service. States the policy concerning the assertive community treatment service. This rule is being rescinded due to the quantity of revisions being made and filed as new.

5160-27-04 (New): Mental health assertive community treatment service. States the policy concerning the assertive community treatment service. Revisions from the rescinded rule include removal of much of the rule text and reference 5122-29-29 as a source of service information.

5160-27-06: Mental health intensive outpatient and partial hospitalization services. Defines the two services and states service requirements and coverage limitations. Revisions include policy clarification regarding group counseling services and treatment intensity.

5160-27-08: Mental health therapeutic behavioral services and psychosocial rehabilitation. Describes two services, therapeutic behavioral service and psychosocial rehabilitation and states Medicaid coverage policy. Revisions include policy clarification concerning service coverage limitations and service activity components.

5160-27-09: Substance use disorder treatment services. Describes and states the purpose of Medicaid covered substance use disorder services and includes the reimbursement policy. Revisions include clarification of existing policy and new policy regarding reimbursement and documentation requirements.

5160-27-10: Substance use disorder targeted case management. Describes and states the coverage limitations for the substance use disorder targeted case management service. Revisions include updating the name of a sister agency mentioned in the rule and updating targeted case management information.

5160-27-14: Behavioral health peer support service. Describes the eligible providers, coverage limitations, and reimbursement policy for the behavioral health peer support service. Revisions include updating the name of a sister agency used in the rule and updating service limitation and reimbursement policy.

3. Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.

560-8-05 Authorized By: [5164.02](#) Amplifies: [5164.02](#) , [5164.03](#)
5160-27-01 Authorized By: [5162.02](#), [5164.02](#) Amplifies: [5162.03](#), [5164.02](#), [5162.371](#)
5160-27-02 Authorized By: [5164.02](#), [5162.05](#), [5162.02](#)
Amplifies: [5164.02](#), [5164.88](#), [5164.76](#), [5164.15](#), [5164.03](#)
5160-27-04 Authorized By: [5162.02](#), [5164.02](#) Amplifies: [5164.02](#) , [5164.03](#)
5160-27-06 Authorized By: [5164.02](#), [5162.05](#), [5162.02](#) Amplifies: [5164.02](#), [5164.03](#)
5160-2708 Authorized By: [5162.02](#), [5164.02](#) Amplifies: [5164.02](#) , [5164.03](#)
5160-27-09 Authorized By: [5162.02](#), [5162.05](#), [5164.02](#) Amplifies: [5164.02](#), [5164.03](#)
5160-27-10 Authorized By: [5162.02](#), [5162.05](#), [5164.02](#) Amplifies: [5164.02](#), [5164.03](#)
5160-27-14 Authorized By: [5164.02](#), [5162.05](#), [5162.02](#) Amplifies: [5162.02](#), [5162.03](#)

**4. 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

5. If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

Not Applicable

6. 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)?

These rules state requirements that support the effective, efficient operation of the Medicaid program by stating requirements practitioners must follow to support the safe provision of Medicaid covered behavioral health services to Medicaid recipients.

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

The major information sources for reviewing outcome measures will be Medicaid claims and reports from key stakeholders. Some examples of outcome measures include changes in consumer utilization of behavioral health services and improved health outcomes of Medicaid recipients receiving behavioral health services.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?

If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. 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.

ODM held three virtual public stakeholder meetings in July that addressed the proposed rules. Several comments were received from many organizations and individuals. In addition, a public posting of the rules for seven calendar days (9/12-9/18) allowed stakeholders and the public to review the rules and submit comments. Here is a list of major behavioral health stakeholders that provided comments.

The Ohio Council of Behavioral Health & Family Services Providers

Coleman Health Services

The Buckeye Ranch

Ohio Guidestone

Child Focus

Empower Behavioral Health & Intervention Services

I am Boundless

Zepf Center

Team Recovery

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

Several comments were provided by stakeholders, the following is a list of issues most cited and ODM's response:

- 1) Confusion was expressed concerning what commenters called the "Master List" (associated with service prior authorization). The "ODM Master List for Prior Authorization" as posted on the ODM website is associated with the appendix to rule 5160-1-31 which is being revised in a separate rule package and will be available for public review and comment.
- 2) There were requests for utilization management and policies associated with service implementation guidelines and readiness support. ODM intends to provide additional stakeholder workgroups to support provider readiness prior to the effective date of the rules.
- 3) Significant feedback was provided regarding the new definitions of supervision. Based on these comments, ODM revised the definitions to align with stakeholder preference.
- 4) Comments were provided concerning the reimbursement of collateral contacts within a provider organization. Rule language was revised to allow for reimbursement for contact between employees of the same organization if they represent different lines of business within the organization.
- 5) Comments were provided related to changes to level of care treatments related to a single mental health service and potential conflicts with Ohio Department of Behavioral Health (DBH) rules. ODM worked with DBH to clarify the desired language, eliminate any potential conflicts, and to revise reimbursement policy for the service.
- 6) Comments were provided concerning therapeutic behavioral service delivery by providers. Stakeholder interpretation of the rule language was incorrect, and ODM has revised rule language to clarify the desired policy.

11. 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?

Ohio Medicaid claims data were the main source of information used to guide the policy decisions represented in these rules.

12. 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?
Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to

comply.

ODM enforces requirements using rules in the Ohio Administrative Code (OAC) Chapter 25 and rule 5160-8-05 which is specific to Medicaid covered behavioral health services. Services are aligned with Ohio's Medicaid State Plan with the Centers for Medicare and Medicaid Services (CMS). A State Plan Amendment will be submitted to CMS to address any State Plan changes needed because of these rules.

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

The proposed rules were reviewed by the Ohio Department of Behavioral Health (DBH) to ensure that duplicative rules did not exist in their sets of rules but rather the proposed rules are complementary to those from DBH.

14. 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.

ODM maintains, on its website, a manual that provides information regarding the behavioral health services it covers. It is revised on a regular basis and will be again once these rules are in effect. ODM also maintains an electronic mailbox that providers and stakeholders can use to send email if they have questions regarding regulations outlined in the rules.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:

a. Identify the scope of the impacted business community, and

1. Behavioral health provider agencies that choose to render services to Medicaid recipients must be certified by the Ohio Department of Behavioral Health (DBH).
2. Service provision authorization requirements (strengthening to support fraud, waste, and abuse policies) may limit the provision of some services.
3. To render some specific services, a practitioner must hold a required degree, license, or certification in a specific field.
4. To render one specific service, assertive community treatment (ACT), a team of practitioners must meet service fidelity requirements.
5. To receive ACT a recipient must meet specific clinical or other criteria.
6. A provider agency wishing to render and bill for ACT must hold current ACT certification given by DBH.
7. ODM may suspend or terminate payment for ACT if the ACT practitioner team does not meet fidelity criteria.
8. In some situations, if a practitioner must document client information, specific documentation requirements must be met.

b. Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).

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.

1. Provider certification costs vary according to the size of the provider agency and which services it chooses to provide thus the certification cost can vary from agency to agency. The cost is determined by the Ohio Department of Behavioral Health.
2. Revenue reduction from potential service provision limitations will vary significantly among agencies depending on the quantity of services not authorized.
3. Degree, certification, or licensure costs will vary depending on the entity granting the degree, certification, or license.
4. To meet ACT fidelity requirements, a practitioner team will work with Case Western Reserve University to determine what preparation needs to be done and costs (if any) involved.
5. If a recipient does not meet the medical necessity criteria to receive ACT, they could not receive the service but would be eligible for a more appropriate clinical service.
6. The cost for a provider agency to obtain ACT certification is determined by DBH specific provider requirements and therefore will vary among provider agencies.
7. The amount of suspended or terminated payment by ODM would vary depending on the quantity of ACT service rendered.
8. Providing documentation will take some of the practitioner's time but is usually a clinical requirement.

16. Are there any proposed changes to the rules that will reduce a regulatory burden imposed on the business community? Please identify. (*Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors*).

No proposed change in any of the rules would result in a reduction of regulatory burden.

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

1. Provider agency certification supports the goal that agencies are equipped and qualified to provide appropriate and needed behavioral health services to Medicaid recipients.
2. Service provision requirements support the goal of Medicaid coverage only for appropriate, medically necessary services as well as supporting fraud, waste, and abuse prevention activities.
3. Practitioner requirements support the goal that individuals are equipped and qualified to provide appropriate and needed services to Medicaid recipients.
4. Meeting fidelity requirements supports the goal that an ACT team is equipped and qualified to provide appropriate and needed ACT services to Medicaid recipients.
5. Medical necessity for a specific service, by a Medicaid recipient, is a Medicaid requirement.
6. Provider agency ACT certification supports the goal that agencies are equipped and qualified to provide appropriate and needed ACT services to Medicaid recipients.
7. Reducing and eliminating fraud, waste, and abuse policies are strengthened by withholding payment to providers who are not qualified to render ACT services.
8. Service provision documentation is good clinical policy and helps support the medical necessity requirement.

Regulatory Flexibility

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

To ensure uniform and consistent treatment of Medicaid providers, the proposed rules do not offer any exemptions or alternate means of compliance based on a provider's size.

19. 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?

This regulation does not apply to this rule package because it does not impose any fine or penalty for a paperwork violation.

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

Medicaid providers in need of assistance can contact the Medicaid provider assistance telephone line at 1-800-686-1516. They and other stakeholders have access to behavioral health information on the Ohio Medicaid website, bh.medicaid.ohio.gov. The website also provides access to the behavioral health provider manual.

5160-8-05

Behavioral health services-other licensed professionals.

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

(1) Provisions governing payment for 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.

(2) 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) "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~~ services rendered by a psychiatrist nor medication management.

