Optum

Optum Behavioral Health Solutions
Medicaid State-Specific
Supplemental Clinical Criteria

Ohio Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Clinical Criteria

When deciding coverage, the member's specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.
These Clinical Criteria are provided for informational purposes and do not constitute medical advice. The following are the Clinical Criteria used by Optum Behavioral Health to make coverage decisions.

Externally Adopted Clinical Criteria

- American Society of Addiction Medicine (ASAM) Criteria®, Third Edition
- Level of Care Utilization System (LOCUS)
- Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII)
- Early Childhood Service Intensity Instrument (ECSII)
- American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide

Medicare Required Clinical Criteria

- Centers for Medicaid and Medicare (CMS) National and Local Coverage Determinations (NCDs/LCDs)
- State/Contract Specific Clinical Criteria
- State-Specific Supplemental Clinical Criteria: State or contract specific Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements outside of the Criteria above.

National Clinical Practice Guidelines

- Clinical Practice Guidelines: Criteria that provide guidance about evidence-based practices adopted from nationally recognized entities such as by the American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry.

Optum National Behavioral Health Clinical Criteria

- Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments, and are used to make determinations regarding proven or unproven services and treatments.
- Optum Psychological and Neuropsychological Testing Guidelines: Criteria used to make determinations related to psychological and neuropsychological testing.
- Optum Electroconvulsive Therapy Supplemental Clinical Criteria: Criteria used to make determinations for ECT.
- Optum Extended Outpatient Therapy Supplemental Clinical Criteria: Criteria used to make determinations for Extended Sessions.
- Optum Quality Performance Tools: Quality tools that annually measure performance against at least two important aspects of each of two clinical practice guidelines to determine provider adherence. Performance measurement is related to the clinical process of care found within Optum's clinical practice guidelines that is most likely to affect care.

Additional information can be found here:

https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies.html.

State Specific Rules, Coverage and Limitations

Ohio Medicaid Specific Rules, Coverage and Limitations

Medical Necessity

- Conditions of medical necessity for a procedure, item, or service are met if all the following apply:
    - Meets generally accepted standards of medical practice;
    - It is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
    - It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
    - It is the lowest cost alternative that effectively addresses and treats the medical problem;
    - It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
    - It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.

- The fact that a physician, dentist or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment.
- The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within the Ohio Department of Medicaid (ODM) coverage policies or rules.
- Additional Information can be found in rule 5160-1-01.

Coverage and Limitations of Behavioral Health Services

- Medicaid reimbursable behavioral health services must 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.
- Medicaid reimbursable behavioral health services are limited to medically necessary services defined in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code.
- The following services have limitations on the amount, scope or duration of service that can be rendered to a recipient within a certain timeframe. These limits can be exceeded with prior authorization.
    - Screening, brief intervention and referral to treatment (SBIRT) Limitation for this service is one per code, per recipient, per billing provider, per calendar year.
    - Assertive community treatment (ACT) as defined in rule 5160-27-04 of the Administrative Code is available on or after the date as determined by prior authorization approval.
    - Community psychiatric supportive treatment (CPST) services as defined in rule 5122-29-17 of the Administrative Code and meet the following requirements:
        - All CPST services provided in social, recreational, vocational, or educational settings are allowable only if they are documented mental health service interventions addressing the specific individualized mental health treatment needs as identified in the recipient's individualized service plan.
        - A billable unit of service for CPST may include contact between the mental health professional and the recipient or an individual essential to the mental health treatment of the recipient.
        - CPST services are not covered under this rule when provided in a hospital setting, except for the purpose of coordinating admission to the inpatient hospital or facilitating discharge from an inpatient hospital.
- Psychiatric diagnostic evaluation and psychiatric diagnostic evaluation with medical services are each limited to one encounter per recipient, per billing provider, per calendar year.
- 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 CPST, therapeutic behavioral services, or psychiatric diagnostic evaluation is not allowable for provision of the Ohio brief or Ohio comprehensive CANS assessment.
- Additional Information can be found in rule 5160-1-01.

Coverage and Limitations of Substance Use Treatment

- The following services delivered to recipients with substance use disorders have limitations on the amount, scope or duration of service that can be rendered to a recipient within a certain timeframe. These limits can be exceeded with prior authorization.
    - Substance use disorder assessment as referenced in rule 5160-27-09 of the Administrative Code is limited to two assessments per recipient, per billing agency, per calendar year.
    - Substance use disorder urine drug screening as referenced in rule 5160-27-09 of the Administrative Code, is limited to one per day, per recipient.
    - Peer recovery support as referenced in rules 5160-27-09 and 5160-43-04 of the Administrative Code is limited to four hours per day per recipient.
    - Substance use disorder partial hospitalization as described in rule 5160-27-09 of the Administrative Code.
    - Substance use disorder residential level of care as described in rule 5160-27-09 of the Administrative Code.
- Additional Information can be found in rule 5160-1-01.
- Ohio Medicaid BH Limits can be found here: https://bh.medicaid.ohio.gov/manuals.

Coverage and Limitations of BH and SUD Medications, Laboratory, and Other Services

- Medications listed in the appendix to rule 5160-27-03 or appendix DD to rule 5160-1-60 of the Administrative Code are covered by ODM when rendered and billed by an eligible provider as described in rule 5160-27-01 of the Administrative Code.
- The medication must be administered by a qualified practitioner acting within their professional scope of practice.

- 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 the department when rendered and billed:
    - by an opiate treatment program as described in Chapter 5122-40 of the Administrative Code and licensed as such by the Ohio department of mental health and addiction services
    - and/or federally certified as such as stated in 42 CFR 8.11 (October 1, 2016).
- Laboratory services, vaccines, and medications administered in a prescriber office may be administered in accordance with rule 5160-1-60 of the Administrative Code.
- 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:
    - 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
    - A pharmacist, rendering services in accordance with rule 5160-8-52 of the Administrative Code.

Coverage and Limitations BH and SUD Treatment Plan and Documentation

- Activities that comprise or are included in the aforementioned Medicaid reimbursable behavioral health services must be intended to achieve identified treatment plan goals or objectives.
    - Providers shall maintain treatment records and progress notes as specified in rules 5160-01-27 and 5160-8-05 of the Administrative Code.
    - A treatment plan for mental health services may only be developed by a practitioner who, at a minimum, meets the practitioner requirements found in paragraph (A)(6)(a) of rule 5160-27-01 of the Administrative Code.
    - A treatment plan for substance use disorder services may only be developed by a practitioner who, at a minimum meets the practitioner requirements found in paragraph (A)(6)(b)(i) or (A)(6)(b)(iii) of rule 5160-27-01 of the Administrative Code.

Non-Covered Services BH and SUD services

- The following services are not reimbursable by Medicaid for the treatment of BH or SUD:
    - Educational, vocational, or job training services.
    - Room and board.
    - Habilitation services including but not limited to financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature.
    - Services to recipients who are being held in a public institution as defined in 42 C.F.R. 435.1010 (October 1, 2016);
    - Services to individuals residing in institutions for mental diseases as described in 42 C.F.R. 435.1010 (October 1, 2016);
    - Recreational and social activities, including but not limited to art, music, and equine therapies;
    - Services that are covered elsewhere in agency 5160 of the Administrative Code; and
    - Transportation for the recipient or family.
- Ohio Medicaid does not cover services to individuals that meet the following criteria: CFR 42 § 435.1009 Institutionalized individuals.
    - Federal Financial Participation (FFP) is not available in expenditures for services provided to;
        - (1) Individuals who are inmates of public institutions as defined in § 435.1010;
        - or (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter. (As authorized in 42 CFR 438.6, a managed care plan may cover a short-term IMD stay for a member aged 21-64. This may not be covered through fee-for-service Medicaid).
    - The exclusion of FFP described in paragraph above, does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.
    - An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.
- Additional Information can be found in rule 5160-1-01, 5160-1-61, and 5160-27-02 (K).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Medical necessity for individuals covered by early and periodic screening, diagnosis and treatment (EPSDT)

- Criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, *correct, ameliorate*, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
- Medical necessity for individuals not covered by EPSDT:
    - Criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.
- Healthchek: early and periodic screening, diagnostic, and treatment (EPSDT) covered services benefit (see below).
- Additional Information can be found in rule 5160-1-01 and 5160-1-14.

Ohio Medicaid Specific Guidance on Fee-for-Service, Schedules, and Codes

Prior Authorization

- Pursuant to Ohio Revised Code 5160.34, the Ohio Department of Medicaid (ODM) has consolidated links to Medicaid prior authorization requirements. All changes to prior authorization requirements for ODM-administered services and Managed Care Organization-administered services can be accessed via links here: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements.