(2) "Licensed psychologist" has the same meaning as in ~~section 4732.01 of the Revised~~ rule 4732-1-02 of the Administrative 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~~ Administrative Code:

(a) Licensed professional clinical counselor, ~~section 4757.22~~ rule 4757-13-03;

(b) Licensed independent social worker, ~~section 4757.27~~ rule 4757-19-02;

(c) ~~Licensed independent~~ Independent marriage and family therapist, ~~section 4757.30~~ rule 4757-25-04;

(d) Licensed independent chemical dependency counselor, rule ~~4758-4-01-4758-5-05~~ 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 supervision in accordance with the indicated portion of the ~~Revised~~ Administrative Code:
- (a) Licensed professional counselor, ~~section 4757.23~~ rule 4757-13-02;
 - (b) Licensed social worker, ~~section 4757.28~~ rule 4757-19-01;
 - (c) ~~Licensed marriage~~ Marriage and family therapist, ~~section 4757.30~~ rule 4757-25-03;
 - (d) Licensed chemical dependency counselor II, rule ~~4758-4-01~~ 4758-5-03 ~~of the Administrative Code~~; and
 - (e) Licensed chemical dependency counselor III, rule ~~4758-4-01~~ 4758-5-04 ~~of the Administrative Code~~.
- (5) "Supervised trainee" is a collective term used in this rule to designate the following individuals ~~who can operate under the general or direct supervision of a licensed practitioner~~:
- (a) Registered counselor trainee, defined in rule ~~4757-13-09~~ 4757-1-10 of the Administrative Code;
 - (b) Registered social work trainee, defined in rule ~~4757-19-05~~ 4757-1-10 of the Administrative Code;
 - (c) Marriage and family therapist trainee, defined in rule ~~4757-25-08~~ 4757-1-10 of the Administrative Code;
 - (d) Chemical dependency counselor assistant, defined in rule ~~4758-4-01~~ 4757-5-01 of the Administrative Code; and
 - (e) Any individual registered with the Ohio board of psychology in compliance with requirements in rule ~~4732-13-04~~ 4732-15-01 of the Administrative Code, working under the supervision of a licensed psychologist, and assigned by the supervising psychologist a title appearing in rule 4732-13-03 of the Administrative Code, such as "assistant," "psychology assistant," "psychology intern," "psychology fellow," or "psychology resident."
- (6) "General supervision" is defined as supervision is available, although not necessarily present in the practice setting, to provide assistance and direction throughout the provision of services. A supervisor who is not physically present

has the capability to provide immediate consultation by communications device and can travel to the practice setting quickly in case of emergency. ~~as the supervising practitioner being available by phone to provide assistance as needed.~~

(7) "Direct supervision" ~~is defined~~ refers to a supervisor who is present in the practice setting, although not necessarily in the same room, and is immediately available either in person or via real-time audio-visual technology as allowed by the practitioner's licensing board to provide assistance and direction throughout the provision of services. ~~as the supervising practitioner being immediately available and interruptible to provide assistance as needed.~~

(8) "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 [Ohio department of](#) medicaid [\(ODM\)](#) 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 behavioral health services:
 - (a) Psychiatric diagnostic evaluation;

- (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) Effective July 1, 2027, child and adolescent needs and strengths (CANS) assessments, when administered by a CANS assessor.
- (d) Therapeutic services:
 - (i) Individual psychotherapy:
 - (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)~~ (b) 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);~~
 - (ii) Family psychotherapy for which the primary purpose is the treatment of the ~~patient~~ recipient and not family members:
 - (a) Family psychotherapy without ~~patient~~ recipient present; and
 - (b) Family psychotherapy with ~~patient~~ recipient present;
 - (iii) Group psychotherapy:
 - (a) Group psychotherapy; and
 - (b) Multiple-family group psychotherapy;
 - (iv) Interactive complexity

~~(v) Prolonged service~~

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

- (a) To a physician, group practice, clinic, or a community behavioral health center ~~that meets the requirements found in rule 5160-27-01 of the Administrative Code~~that is certified by the Ohio department of behavioral health, for a behavioral health service rendered by a licensed psychologist, or independent practitioner, employed by or under contract with the physician group practice, 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 or supervised trainee 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~~recipient's care has contact with the ~~patient~~recipient during the initial visit and 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~~recipient's care reviews and updates the ~~patient's~~recipient's medical record at least once after each treatment visit.
- (d) To a physician, advanced practice registered nurse, physician assistant, licensed psychologist in independent practice, or independent practitioner in independent practice for a behavioral health service personally rendered by that health care professional;.

(e) To a federally qualified health center (FQHC) or rural health center (RHC) in accordance with Chapter 5160-28 of the Administrative Code.

(3) At any time, with proper notice as defined in rule 5160-1-31 of the Administrative Code, ODM may subject the services listed in paragraph (D)(1) of this rule to limitations on initiation and continuation of services, frequency, scope, and duration of services and allowances for services to be provided on the same day. Current and historical limitations will be posted on the the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization."

~~(3) The following coverage limits, which may be exceeded only with prior authorization from the ODM designated entity, are established for behavioral health services provided to a medicaid recipient:~~

~~(a) For diagnostic evaluation, one 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 a maximum of twelve hours per recipient, per calendar 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.~~

(E) Constraints.

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

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

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

- (c) Services that are unrelated to the treatment of a specific behavioral health diagnosis 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,~~arts and crafts, game play, dance, listening ~~music~~to music watching television, movies or other forms of visual media, cosmetology, snack or meal breaks);
 - (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);
- (d) Psychotherapy services if the ~~patient~~recipient cannot establish a relationship with the provider because of a cognitive deficit;
- (e) Family therapy for the purpose of training family members or caregivers in the management of the ~~patient~~recipient; and
- (f) Self-administered or self-scored tests of cognitive function.;
- (g) Art, music, and equine therapies.

(F) Documentation of services.

- (1) The ~~patient's~~recipient'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 in addition to the following:-
- (a) All relevant diagnoses pertaining to medical or physical conditions as well as to behavioral health;
 - (b) A treatment plan which must be completed within five sessions or one month of admission, whichever is longer and must specify mutually agreed upon treatment goals, track responses to ongoing treatment, and present a

prognosis that documents that the plan has been reviewed with the ~~patient~~recipient and, as appropriate, with family members, parents, legal guardians or custodians or significant others;

- (c) The inability or refusal of the ~~patient~~recipient to participate in treatment planning or services must be documented and the reason given.
 - (d) Test results, if applicable, with interpretation;
 - (e) Evidence that the ~~patient~~recipient has sufficient cognitive capacity to benefit from treatment; and
 - (f) Discharge summaries which include date of admission, date of last service, outcome of the service and recommendations and referrals made to the ~~patient~~recipient.
- (2) The following items must be included as progress note documentation and shall be completed at a minimum on a per provision basis, or on a daily or weekly basis:
- (a) The type, description, date, time of day, duration, location and, if documenting weekly services, the frequency of treatment, with dates of service;
 - (b) A description of the ~~patient's~~recipient's current symptoms and changes in functional impairment;
 - (c) Changes in medications taken by or prescribed for the ~~patient~~recipient when applicable;
 - (d) The amount of time spent by the provider with the ~~patient~~recipient;
 - (e) The amount of time spent by the provider in interpreting and reporting on procedures represented by "Central Nervous System Testing" codes, when applicable;
 - (f) Progress notes shall include assessment of the ~~patient's~~recipient's progress or lack of progress and a brief description of the progress made, if any, significant changes in symptoms, functioning, or events in the life of the ~~patient~~recipient and recommendation for modifications to the treatment plan, if applicable; and
 - (g) Evidence of clinical supervision, as required.

(G) Claim payment.

The payment amount for a behavioral health service [stated in the appendix to rule 5160-27-03 of the Administrative Code and](#) rendered by a community behavioral health center that meets the requirements found in rule 5160-27-01 of the Administrative Code is the lesser of the provider's submitted charge or the amount specified in [the appendix to](#) rule 5160-27-03 of the Administrative Code. For all other providers of behavioral health services, the payment amount is the lesser of the provider's submitted charge or the applicable percentage of the amount specified in the appendix to rule 5160-1-60 of the Administrative Code:

- (1) For [psychological](#) testing, one hundred per cent;
- (2) For a behavioral health service other than [psychological](#) 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 [of the maximum rate](#).
 - (b) For a service rendered by a licensed practitioner or a supervised practitioner, it is eighty-five per cent [of the maximum rate](#).
 - (c) For a service rendered by a supervised trainee/assistant under direct supervision, the rate of their supervising practitioner.
 - (d) For a service rendered by a supervised trainee/assistant under general supervision, it is eighty-five per cent of the rate of their supervising practitioner.

5160-27-01 **Eligible provider of community behavioral health services.**

(A) For the purposes of this chapter, an "eligible billing provider" is an entity that meets the conditions in paragraph (A)(1) or (A)(2) of this rule. An "eligible rendering provider" is an individual who meets one or more of the conditions stated in paragraphs (A)(3) to (A)(8) of this rule and is employed by or under contract with an eligible billing provider.

- (1) An entity certified by the Ohio department of ~~mental health and addiction services~~ behavioral health (DBH) operating in accordance with sections 5119.35 and 5119.36 of the Revised Code and Chapters 5122-24 to 5122-29 and Chapter 5160-1 of the Administrative Code and providing mental health or substance use disorder treatment services in accordance with the services and supports listed on their DBH certifications and national accreditation standards.
- (2) An out-of-state entity furnishing mental health and/or substance use disorder services and operating in accordance with rule 5160-1-11 of the Administrative Code.
- (3) Physician or physician assistant in accordance with agency 4731 and agency 4730 of the Administrative Code, respectively, and Chapter 5160-4 of the Administrative Code, or a clinical nurse specialist or certified nurse practitioner, as described in Chapter 4723. of the Revised Code.
- (4) Registered nurse or licensed practical nurse as defined in section 4723.01 of the Revised Code and working under an order authorized by one of the practitioners listed in paragraph (A)(3) of this rule, except as allowable in accordance with section 4723.01 of the Revised Code or rule 5160-27-11 of the Administrative Code.
- (5) A practitioner type described in rule 5160-8-05 of the Administrative Code.
- (6) An unlicensed practitioner who operates under general supervision, as described in rule 5160-8-05 of the Administrative Code, of one of the practitioners listed in paragraphs (D)(1) to (D)(~~17~~16) of this rule and meets the requirements for one of the following practitioner types:
 - (a) A qualified mental health specialist providing mental health services who:
 - (i) Meets the requirements for a qualified behavioral health specialist in accordance with agency 5122 of the Administrative Code,
 - (ii) Holds a valid high school diploma or equivalent, and

(iii) Has both work experience and training related to the service(s) being provided.

(b) A care management specialist providing substance use disorder services who:

(i) Meets the requirements for a qualified behavioral health specialist in accordance with agency 5122 of the Administrative Code,

(ii) Is eighteen years of age or older and has a high school diploma or equivalent, and

(iii) Has an understanding of substance use disorder treatment and recovery including how to engage a person in treatment and recovery.

(7) A pharmacist operating in accordance with rule 5160-8-52 of the Administrative Code.

(8) A certified peer supporter operating in accordance with rule 5122-29-15.1 of the Administrative Code.

(B) All practitioners will practice within their professional scope of practice.

(C) Supervisors will ensure that individuals whom they supervise meet the appropriate education and training qualifications for the service(s) they render.

(D) The following practitioners operating within their scope of practice, licensure, or certification, and in accordance with any service-specific ~~supervision~~supervision requirements may supervise:

(1) Physician.

(2) Physician assistant.

(3) Certified nurse practitioner.

(4) Clinical nurse specialist.

(5) Psychologist.

(6) Board licensed school psychologist.

(7) Licensed independent social worker.

5160-27-01

3

- (8) Licensed professional clinical counselor.
- (9) ~~Licensed independent~~ Independent marriage and family therapist.
- (10) Licensed independent chemical dependency counselor.
- (11) Registered nurse.
- (12) ~~Licensed marriage~~ Marriage and family therapist.
- (13) Licensed chemical dependency counselor II.
- (14) Licensed chemical dependency counselor III.
- (15) Licensed professional counselor.
- (16) Licensed social worker.
- (17) Certified peer supporter as defined in rule 5122-29-15.1 of the Administrative Code.

5160-27-02

Coverage and limitations of behavioral health services.

- (A) This rule sets forth coverage and limitations for behavioral health services rendered to medicaid recipients by behavioral health provider agencies who meet all obligations found in agency 5160 of the Administrative Code unless otherwise specified.
- (1) All claims for behavioral health services submitted to the Ohio department of medicaid (ODM) will include an ICD-10 diagnosis of mental illness or substance use disorder. The list of recognized diagnoses can be accessed at www.medicaid.ohio.gov.
- (2) ODM reimbursable behavioral health services are limited to medically necessary services defined in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code. Providers will follow the criteria in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code regarding services that cannot be billed in combination with other services.
- (B) The following services may be subject to limitation on amount, scope, or duration of service that can be rendered to a recipient within a certain timeframe without authorization. Current and historical limitations may be found within the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization."
- (1) Individual and group therapeutic behavioral services (TBS) and psychosocial rehabilitation (PSR) as described in rule 5160-27-08 of the Administrative Code;
- (2) Assertive community treatment (ACT) as described in rule 5160-27-04 of the Administrative Code;
- (3) Mental health day treatment hourly and mental health day treatment per diem as described in rule 5160-27-06 of the Administrative Code;
- (4) Behavioral health nursing as described in rule 5160-27-11 of the administrative Code;
- (5) Screening, brief intervention and referral to treatment (SBIRT) as defined by the American medical association's current procedural terminology;
- (6) Psychological or neuropsychological testing;
- (7) Psychiatric diagnostic evaluation with or without medical services;

5160-27-02

2

(8) Psychotherapy, including family, group and multiple-family;

(9) Peer support, as described in rule 5160-27-14 of the Administrative Code.

(C) The following services delivered to recipients with substance use disorders may be subject to limitations on amount, scope or duration of service that can be rendered to a recipient within a certain timeframe without authorization. Current and historical limitations may be found within the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization."

(1) Substance use disorder assessment as referenced in rule 5160-27-09 of the Administrative.

(2) Substance use disorder urine drug screening as referenced in rule 5160-27-09 of the Administrative.

(3) Substance use disorder partial hospitalization as described in rule 5160-27-09 of the Administrative Code.

(4) Substance use disorder residential level of care as described in rule 5160-27-09 of the Administrative Code.

(5) Substance use disorder case management as described in rule 5160-27-10 of the Administrative Code.

(6) Substance use disorder withdrawal management as described in rule 5160-27-09 of the Administrative Code.

(7) Substance use group counseling as described in rule 5160-27-09 of the Administrative Code.

(8) Substance use disorder intensive outpatient services as described in rule 5160-27-09 of the Administrative Code.

(D) The medications listed in appendix DD to rule 5160-1-60 of the Administrative Code, or the fee schedule located on the ODM website are covered by ODM when rendered and billed by an eligible provider as described in rule 5160-27-01 of the Administrative Code. The medication has to be administered by a qualified practitioner acting within their professional scope of practice.

(E) Laboratory services, vaccines, and medications administered in a prescriber office may be administered in accordance with rule 5160-1-60 of the Administrative Code.

(F) Medical and evaluation and management services stated in the appendix to rule 5160-27-03 of the Administrative Code or appendix DD to rule 5160-1-60 of the Administrative Code are covered by ODM when rendered by:

- (1) A practitioner as described in paragraphs (A)(3) and (A)(4) of rule 5160-27-01 of the Administrative Code and operating within their scope of practice; or
- (2) A pharmacist, rendering services in accordance with rule 5160-8-52 of the Administrative Code.

(G) Centers for medicare and medicaid services (CMS) place of service (POS) code set descriptions may be found at www.cms.gov.

- (1) The department further defines place of service 99 as "community," and this place of service may only be used when a more specific place of service is not available. Place of service 99 can not be used to provide services to a recipient of any age if the recipient is being held in a public institution as defined in 42 C.F.R. 435.1010 42 CFR 435.1010 (October 1, 2023) nor can it be used when the actual place of service is not permissible by CMS.
- (2) Place of service 11 can only be used when the full CMS definition is met and cannot be used as a substitute when the actual POS is not permitted by CMS or ODM.
- (3) Services with an allowable place of service 21, 23, and 51 can only be rendered in those locations for the purpose of supporting admission to and discharge from the hospital.

(H) The reimbursable ODM activities listed in paragraphs (B) and (C) of this rule are intended to achieve individualized goals or objectives as identified in the treatment plan and supported by an assessment. Providers will maintain treatment records and progress notes that provide support for medically necessary service provision as specified in rules 5160-01-27 and 5160-8-05 of the Administrative Code.

- (1) A treatment plan for mental health services may only be developed by a licensed practitioner as identified in paragraphs (D)(1) through (D)(6) of rule 5160-27-01 of the Administrative Code. An unlicensed practitioner as defined in paragraph (A)(6)(a) of rule 5160-27-01 of the Administrative Code may develop a treatment plan only under the supervision of a licensed practitioner.
- (2) A treatment plan for substance use disorder services may only be developed by a practitioner who, at a minimum meets the practitioner criteria found in paragraph (A)(6)(b) of rule 5160-27-01 of the Administrative Code.

- (I) The medications and services listed in the appendix to rule 5160-27-03 of the Administrative Code or the opiate treatment service section of appendix DD to rule 5160-1-60 of the Administrative Code are reimbursed by ODM when rendered and billed by an opiate treatment program as described in Chapter 5122-40 of the Administrative Code and licensed as such by the Ohio department of behavioral health or federally certified as such as stated in 42 CFR 8.11 (October 1, 2026). Reimbursement rates are determined by the methodology described in rule 5160-4-12 of the Administrative Code or as listed in the appendix to rule 5160-27-03 of the Administrative Code or as listed in appendix DD to rule 5160-1-60 of the Administrative Code.
- (J) When permitted, provision of any service addressed in Chapter 5160-27 of the Administrative Code has to comply with the appropriate telehealth criteria found in rule 5160-1-18 of the Administrative Code. For community behavioral health providers certified by the Ohio department of behavioral health, telehealth services has to also be rendered in accordance with rule 5122-29-31 of the Administrative Code.
- (K) The services described in this chapter will not substitute or supplant unpaid familial, community, vocational, or educational supports and do not include any of the following:
- (1) Educational, or job training services or vocational and supported employment services unless the recipient is enrolled and receiving any of these types of services through the specialized recovery services program as described in rule 5160-43-01 of the Administrative Code.
 - (2) Room and board.
 - (3) Habilitation services including but not limited to financial management, supportive housing, and basic skill acquisition services that are habilitative in nature.
 - (4) Recreational and social activities, including but not limited to arts and crafts, game play, cosmetology, listening to music, watching television, movies, or other forms of visual media, and equine therapies;
 - (5) Meal or snack time;
 - (6) Clinical supervision is not reimbursable by supervisor or supervisee. Activities fall under supervision include, but are not limited to, individual or group supervision, facilitation of team or program meetings, oversight of treatment plan development, oversight of assessment, education, or training related to primary

job responsibilities, activities to support professional skills development, clinical case consultation, observation, clinical documentation review.