CPT and HCPCS for EAPG and Non-Institutional Codes

- FFS, Schedules, Rate and Reimbursable Services
    - https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates .
- CPT and HCPCS codes covered for Enhanced Ambulatory Patient Groups (EAPG):
    - https://medicaid.ohio.gov/wps/wcm/connect/gov/51743cfd-03b7-4f8a-a257-d11f2914fa3d/Covered_List_OPH_ASC_effective.11.14.2022.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-51743cfd-03b7-4f8a-a257-d11f2914fa3d-oi6WY07 .
- Non-Institutional covered codes:
    - https://codes.ohio.gov/assets/laws/administrative-code/pdfs/5160/0/1/5160-1-60_PH_FF_A_APP1_20211215_1151.pdf .

Ohio Medicaid Telehealth Guidelines

- Please visit most recent Ohio Medicaid BH manual regarding covered telehealth services: https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/Telehealth-Billing-Guidelines.pdf .

Assertive Community Treatment

Purpose

Assertive community treatment (ACT) services are provided to an individual with a major functional impairment or behavior which present a high risk to the individual due to severe and persistent mental illness and which necessitate high service intensity. ACT services are also provided to the individual's family and other support systems. A client receiving ACT services may also have coexisting substance use disorder, physical health diagnoses, and/or mild intellectual disability. The service is available twenty-four hours a day, seven days a week.

The purpose of ACT team services is to provide the necessary services and supports which maximize recovery, and promote success in employment, housing, and the community. Assertive Community Treatment (ACT) is an 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.

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.

Services

- ACT services include but are not limited to the following:
    - Psychiatry and primary care as related to the mental health or substance use disorder diagnoses;
    - Service coordination;
    - Crisis assessment and intervention;
    - Symptom assessment and management;
    - Community based rehabilitative services;
    - Education, support, and consultation to families, legal custodians, and significant others who are part of the recipient's support network.
- The desired outcomes of ACT intervention for recipients include but are not limited to:
    - Achieving and maintaining a stable life in a community-based setting;
    - Reducing the need for inpatient hospital admission and emergency department visits;
    - Improving mental and physical health status and improving life satisfaction.

Admission Criteria

- 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; and
- 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
- The recipient has one or more of the following:
    - Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months; or
    - Two or more occasions of utilizing psychiatric emergency services during the past twelve months; or
    - Significant difficulty meeting basic survival needs within the last twenty-four months; or
    - History within the past two years of criminal justice involvement including but not limited to arrest, incarceration, or probation; and
- The recipient experiences one or more of the following:
    - Persistent or recurrent severe psychiatric symptoms; or
    - Coexisting substance use disorder of more than six month in duration; or
    - 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
    - At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available; or
    - Has been unsuccessful in using traditional office-based outpatient services; and
- The recipient is eighteen years of age or older at the time of ACT enrollment.

Discharge Criteria

- A planned disenrollment is appropriate when:
    - 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
    - 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
    - The recipient or their guardian requests a disenrollment; or
    - The recipient is determined to no longer meet the eligibility or medical necessity criteria for ACT.

- 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:
    - The reason(s) for the recipient's disenrollment as stated by both the recipient and the ACT team;
    - The recipient's progress toward the goals set forth in the treatment plan;
    - Documentation that the recipient's behavioral health care is being linked and transferred to a provider other than the ACT team;
    - The signature of the recipient or their guardian, the ACT team leader, and the psychiatric prescriber.
- A recipient's disenrollment from ACT may be unplanned and due to circumstances facilitated by:
    - The inability of the ACT team to locate the recipient for more than forty-five days; or
    - 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.
- 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.
- If the recipient's stay is predicted to be longer than two months, the recipient shall be disenrolled from the ACT team.
- 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.
- A recipient may not obtain behavioral health services from a provider other than the ACT team unless the recipient is disenrolled from ACT services.

Service Delivery

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

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

Each team must meet the following criteria:

- 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.
    - Fidelity reviews of ACT teams must be repeated every twelve months from the report date of the previous fidelity review.
    - 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.
- Each team shall have a designated full-time team leader who may serve in that capacity with only one team.
    - An ACT team leader shall have a national provider identification number and be actively enrolled as an Ohio Medicaid provider.
    - 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:
        - Licensed independent social worker.
        - Licensed independent marriage and family therapist.
        - Licensed professional clinical counselor.
        - Licensed psychologist.
        - Physician - medical doctor, psychiatrist, doctor of osteopathy.
        - Clinical nurse specialist
        - Certified nurse practitioner.
        - Physician assistant.
        - Registered nurse.
- 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.
- 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:

    - 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.
    - 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.
    - Not more than two units per Medicaid recipient per month may be billed by an ACT team member such as 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.
- 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.
- 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.
- When a recipient is enrolled on an ACT team, no other Medicaid community behavioral health services are eligible for reimbursement except:
    - Supported employment as identified on a recipient's specialized recovery services program treatment plan if applicable.
    - 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).
    - Crisis services furnished by a provider other than the billing provider agency employing the ACT team.
- Documentation requirements for ACT:
    - Documentation in the recipient's medical record of the services provided by the ACT team must meet the requirements stated in in rules 5160-1-27 and 5160-8-05 of the Administrative Code.
    - 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:
        - 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.
        - The treatment plan shall address, at a minimum, the following key areas:
            - Psychiatric illness or symptom reduction.
            - Stable, safe, and affordable housing.
            - Activities of daily living.
            - Daily structure and activities, including employment if appropriate.
            - Family and social relationships.
    - 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.
    - The treatment plan, and all subsequent revisions of it, shall be reviewed and signed by the recipient and the ACT team practitioner.
- The following activities performed by members of the ACT team are not eligible for reimbursement:
    - Time spent attending or participating in recreational activities.
    - 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.

- Habilitative services for the recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the recipient or family.
- 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.
- Art, movement, dance, or drama therapies.
- Services provided to collaterals of the recipient.
- Contacts that are not medically necessary.
- Any service outside the responsibility of the ACT team.
- 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.
- Crisis intervention provided by the provider agency employing the ACT team.

Limitations and Exclusions

- See BH Manuals and Rates (ohio.gov) on limits for ACT, IHBT, and other BH services.

References

- Additional Information can be found in rule 5122-29-29 and rule 5160-27-04, and 5119.

Behavioral Health Nursing

Purpose

Behavioral health nursing services are mental health and substance use disorder (SUD) nursing services performed by registered nurses or licensed practical nurses. They include those activities that are performed within professional scope of practice and in authorized settings by staff that are licensed by the Ohio board of nursing and are intended to address the behavioral and other physical health needs of individuals receiving treatment for psychiatric symptoms or substance use disorders.

Eligible Providers are Registered nurse (RN) as defined in and Licensed practical nurse (LPN) as defined in Ohio administrative code 5160-27-11 and 5160-27-01.

Services

Activities may include but are not limited to performance of the following:

- Health care screenings
- Nursing assessments
- Nursing exams
- Checking vital signs
- Monitoring the effects of medication
- Monitoring symptoms
- Behavioral health education
- Collaboration with the individual and/or family as clinically indicated
- Group nursing services

Limitations and Exclusions

- Group nursing services and nursing assessments must be provided by an RN.
- When behavioral health nursing services are provided, medication administration will not be reimbursed when provided by the same practitioner, to the same recipient, on the same day.
- Behavioral health nursing services will not be reimbursed when a recipient in enrolled in assertive community treatment (ACT) or in a SUD residential treatment facility.
- Group nursing cannot be provided on the same day as residential treatment, ambulatory detox, or intensive outpatient program for substance use disorders.

- Providers shall adhere to documentation requirements set forth in rules 5160-1-27 and 5160-8-05 of the Administrative Code.
- RN nursing service provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice.

References

- Please refer to BH workgroup limits on the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals.
- Additional Information can be found in rule 5160-27-11 and 5122.

Behavioral Health/Short-Term Respite

Purpose

Behavioral Health Respite Care provides temporary direct care and supervision for the member. The primary purpose is to provide relief to families/caregivers of a member with a serious emotional disturbance.
The service is designed to help meet the needs of the primary caregiver as well as the identified member. Normal activities of daily living are considered content of the service when providing respite care, and these include:

- Support in the home, after school, or at night,
- Transportation to and from school, medical appointments, or other community-based activities,
- Any combination of the above.

Short Term Respite Care can be provided in an individual's home or place of residence or provided in other community settings. Other community settings include:

- Licensed Family Foster Home
- Licensed Crisis House
- Licensed Emergency Shelter
- Out-of-Home Crisis Stabilization House/Unit/Bed.

Short Term Respite care can be provided in a group setting if the safety of the waiver member is maintained.
The cost of transportation is included in the rate paid to providers of these services.