(7) Collateral contacts with another clinician or colleague employed by the same organizational provider under the same line of business are not reimbursable. Contacts between rendering providers under the same organization but in a different line of business are reimbursable by ODM if all the following components are met:

(a) The medicaid recipient has given consent to the collateral contact and this is documented in the medical record. If the recipient is incapacitated or otherwise unable to provide consent, a statement that justifies the need for contact without consent will be documented by the initiating provider.

(b) There is a clearly stated purpose for the cross-disciplinary contact that directly relates to the recipient's treatment plan.

(c) The outcome of the contact is beneficial to the recipient served and is documented in the medical record.

(d) Concurrent reimbursement for the contact by each individual provider is prohibited.

(8) Services that are covered elsewhere in agency 5160 of the Administrative Code; and

(9) Transportation for the recipient or family unless otherwise permitted by rule 5160-27-13 of the Administrative Code.

(L) The "Ohio children's initiative brief CANS assessment" and the "Ohio children's initiative comprehensive CANS assessment" are covered as defined in rule 5160-59-01 of the Administrative Code and may be billed separately for reimbursement. Payment for therapeutic behavioral services, psychosocial rehabilitation, psychotherapy, or psychiatric diagnostic evaluation is not allowable for provision of the Ohio brief or Ohio comprehensive CANS assessment.

TO BE RESCINDED

5160-27-04

Mental health assertive community treatment service.

- (A) For the purposes of medicaid reimbursement, assertive community treatment (ACT) refers to the evidence based model of delivering comprehensive community based behavioral health services to adults with certain serious and persistent mental illnesses who have not benefited from traditional outpatient treatment. The ACT model utilizes a multidisciplinary team of practitioners to deliver services to eligible individuals.
- (B) For the purposes of this rule, collateral contact occurs when the practitioner contacts individuals who play a significant role in a medicaid recipient's life. The information gained from the collateral contact can provide insight into treatment or the basic psychoeducation provided to that collateral contact can assist with the treatment of the medicaid recipient.
- (C) The ACT team is the sole provider to ACT recipients of outpatient behavioral health services, including level one outpatient services as defined by the American society of addiction medicine.
- (D) ACT services include but are not limited to the following:
 - (1) Psychiatry and primary care as related to the mental health or substance use disorder diagnoses;
 - (2) Service coordination;
 - (3) Crisis assessment and intervention;
 - (4) Symptom assessment and management;
 - (5) Community based rehabilitative services;
 - (6) Education, support, and consultation to families, legal custodians, and significant others who are part of the recipient's support network.
- (E) The desired outcomes of ACT intervention for medicaid recipients include but are not limited to:
 - (1) Achieving and maintaining a stable life in a community based setting;

(2) Reducing the need for inpatient hospital admission and emergency department visits;

(3) Improving mental and physical health status, and improving life satisfaction.

(F) A medicaid recipient may receive ACT services when determined by the ODM designated entity to have met all of the following:

(1) The recipient has a diagnosis of schizophrenia, bipolar, or major depressive disorder with psychosis, in accordance with the ICD-10 diagnosis code group list found at <https://bh.medicaid.ohio.gov/manuals>;

(2) The recipient has a supplemental security income or social security disability insurance determination or has a score of two or greater on at least one of the items in the "mental health needs" or "risk behaviors" sections or a score of three on at least one of the items in the "life domain function" section of the adult needs and strengths assessment (ANSA) administered by an individual with a bachelor's degree or higher and with training in the administration of the assessment; and

(3) The recipient has one or more of the following:

(a) Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months; or

(b) Two or more occasions of utilizing psychiatric emergency services during the past twelve months; or

(c) Significant difficulty meeting basic survival needs within the last twenty-four months; or

(d) History within the past two years of criminal justice involvement including but not limited to arrest, incarceration, or probation; and

(4) The recipient experiences one or more of the following:

(a) Persistent or recurrent severe psychiatric symptoms; or

(b) Coexisting substance use disorder of more than six month in duration; or

(c) Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided; or

(d) At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available; or

(e) Has been unsuccessful in using traditional office-based outpatient services; and

(5) The recipient is eighteen years of age or older at the time of ACT enrollment.

(G) Prior authorization of ACT services.

(1) The provider must submit a request for prior authorization and receive approval from the ODM designated entity before ACT services can be rendered. The request for prior authorization must be accompanied by the appropriate documentation which includes, but is not limited to, the ANSA results or the documentation that supports the social security determination. The maximum amount of ACT service which may be prior authorized at any one time is twelve months.

(2) At the conclusion of the previous ACT service period, the provider agency may request additional ACT service to be prior authorized by the ODM designated entity.

(3) The provider may begin submitting claims for medicaid reimbursement of ACT services for dates of service within the subsequent calendar month following the date on which prior authorization is approved by the ODM designated entity.

(H) Disenrollment of a recipient from ACT. Upon planned or unplanned disenrollment of an ACT recipient, the ACT team shall document the circumstances regarding disenrollment in the recipient's medical record.

(1) A planned disenrollment from ACT occurs when a recipient, or recipient's guardian and ACT team members mutually agree to the termination of ACT services and transition of the recipient to a different care setting, provider, or benefit package. A planned disenrollment is appropriate when:

(a) The recipient has successfully reached established goals for disenrollment and the recipient and/or their guardian and ACT team members agree to the discharge from ACT; or

(b) The recipient moves outside the geographic area of the ACT team's responsibility. In such cases, the ACT team shall arrange to transfer mental health and substance use disorder service responsibility to another ACT program or other provider wherever the recipient is moving.

The ACT team shall maintain contact with the recipient until the transfer is complete; or

- (c) The recipient or their guardian requests a disenrollment; or
 - (d) The recipient is determined by the ODM designated entity to no longer meet the eligibility or medical necessity criteria for ACT.
- (2) As part of a planned disenrollment, the ACT team shall document that the recipient has actively participated in disenrollment activities by documenting in the recipient's medical record the following information:
- (a) The reason(s) for the recipient's disenrollment as stated by both the recipient and the ACT team;
 - (b) The recipient's progress toward the goals set forth in the treatment plan;
 - (c) Documentation that the recipient's behavioral health care is being linked and transferred to a provider other than the ACT team;
 - (d) The signature of the recipient or their guardian, the ACT team leader, and the psychiatric prescriber.
- (3) A recipient's disenrollment from ACT may be unplanned and due to circumstances facilitated by:
- (a) The inability of the ACT team to locate the recipient for more than forty-five days; or
 - (b) The recipient's incarceration, hospitalization or admission to a residential substance use disorder treatment facility. In these circumstances, the primary responsibility for the recipient's health care is transferred to the aforementioned setting.
 - (i) The ACT team is expected to maintain contact with the recipient to assist with transition between settings if the recipient is likely to be discharged and resume service from the ACT team within two months.
 - (ii) If the recipient's stay is predicted to be longer than two months, the recipient shall be disenrolled from the ACT team.
 - (iii) The recipient may be re-enrolled with the ACT team when discharged from the incarcerated, inpatient or residential setting. Any re-

enrollment shall follow the eligibility determination criteria described in paragraph (F) of this rule.

- (4) Except for services found in paragraph (O) of this rule, a recipient may not obtain behavioral health services from a provider other than the ACT team unless the recipient is disenrolled from ACT services.
- (5) The provider must inform the ODM designated entity of disenrollment within three business days of the discharge date. The ODM designated entity shall deactivate the authorization for the ACT service. Failure to timely dis-enroll the recipient from ACT may result in claim denial for other mental health or substance use disorder services.

(I) A provider furnishing ACT services must meet both of the following criteria:

- (1) Meets the eligibility requirements found in paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code; and
- (2) Employs one or more teams of mental health and substance use disorder practitioners who comprise the ACT treatment team.

(J) Each team must meet the following criteria:

- (1) Completed a fidelity review within the previous twelve months by an independent validation entity recognized by ODM. In year one of an ACT team's participation with Ohio medicaid the team must participate in a fidelity review based on the dartmouth assertive community treatment scale (DACTS) and performed by an independent validation entity recognized by ODM. The DACTS fidelity scale and protocol can be found at www.medicaid.ohio.gov.
 - (a) Fidelity reviews of ACT teams must be repeated every twelve months from the report date of the previous fidelity review.
 - (b) An ACT team must have documented evidence of compliance to the requirements stated in paragraph (J) of this rule prior to submitting any prior authorization requests for recipients of ACT services.
- (2) Each team shall have a designated full-time team leader who may serve in that capacity with only one team.
 - (a) An ACT team leader shall have a national provider identification number and be actively enrolled as an Ohio medicaid provider.

- (b) A team leader shall have psychiatric training and shall hold one of the following valid licenses from the appropriate Ohio professional licensure board or licensure equivalents for ACT teams located in other states:
 - (i) Licensed independent social worker.
 - (ii) Licensed independent marriage and family therapist.
 - (iii) Licensed professional clinical counselor.
 - (iv) Licensed psychologist.
 - (v) Physician – medical doctor, psychiatrist, doctor of osteopathy.
 - (vi) Clinical nurse specialist
 - (vii) Certified nurse practitioner.
 - (viii) Physician assistant.
 - (ix) Registered nurse.
 - (c) Team leaders who are licensed in accordance with paragraph (A)(5) of rule 5160-27-01 of the Administrative Code but do not have independent licensure status from one of the boards referenced in paragraph (A)(5) of rule 5160-27-01 of the Administrative Code must receive approval from ODM before the ACT team to which they are assigned can begin billing Ohio medicaid.
- (3) ACT teams that employ peer recovery supporters must ensure that they meet the criteria and requirements for the peer recovery support services set forth in rule 5160-43-09 of the Administrative Code.
- (4) ACT teams must have a caseload no greater than one hundred and twenty and must maintain an average caseload ratio of one practitioner for every ten ACT recipients. Upon request from the ODM, the ACT team must provide to the ODM or its designated entity the ACT team caseload size and composition of medicaid and non-medicaid enrollees.
- (K) ODM reserves the right to suspend or terminate the payment of ACT services and to require subsequent review of an ACT team's fidelity performance if ODM has reason to believe that the ACT team's fidelity to the DACTS model described in paragraph (J)(1) of this rule may be in question. ODM may, at its discretion, suspend payment of ACT medicaid claims from the provider agency employing the ACT team until such

time as ODM receives documentation from its independent validation entity that the team does meet the fidelity criteria described in paragraph (J)(1) of this rule.

(L) A provider employing an ACT team may bill up to four ACT units per month per recipient when all clinical and billing requirements for each unit are met. The billing of ACT units are subject to the following limits per provider category, per recipient, per month:

(1) Not more than one unit may be billed per medicaid recipient per month for services rendered by the ACT team medical prescriber including physician, clinical nurse specialist, certified nurse practitioner, or physician assistant operating within their respective scopes of practice.

(2) Not more than one unit per medicaid recipient per month may be billed for services rendered by any one of the following ACT team members: psychologist, licensed independent social worker, licensed social worker, licensed clinical social worker, licensed professional counselor, licensed professional clinical counselor, licensed independent clinical counselor, licensed independent marriage and family therapist, licensed marriage and family therapist, licensed practical nurse, registered nurse, licensed independent chemical dependency counselor, licensed chemical dependency counselor II or licensed chemical dependency counselor III.

(3) Not more than two units per medicaid recipient per month may be billed by an ACT team member not listed in paragraph (L)(1) or (L)(2) of this rule. This unit category includes: psychology assistant, psychology intern, psychology trainee, social worker assistant, social worker trainee, marriage and family therapist trainee, counselor trainee, chemical dependency counselor assistant, qualified mental health specialist (QMHS), including QMHS with three or more years of experience, and peer recovery supporter.

(M) The medicaid payment rates for ACT are stated in the appendix to rule 5160-27-03 of the Administrative Code. Payment for services provided by authorized ACT teams is only available for dates of services on or after January 1, 2018.

(N) ACT teams shall maintain regular contact and deliver all medically necessary outpatient mental health and substance use disorder services and supports to ACT recipients enrolled with their team.

(O) Services rendered by the ACT team medical prescriber, including physician, clinical nurse specialist, certified nurse practitioner, or physician assistant, are billable when rendered to an ACT recipient or via a case specific consultation with another member of the ACT team regarding the medical aspects of the ACT recipient's treatment plan.

The ACT team medical prescriber must have at least one contact with each ACT recipient every three months.

(P) When a recipient is enrolled on an ACT team, no other medicaid community behavioral health services, as defined in Chapter 5160-27 of the Administrative Code, are eligible for reimbursement except:

- (1) Supported employment as identified on a recipient's specialized recovery services program treatment plan if applicable, as described in rule 5160-43-01 of the Administrative Code.
- (2) Substance use disorder services that are not considered part of the benefit package encompassed under level one of the american society of addiction medicine (ASAM) as defined in rule 5160-27-09 of the Administrative Code. Prior authorization from the ODM designated entity is required.
- (3) Crisis services furnished by a provider other than the billing provider agency employing the ACT team.

(Q) Documentation requirements for ACT.

- (1) Documentation in the recipient's medical record of the services provided by the ACT team must meet the requirements stated in this paragraph as well as those stated in rules 5160-1-27 and 5160-8-05 of the Administrative Code.
- (2) The ACT team must develop a specific treatment plan for each enrolled recipient. The treatment plan must, at a minimum, meet the requirements of rule 5160-8-05 of the Administrative Code plus the following additional requirements:
 - (a) The treatment plan shall be individualized based on the recipient's needs, strengths, and preferences and shall set measurable long-term and short-term goals and specify approaches and interventions necessary for the recipient to achieve the recipient goals. The treatment plan shall also identify who will carry out the approaches and interventions.
 - (b) The treatment plan shall address, at a minimum, the following key areas:
 - (i) Psychiatric illness or symptom reduction.
 - (ii) Stable, safe, and affordable housing.
 - (iii) Activities of daily living.
 - (iv) Daily structure and activities, including employment if appropriate.

(v) Family and social relationships.

(c) The treatment plan shall be reviewed and revised by a member of the ACT team with the recipient whenever a change is needed in the recipient's course of treatment or at least every six months. In conjunction with a treatment plan review, the ACT team member shall prepare a summary of the recipient's progress, goal attainment, effectiveness of the intervention and recipient's satisfaction with the ACT team interventions since enactment of the previous treatment plan.

(d) The treatment plan, and all subsequent revisions of it, shall be reviewed and signed by the recipient and the ACT team practitioner.

(R) The following activities performed by members of the ACT team are not eligible for reimbursement:

(1) Time spent attending or participating in recreational activities.

(2) Services provided to teach academic subjects or as a substitute for educational personnel, including but not limited to a teacher, teacher's aide, or an academic tutor.

(3) Habilitative services for the recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.

(4) Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.

(5) Respite care.

(6) Transportation for the recipient or family.

(7) Services provided to children, spouse, parents, or siblings of the eligible recipient under treatment or others in the eligible recipient's life to address problems not directly related to the eligible recipient's issues and not listed in the eligible recipient's ACT treatment plan.

(8) Art, movement, dance, or drama therapies.

(9) Services provided to collaterals of the recipient.

(10) Contacts that are not medically necessary.

- (11) Any service outside the responsibility of the ACT team.
- (12) Vocational training and supported employment services, unless the recipient is enrolled in the specialized recovery services program as described in rule 5160-43-01 of the Administrative Code.
- (13) Crisis intervention provided by the provider agency employing the ACT team.

Effective:

Five Year Review (FYR)
Dates:

Certification

Date

Promulgated	119.03
Under:	
Statutory Authority:	5162.02, 5164.02
Rule Amplifies:	5164.02 , 5164.03
Prior Effective	01/01/2018, 08/01/2019 (Emer.), 11/29/2019,
Dates:	06/12/2020 (Emer.), 01/01/2021

5160-27-04

Mental health assertive community treatment service.

- (A) For the purposes of Ohio department of medicaid (ODM) reimbursement, assertive community treatment (ACT) as described in rule 5122-29-29 of the Administrative Code refers to the evidence based model of delivering comprehensive community based behavioral health services to adults with certain serious and persistent mental illnesses who have not benefited from traditional outpatient treatment. The ACT model utilizes a multidisciplinary team of practitioners to deliver services to eligible recipients.
- (B) The ACT team is the sole provider of outpatient behavioral health services, including level one outpatient services as defined by the American society of addiction medicine.
- (C) ACT services include but are not limited to the following:
- (1) Psychiatry and primary care as related to the mental health or substance use disorder diagnoses;
 - (2) Service coordination;
 - (3) Crisis assessment and intervention;
 - (4) Symptom assessment and management;
 - (5) Community based rehabilitative services;
 - (6) Education, support, and consultation to families, legal custodians, and significant others who are part of the recipient's support network.
- (D) A medicaid recipient may receive ACT services when determined by the ODM designated entity to have met all of the following:
- (1) The recipient has a valid and current behavioral health diagnosis in accordance with the ICD-10 diagnosis code group list found at <https://bh.medicaid.ohio.gov/manuals>;
 - (2) The recipient has one or more of the following:
 - (a) A supplemental security income or social security disability insurance determination.
 - (b) A score of two or greater on at least one of the items in the "mental health needs" or "risk behaviors" section of the adult needs and strengths assessment (ANSA) that is administered by an individual with a bachelor's

5160-27-04

2

degree or higher and with documented training in the administration of the assessment; or

(c) A score of three on at least one of the items in the "life domain function" section of the ANSA that is administered by an individual with a bachelor's degree or higher and with documented training in the administration of the assessment, and

(3) The recipient has one or more of the following:

(a) Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months;

(b) Two or more occasions of utilizing psychiatric emergency services during the past twelve months;

(c) Significant difficulty meeting basic survival needs within the last twenty-four months; or

(d) History within twenty-four months of criminal justice involvement including but not limited to arrest, incarceration, or probation; and

(4) The recipient experiences one or more of the following:

(a) Persistent or recurrent severe psychiatric symptoms;

(b) Coexisting substance use disorder of more than six month in duration;

(c) Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided;

(d) At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available; or

(e) Has been unsuccessful in using traditional office-based outpatient services; and

(5) The recipient is eighteen years of age or older at the time of ACT enrollment.

(E) ACT services may be subject to limitations on initiation and continuation of services which will be listed on the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization." If applicable, a provider may begin submitting claims for medicaid

5160-27-04

3

reimbursement of ACT services for dates of service within the subsequent calendar month following the date on which services are authorized by ODM or its designee if applicable.

(F) Upon disenrollment of an ACT recipient, the ACT team will document the circumstances regarding disenrollment in the recipient's medical record.

(1) Except for services found in paragraph (K) of this rule, a recipient may not obtain behavioral health services from a provider other than the ACT team unless the recipient is disenrolled from ACT services.

(2) The provider has to inform ODM or its designee of enrollment within three business days of the discharge date so that ODM or its designee can deactivate the recipient's authorization for the ACT service. Failure to inform ODM or its designee of disenrollment from ACT within this timeline may result in claim denial for other mental health or substance use disorder services.

(G) An agency providing ACT services will hold current ACT certification given by the Ohio department of behavioral health.

(1) The ACT team will be in compliance with the fidelity requirements as stated in rule 5122-29-29 of the Administrative Code.

(2) ACT teams that employ certified peer supporters will ensure that they meet the criteria for the peer recovery support services set forth in rules 5122-29-15 and 5122-29-15.1 of the Administrative Code.

(H) ODM reserves the right to suspend or terminate the payment of ACT services and to expect subsequent review of an ACT team's fidelity performance if ODM has reason to believe that the ACT team's fidelity to the DACTS model described in paragraph (J)(1) of this rule may be in question. ODM may, at its discretion, suspend payment of ACT medicaid claims from the provider agency employing the ACT team until such time as ODM receives documentation from its independent validation entity that the team does meet the fidelity criteria described in paragraph (J)(1) of this rule.

(I) A provider employing an ACT team may bill up to four ACT units per month per recipient when all clinical and billing criteria for each unit are met. The billing of ACT units are subject to the following limits per provider category, per recipient, per month:

(1) Not more than one unit may be billed per medicaid recipient per month for services rendered by the ACT team medical prescriber including physician, clinical nurse specialist, certified nurse practitioner, or physician assistant operating within their respective scopes of practice.

- (2) Not more than one unit per medicaid recipient per month may be billed for services rendered by any one of the following ACT team members: psychologist, licensed independent social worker, licensed social worker, licensed clinical social worker, licensed professional counselor, licensed professional clinical counselor, licensed independent clinical counselor, licensed independent marriage and family therapist, marriage and family therapist, licensed practical nurse, registered nurse, licensed independent chemical dependency counselor, licensed chemical dependency counselor II or licensed chemical dependency counselor III.
- (3) Not more than two units per medicaid recipient per month may be billed by an ACT team member not listed in paragraph (L)(1) or (L)(2) of this rule. This unit category includes: psychology assistant, psychology intern, psychology trainee, social worker assistant, social worker trainee, marriage and family therapist trainee, counselor trainee, chemical dependency counselor assistant, qualified mental health specialist (QMHS), including QMHS with three or more years of experience, and peer recovery supporter.
- (J) Services rendered by the ACT team medical prescriber, including physician, clinical nurse specialist, certified nurse practitioner, or physician assistant, are billable when rendered to an ACT recipient or via a case specific consultation with another member of the ACT team regarding the medical aspects of the ACT recipient's treatment plan. The ACT team medical prescriber has to have at least one direct contact with each ACT recipient every three months.
- (K) When a recipient is enrolled on an ACT team, no other ODM reimbursable community behavioral health services, as defined in Chapter 5160-27 of the Administrative Code, are eligible for reimbursement except:
- (1) Supported employment as identified on a recipient's specialized recovery services program treatment plan if applicable, as described in rule 5160-43-01 of the Administrative Code.
- (2) Crisis services furnished by a provider other than the billing provider agency employing the ACT team.
- (3) Other allowable services as described in the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization."
- (L) The following activities performed by members of the ACT team are not eligible for reimbursement:

- (1) Activities listed in paragraph (K) of rule 5160-27-02 of the Administrative Code.
- (2) Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- (3) Respite care.
- (4) Services provided to children, spouse, parents, or siblings of the eligible recipient under treatment or others in the eligible recipient's life to address problems not directly related to the eligible recipient's issues and not listed in the eligible recipient's ACT treatment plan.
- (5) Drama therapies.
- (6) Any service outside the responsibility of the ACT team.
- (7) Vocational training and supported employment services, unless the recipient is enrolled in the specialized recovery services program as described in rule 5160-43-01 of the Administrative Code.
- (8) Crisis intervention provided by the provider agency employing the ACT team.

5160-27-06

Mental health day treatment hourly and per diem group counseling services.

(A) Mental health day treatment programs are multimodal services as described in rule 5122-29-06 of the Administrative Code. Mental health day treatment programs are intensive, structured, goal-oriented, distinct and identifiable treatment services that address the individualized mental health needs of the recipient and that have been clinically indicated by assessment. The environment at this level of treatment is highly structured. The purpose and intent of mental health day treatment programs are to stabilize, increase or sustain the highest level of functioning. Recipients receiving mental health day treatment will have a treatment plan that includes explicit and measurable goals that define patient improvement.

(B) For the purpose of Ohio department of medicaid (ODM) reimbursement, this rule refers to the group counseling component of mental health day treatment programs.

(1) These group counseling services include but are not limited to the following:

(a) Development and strengthening of interpersonal and social competencies, including problem-solving, conflict resolution, and other skills necessary for the maintenance of functional relationships in home, school, community or vocational settings;

(b) Identification, development, and facilitation of positive coping mechanisms for the regulation and management of emotions and behavior;

(c) Managing mental health and behavioral symptoms to enhance vocational or educational opportunities or independent living skills; and

(d) Psychoeducational services including instruction and training of the recipient to increase their knowledge and understanding of their psychiatric diagnosis(es), prognosis(es), treatment, and recovery, improve their skills, and favorably affect their outcomes.

(C) Service criteria.

(1) As defined in rule 5122-29-06 of the Administrative Code, mental health day treatment is distinguished by treatment intensity. Treatment intensity (i.e. number of hours per week), treatment duration and the delivery of additional individual treatment services are individualized, designed to meet the needs of the recipient and adjusted according to the recipient's response to therapy and their ability to participate effectively in all treatment elements. For the purposes of ODM reimbursement, the group counseling services of mental health day treatment can be delivered as an hourly or per diem service.

(a) Mental health day treatment hourly group counseling. Reimbursement for mental health day treatment hourly is limited to ten hours per week and is reimbursed on an hourly basis:

(b) Mental health day treatment per diem group counseling is reimbursed as a per diem rate. Mental health day treatment per diem group counseling service provision has to meet the following criteria:

(i) Be provided for 3.5 hours or more per day; and

(a) If a recipient attends a session for at least one hour and forty-five minutes but for less than 3.5 hours, the rendering provider may be reimbursed at fifty per cent of their provider type per diem rate for that session.

(ii) Be provided for a minimum of 10.5 hours per week.

(a) If at any time during the episode of care, a recipient fails to complete the minimum weekly service criteria of 10.5 hours per week of group counseling for two consecutive weeks, any existing service authorizations will be rescinded, but services may still be reimbursed at a lower level of care not to exceed ten hours per week.

(2) Mental health day treatment hourly and per diem services are:

(a) Provided by a licensed practitioner or unlicensed mental health practitioner as defined in paragraph (A)(2) of rule 5160-27-08 of the Administrative Code.

(i) Effective July 1, 2027, mental health day treatment hourly and per diem group counseling services can only be provided by a licensed practitioner as described in rule 5160-27-01 of the Administrative Code.

(b) Maintain a staff to recipient ratio that does not exceed 1:12.

(D) Limitations.

(1) Reimbursement for mental health day treatment hourly and per diem group counseling services will not be made while the recipient is enrolled in assertive community treatment (ACT), or a substance use disorder (SUD) residential treatment facility.

5160-27-06

3

(2) Mental health day treatment hourly and per diem group counseling services may be subject to limitations, which will be described on the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization." Limitations may apply to initiation and continuation of services, frequency, scope, and duration of services, and allowances for services to be provided on the same day.

(3) Mental health day treatment hourly and per diem group counseling services cannot be reimbursed when delivered on the same day to the same recipient by any billing provider.

(E) Providers have to adhere to documentation criteria set forth in rules 5160-1-27 and 5160-8-05 of the Administrative Code.

5160-27-08

Mental health therapeutic behavioral services and psychosocial rehabilitation.

(A) Therapeutic behavioral services (TBS) and psychosocial rehabilitation (PSR) are an array of activities intended to provide individualized supports to eligible recipients. These activities are trauma informed and intended to achieve the identified goals or objectives as set forth in the recipient's treatment plan.

(B) For the purposes of Ohio department of medicaid (ODM) reimbursement, both TBS and PSR include the following activities:

(1) Treatment planning. Participating in and supporting strengths-based treatment planning with direct involvement of the recipient which can include assisting the recipient and family members or other collaterals with identifying strengths and needs. Treatment planning should occur across the episode of care and includes ongoing needs assessment and planning for transition to other levels of care and discharge from services.

(2) Psychoeducation services. Instruction, training ongoing support of, and advocacy for recipients and family members or other collaterals to increase knowledge and understanding of the recipient's mental illness, functional impairments, associated symptoms, anticipated prognosis, treatment, rehabilitation, and needed supports for community navigation and integration; and

(3) Crisis prevention and amelioration. Assisting the recipient with effectively responding to or avoiding identified precursors or triggers that present risk to remaining in a community setting or that result in functional impairments. Activities may include, but are not be limited to, assisting the recipient and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and, as appropriate, seeking other supports to restore stability and functioning.

(C) For the purpose of ODM reimbursement, additional activities permitted under therapeutic behavioral services (TBS) are focused on psychoeducation and evidence-based interventions to decrease negative effects and symptoms of mental illness.

(1) These activities include:

(a) Identification, provision, and ongoing monitoring of strategies or treatment options and recipient progress. Assisting the recipient and family members or other collaterals to identify advocate for, implement, and assess effectiveness of strategies or treatment options to address the negative effects of psychiatric symptoms, emotional disturbances or

5160-27-08

2

associated behavioral health stressors that interfere with the recipient's home, interpersonal, and community functioning.

(b) Develop and provide solution- focused interventions and social, emotional and behavioral management skills training informed by evidence-based practices and associated activities and methodologies, including but not limited to:

(i) Cognitive behavioral therapy;

(ii) Dialectrical behavior therapy;

(iii) Motivational interviewing;

(iv) Mindfulness;

(v) Exposure therapy.

(2) Eligible providers of TBS can be a licensed or an unlicensed mental health practitioner in accordance with rule 5160-27-01 of the Administrative Code who have at a minimum:

(a) A bachelor's or master's degree in social work, psychology, nursing, or in related human services, or

(b) A high school diploma with a minimum of three years of relevant experience as determined by the employing agency and documented in the employee's record.

(D) For the purposes of ODM reimbursement, additional activities permitted under psychosocial rehabilitation (PSR) will support eligible recipients through interventions that compensate for or eliminate functional deficits and supports skills to promote independent living skills in a natural community environment.

(1) Activities include:

(a) Restoration, rehabilitation, and support of functioning and implementation of routines and skills critical to remaining successful in home, school, work, and community. Activities may include:

(i) Symptom management. Assisting recipients with developing skills to minimize interference from symptoms which negatively affect daily functioning and community integration;

- (ii) Independent living skills. Training and support to develop skills for completion of daily tasks necessary for independent living such as, but not limited to, budgeting, grocery shopping, personal hygiene or self-care, and managing medications;
- (iii) Social skills. Improving the recipient's communication, conflict resolution, and interpersonal relationship skills;
- (iv) Service navigation. Supporting recipients in learning to navigate and maintain linkage to social services and community resources;
- (v) Community integration. Supporting recipients as they choose, achieve, and maintain valued roles in their community.

(2) Eligible recipients of PSR will have a mental health diagnosis co-occurring with deficits in daily, independent, or community functioning which may be attributable to a developmental disorder, intellectual delay, cognitive impairment or decline, medical condition, or other etiology.

(3) Eligible providers of PSR can be licensed or an unlicensed mental health practitioner in accordance with rule 5160-27-01 of the Administrative Code and have at a minimum:

- (a) a bachelor's or master's degree in social work, psychology, nursing, or in a related human services field, or
- (b) A high school diploma and be at least eighteen years of age, and
- (c) Completed population-specific training as determined by the employing agency and documented in the employee's record.

(E) For the purposes of this rule, collateral contact occurs when the practitioner has meaningful interaction with a recipient who play a significant role in a recipient's life. The information gained from the collateral contact will provide insight into the recipient's treatment and support progress toward treatment goals.

(F) Limitations.

- (1) TBS and PSR will not be reimbursed when a recipient is enrolled in assertive community treatment (ACT) or receiving residential substance use disorder treatment services.
- (2) Individual TBS can be delivered as an intervention with the recipient, family members, or other collaterals.

5160-27-08

4

(3) TBS may be delivered in a group setting with the recipient under the following conditions:

(a) Service provision is limited to less than 10.5 hours per week. Recipients in need of additional group services beyond this threshold will be evaluated for admission to mental health day treatment hourly or mental health day treatment per diem program as described in rule 5160-27-06 of the Administrative Code;

(b) The behavioral health professional-to-recipient ratio of the group does not exceed 1:12.

(4) PSR can be delivered as an individual or group intervention with the recipient. Service delivery may also occur with family members or other collaterals for the activities described in paragraphs (B)(1)(b) and (B)(1)(c) of this rule. Group PSR encounters may not exceed a 1:6 behavioral health professional to recipient ratio.

(5) TBS and PSR may be subject to limitations on coverage and reimbursement, which will be described on the the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization."

(G) Providers have to adhere to documentation criteria set forth in rules 5160-01-27 and 5160-8-05 of the Administrative Code.

5160-27-09

Substance use disorder treatment services.

- (A) For the purpose of Ohio department of medicaid (ODM) reimbursement, substance use disorder (SUD) treatment services will be defined by and provided according to the American society of addiction medicine also known as the ASAM treatment criteria for addictive, substance related and co-occurring conditions for admission, continued stay, discharge, or referral to each level of care (LOC).
- (B) ODM will reimburse for two SUD assessment types, level of care and treatment planning, separately from a psychiatric diagnostic evaluation, for ASAM levels of care 1, 2.1, and 2.5.
- (1) Level of care assessment. The level of care assessment is a full evaluation of the ASAM dimensional criteria completed at admission and at any transition between levels of care. The purpose of this assessment is to identify clinical needs, strengths, risks, and barriers relevant to level-of-care placement and to evaluate appropriateness for transfer or discharge based on ASAM criteria. This assessment includes the development or update of an individualized treatment plan that includes level of care recommendation and measurable goals and interventions.
- (2) Treatment planning assessment. The SUD treatment planning assessment is used to measure a recipient's progress within a level of care and is completed at regular intervals determined by program standards or when clinically indicated. This assessment includes evaluation of the recipient's response to treatment interventions, treatment progress, and treatment barriers, and utilizes validated measurement tools, when appropriate, to assess change over time. The recipient's record will include documentation of the assessment results and associated treatment plan updates.
- (C) ODM will reimburse for the services provided under the following ASAM levels of care:
- (1) LOC 1: outpatient services. LOC 1 services are designed to treat the recipient's level of clinical severity and function. These services may be delivered in a variety of settings. Addiction, mental health, or general health care treatment personnel provide professionally directed screening, assessment, evaluation, treatment, and ongoing recovery and disease management services. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols. Service provision is limited to less than nine hours per week for adults and less than six hours per week for adolescents.
- (2) LOC 2: intensive outpatient or partial hospitalization programs including LOC 2 withdrawal management (WM) LOC 2 services will be capable of meeting

the complex needs of people with addiction and co-occurring conditions. SUD group counseling per diem services include all SUD group counseling delivered that day whether rendered continuously or in intervals throughout the day. If services are rendered non-continuously, any breaks should be documented in the recipient's record and the time elapsed to accommodate the break should not be counted toward the total billable service time. Services can occur during the day, before or after work or school, in the evening, and on weekends.

(a) LOC 2.1 intensive outpatient (IOP) is nine to nineteen hours of SUD group counseling service per week (six to nineteen hours for adolescents).

(b) Effective July 1, 2027, the minimum length of service necessary to receive reimbursement for one hundred per cent of the applicable IOP group counseling per diem rate is three hours and one minute. If a recipient is unable to attend a full session, but participates for at least one hour and thirty one minutes, the rendering provider may be reimbursed at fifty per cent of their provider type SUD IOP per diem rate.

(c) LOC 2.5 partial hospitalization program (PHP) is twenty or more hours of SUD group counseling service per week.

(d) Effective July 1, 2027, the minimum length of service necessary to receive reimbursement for one hundred per cent of the applicable PHP group counseling per diem rate is four hours and one minute. If a recipient is unable to attend a full session, but participates for at least two hours and one minute, the rendering provider may be reimbursed at fifty per cent of their provider type SUD PHP per diem rate.

(e) LOC 2 withdrawal management services are rendered by medical and nursing professionals who provide evaluation, withdrawal management and referral services. This level of care supports the management and easing of the physiological and psychological features associated with withdrawal and is inclusive of the following services:

(i) Ongoing monitoring of symptoms and assessment of progress;

(ii) Pharmacological support to manage the signs and symptoms of intoxication and withdrawal;

(iii) Presumptive urine drug screening, including specimen collection and analysis;

(iv) Venipuncture for lab testing;

5160-27-09

3

- (v) Non-medical support including referral to case management, counseling and involvement in community recovery support groups;
 - (vi) Discharge planning as described in paragraph (E)(4) of this rule that includes comprehensive education on the continuum of substance use disorder treatment, including medications for opioid use disorder.
- (3) LOC 3: Residential services/inpatient services including withdrawal management. These services are co-occurring capable, co-occurring enhanced, and complexity capable in nature and provided by certified or licensed addiction treatment, mental health and general medical personnel in a twenty-four-hour treatment setting. Services are provided in Ohio department of behavioral health (DBH) certified permanent facilities which are staffed twenty four hours a day. The services listed in paragraphs (C)(3)(a) to (C)(3)(g) of this rule are included in the residential treatment service and will not be reimbursed separately:
 - (a) Initial and ongoing assessments including diagnostic evaluations., SUD level of care assessments, and SUD treatment planning assessments;
 - (b) Crisis intervention.
 - (c) Individual, group, and family psychotherapy and counseling.
 - (d) SUD case management.
 - (e) Behavioral health peer recovery services.
 - (f) Presumptive urine drug screen specimen collection and analysis;
 - (g) Basic medical services.
 - (h) The following services are eligible for reimbursement for recipients in residential treatment:
 - (i) Therapeutic behavioral services.
 - (ii) Psychosocial rehabilitation.
 - (iii) Mental health day treatment.
 - (iv) Assertive community treatment.
 - (v) Intensive home based treatment.

- (j) ODM will only reimburse a provider who is not directly affiliated with, or a staff member of, the residential treatment program for a service outside the SUD residential per diem for an essential medically necessary service that could not be delayed until discharge. Examples include, but are not limited to:

 - (i) Psychiatry for the treatment of a co-occurring mental health disorder;
 - (ii) Medication-assisted treatment.
 - (iii) Specialized health care for treatment of an acute or chronic health condition outside a residential provider's scope of practice;
 - (iv) Definitive urine drug testing at an offsite laboratory when necessary to finalize assessment and guide treatment decisions;
 - (v) Or other necessary medical treatment that is outside the scope of the residential level of care as defined by ASAM.
- (j) All treatment services, regardless of provider type or provider agency, will be documented in the recipient's treatment plan maintained by the residential treatment provider. If the residential treatment provider initiated the referral for an outside service, this will be documented in the medical record along with justification for the referral.
- (k) Withdrawal management services in the residential level of care will include components identified in paragraph (B)(2)(e) of this rule and will be provided within a twenty four hour supervised setting.
- (l) The entity providing a residential service will ensure that the recipient has access to the appropriate provider for receipt of clinical services as stated in the ASAM treatment criteria.
- (m) Eligible practitioners of substance use disorder treatment services will meet all applicable criteria stated in rule 5160-27-01 of the Administrative Code. Qualified mental health specialists are not eligible to be a residential treatment team practitioner.
- (D) For SUD services at all levels of care, the medical record will substantiate the medical necessity and individualization of services rendered. Providers will adhere to documentation criteria set forth in rules 5160-1-27 and 5160-8-05 of the Administrative Code.

5160-27-09

5

(E) Documentation of SUD services will reflect adherence to ASAM guidelines, as evidenced by the following:

- (1) The recipient's medical record will substantiate clinical justification for level of care placement and include documentation of ASAM dimensional risk ratings, individualized treatment goals linked to those dimensions, and evidence of outcomes-based care.
- (2) Providers will record baseline and interval scores using validated instruments appropriate to the level of care including but not limited to the "Clinical Institute Withdrawal Assessment of Alcohol Scale - Revised (CIWA-Ar)" for alcohol withdrawal, "Clinical Opiate Withdrawal Scale (COWS)" for opioid withdrawal, "Patient Health Questionnaire - 9 (PHQ-9)" for depression, or "General Anxiety Disorder - 7 (GAD-7)" for anxiety.
- (3) Progress notes will demonstrate linkage between services delivered, dimensional needs, or measurable outcomes.
- (4) Transfer or discharge readiness should be assessed on an ongoing basis through review of the recipient's progress, or lack thereof, toward meeting their individualized treatment plan goals and reviewed in comparison to the ASAM dimensions for the level of care placement.

(F) Limitations.

- (1) Twelve step or other self-led recovery support programs are not covered services nor reimbursable by ODM.
- (2) For withdrawal management services, if there is a step-up or step-down to a different withdrawal management level of care, the consecutive billing per day by the same organizational provider is counted as a single event.
- (3) Limitations for SUD assessment and services at all levels of care will be described on the the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization." Limitations may apply to initiation and continuation of services, frequency, scope, and duration of services, and allowance for services to be provided on the same day or during the same episode of care.
- (4) The following limitations apply specifically to LOC 2 services:
 - (a) Additional SUD group counseling will not be reimbursed on the same day as SUD IOP or PHP.

5160-27-09

6

(b) For recipients of IOP, if, after the first four consecutive weeks of treatment, the weekly average of SUD group counseling is less than an average of nine to nineteen hours, services can be reimbursed at a lower level of care not to exceed nine hours per week for adults or six hours per week for adolescents, as supported by an assessment.

(c) For recipients of PHP, if, after the first four consecutive weeks of treatment, the weekly average of SUD group counseling is less than twenty hours, services can still be reimbursed at a lower level of care not to exceed 19.9 hours per week, as supported by an assessment.

(5) The following limitations apply specifically to LOC 3 services:

(a) Residential levels of care are mutually exclusive.

(b) When a recipient transitions between residential levels of care, the admitting organizational provider can receive per diem reimbursement on the day of admissions.

(c) SUD residential service per diem cannot be billed on the day of discharge to any level of care:

(i) If the level of care transition involves transition to a new organizational residential billing provider, the discharging residential provider can bill for unbundled services provided on the day of discharge.

(ii) If the level of care transition involves movement up or down within the same organization, the consecutive billing per day is counted as a single event.

(d) Service gaps in excess of twenty-four hours are considered a termination of one admission.

5160-27-10

Substance use disorder targeted case management.

- (A) Targeted case management assists an individual receiving alcohol or substance use disorder treatment services from an Ohio department of ~~mental health and addiction services (OhioMHAS)~~behavioral health (DBH) certified substance use disorder treatment program to gain access to needed medical, social, educational and other services.
- (1) Targeted case management services shall include, at a minimum, the following activities:
- (a) Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. Assessment activities include taking client history; identifying the individual's needs and completing related documentation and gathering information from other sources such as family members, medical providers, social workers and educators to form a complete assessment of the eligible individual.
 - (b) Development and periodic revision of a specific care plan that is based on the information gathered through the assessment. The care plan must include the following requirements:
 - (i) Goals and actions to address the medical, social, educational and other services needed by the individual; and
 - (ii) A plan to ensure the active participation of the eligible individual and or their authorized health care decision maker; and
 - (iii) A course of action to respond to the assessed needs of the eligible individual.
 - (c) Referral and related activities to help the eligible individual obtain needed services
 - (d) Monitoring and follow-up activities or contacts that are necessary to ensure that the care plan is implemented and adequately addresses the eligible individual's needs. Changes in needs or status must be reflected in the care plan. Monitoring shall be performed no less frequently than annually. Monitoring may be performed in person or by electronic communication.
- (B) In order to provide targeted case management, practitioners must meet the requirements in rule 5160-27-01 of the Administrative Code. For the purposes of

5160-27-10

2

this rule, the following unlicensed practitioners are excluded: qualified mental health specialists and certified peer supporters.

(C) The following activities or contacts do not constitute targeted case management and are ineligible for reimbursement as targeted case management:

(1) Transportation.

(2) Waiting with an individual for appointments at social service agencies, court hearings and similar activities does not, in and of itself, constitute case management.

(3) Direct services to which the ~~client~~recipient has been referred such as medical, educational or social services.

(4) Internal quality assurance activities, such as clinical supervisory activities ~~and/~~or case review/staffing sessions.

(D) Targeted case management services will not be separately reimbursed when a recipient is enrolled in a substance use disorder (SUD) residential treatment facility.

(E) SUD targeted case management services may be subject to additional limitations in scope, duration, frequency, and co-occurring services, which will be described on the the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization."

~~(E) Targeted case management services require prior authorization from the Ohio department of medicaid (ODM) designated entity when a recipient is enrolled in an assertive community treatment (ACT) or intensive home based treatment (IHBT) team.~~

5160-27-14

Behavioral health peer support service.

(A) For the purposes of this rule, behavioral health peer support service is the service as set forth by the Ohio department of ~~mental health and addiction services (OhioMHAS)~~behavioral health (DBH) in rule 5122-29-15 of the Administrative Code.

(B) Eligible providers.

(1) An eligible rendering provider of peer support services is:

(a) A person who is eligible to provide peer support services in accordance with rule 5122-29-15.1 of the Administrative Code; and

(b) An eligible provider of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code.

(2) An eligible billing provider is:

(a) An eligible behavioral health provider that meets the conditions in paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code; and

(b) Employs or contracts with an eligible rendering provider of peer support services as described in this rule.

(C) Coverage.

(1) The peer support service is covered when:

(a) Provided in accordance with the activities as described in rule 5122-29-15 of the Administrative Code.

(b) Rendered as a component of behavioral health treatment for the purpose of addressing the ~~individual~~recipient's behavioral health care needs relating to a mental health or substance use disorder.

(c) Intended to achieve goals or objectives based on and documented in a current individualized treatment plan meeting the requirements in rule 5122-27-03 of the Administrative Code.

(D) Limitations.

~~(1) The peer recovery service has to be prior authorized when rendered for more than four hours to the same individual on the same date of service.~~

- (2)(1) Transportation activities that do not include the provision of a peer support service are not covered.
- (3)(2) Provision of a peer support service is reimbursed in accordance with this rule and may not be reimbursed as another covered medicaid service, including, but not limited to, the following:
- (a) ~~Community psychiatric supportive treatment.~~
 - (b)(a) Therapeutic behavioral services.
 - (c)(b) Psychosocial rehabilitation.
 - (d)(c) Substance use disorder target case management.
- (4)(3) Payment is not allowable when a peer support service is provided in a group setting and the certified peer supporter to ~~client~~ recipient ratio exceeds one to twelve.
- (5)(4) When peer support service is delivered to caregivers or family members of the ~~individual~~ recipient, it is ~~reimburseable~~ reimbursable when the purpose of the service is to address the behavioral health needs, goals, and objectives as documented in the ~~individual~~ recipient's treatment plan.
- (5) Any other limitations to the delivery of peer support services will be described on the the appendix to rule 5160-1-31 of the Administrative Code, which is also posted to WWW.Medicaid.Ohio.gov as "ODM Master List for Prior Authorization."

(E) Reimbursement.

- (1) The ~~medicaid~~ ODM reimbursement rate for the peer support service is stated in the appendix to rule 5160-27-03 of the Administrative Code. The peer support service is not reimbursable when covered as part of another ~~medicaid~~ ODM reimbursable service. Reimbursement will not be made for peer support services when an ~~individual~~ recipient is:
- (a) Receiving intensive home-based treatment (IHBT) as described in rule 5122-29-28 of the Administrative Code.
 - (b) Receiving assertive community treatment (ACT) as described in rule 5160-27-04 of the Administrative Code.

- (c) Receiving mobile response and stabilization service (MRSS) as described in rule 5160-27-13 of the Administrative ~~Code~~unless the recipient was actively receiving unrelated peer support services from another billing provider prior to the initiation of the crisis response by the regional mobile crisis response provider.
- (d) Receiving substance use disorder residential treatment services as described in rule 5160-27-09 of the Administrative Code, except when the peer support service is necessary to support admission to ~~and~~or discharge from the substance use disorder residential treatment. Payment for the services provided during a substance use disorder residential treatment stay is made in accordance with rule 5160-27-09 of the Administrative Code.
- (e) Receiving inpatient hospital psychiatric services as described in Chapter 5160-2 of the Administrative Code, except when the peer support service is necessary to support admission to ~~and~~or discharge from the hospital. Payment for the services provided during an inpatient hospital stay is made in accordance with Chapter 5160-2 of the Administrative Code.
- (f) Receiving psychiatric residential treatment facility (PRTF) services as described in Chapter 5122-41 of the Administrative Code and rule 5160-59-03.6 of the Administrative Code, except when the peer support service is necessary to support admission to ~~and~~or discharge from the PRTF. Payment for the services provided during a PRTF stay is made in accordance with rule 5160-59-03.6 of the Administrative Code.