OhioRISE Behavioral Health Respite

- See OhioRISE
- Coverage of behavioral health respite is subject to authorization by the OhioRISE plan in accordance with rule 5160-59-03.1 of the Administrative Code.
    - Behavioral health respite services may be authorized in an amount, scope, and duration consistent with the youth's needs and behavioral health history.
    - Coverage of the behavioral health respite services is based on a determination that the youth's primary caregiver has a demonstrated need for temporary relief from the care of the youth as a result of the youth's behavioral health needs.
    - Behavioral health respite is identified on a youth's child and family-centered care plan developed by the care management entity or the OhioRISE plan.

Admission Criteria

- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.

Service Delivery

- Limitations include:
    - Short Term Respite Care may not be provided simultaneously with Professional Resource Family Care services. The service being provided at midnight is the service to be billed that day.
    - Short Term Respite Care is not available to members in foster care because that service is available through child welfare contractors. It can be provided to members who are in DCF or JJA custody who are living at home. It can be provided to members who are in DCF custody but who are living at home.

- Short Term Respite Care will not duplicate any other Medicaid State Plan service or other services otherwise available to recipient at no cost.

Complementary And Alternative Medicine (CAM) for BH and SUD

Purpose

According to the National Center for Complementary and Integrative Health (NCCIH, 2018a), treatments that are "complementary" or "alternative" represent approaches developed outside of mainstream Western, or conventional, medicine. These terms are often used interchangeably, but refer to different concepts:

- If a non-mainstream practice is used together with conventional medicine, it is considered "complementary";
- If a non-mainstream practice is used in place of conventional medicine, it is considered "alternative."

State specific policy for Behavioral Health services by Other Licensed Professionals, Acupuncture Services, and Skilled Therapies for BH and SUD are located under 5160-8 Therapeutic and Diagnostic Services of the Administrative code.

Refer to Optum Policy: BH727CAM_0622 for additional information, clinical evidence, rationale and references regarding each of the categories below.

The following complementary and alternative medicine treatments are unproven and not medically necessary for treating behavioral and substance use disorders due to insufficient evidence of efficacy:

- Acupuncture
- Art therapy
- Dance/movement therapy
- Equine therapy
- Music therapy
- Naturopathic detoxification
- Sauna/niacin detoxification (e.g., New Life Detox)

Acupuncture

According to the NCCIH (2018b), acupuncture describes varying procedures and techniques that involve the stimulation of points on the body. The most studied technique comprises penetrating the skin with thin, solid, metallic needles that are manipulated by either hands or electrical stimulation. Most commonly, acupuncture is used for back and neck pain, osteoarthritis, and headache. Research has also been conducted on the use of acupuncture to treat behavioral health conditions, such as depression and substance use disorder.

Services

- Acupuncture Services are a covered Ohio Medicaid benefit as defined in "Ohio Administrative Code Rule 5160-8-51 Acupuncture services".
- Acupuncture services must be delivered by eligible providers as set forth on 5160-8-51.
- Acupuncture services must meet the following criteria:
    - It is medically necessary in accordance with rule 5160-1-01 of the Administrative Code; and
    - It is performed in accordance with section 4762.10 or 4762.11 of the Revised Code;
    - It is rendered for treatment only of the following conditions:
        - Low back pain;
        - Migraine;
        - Cervical (neck) pain;
        - Osteoarthritis of the hip;
        - Osteoarthritis of the knee;
        - Nausea or vomiting related to pregnancy or chemotherapy;
        - Acute post-operative pain.

Limitations and Exclusions

- Payment for more than thirty acupuncture visits per benefit year is subject to prior authorization.
- No separate payment is made for both an evaluation and management service for any of the conditions listed in this rule and an acupuncture service rendered by the same provider to the same individual on the same day.

- No separate payment is made for services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise).
- No separate payment is made to a non-physician acupuncture provider who performs an acupuncture service in a hospital setting. Instead, the provider makes payment arrangements directly with the participating hospital.
- No payment will be made for additional treatment in either of the following circumstances:
    - Symptoms show no evidence of clinical improvement after an initial treatment period; or
    - Symptoms worsen over a course of treatment.
- Claim payment for a covered acupuncture service rendered at an FQHC or RHC, payment is made in accordance with Chapter 5160-28 of the Administrative Code.
- For a covered acupuncture service rendered at any other valid place of service, payment is the lesser of the provider's submitted charge or the maximum amount specified in appendix DD to rule 5160-1-60 of the Administrative Code.

Art Therapy, Dance Movement Therapy (DMT), and Equine Therapy

Art therapy, Dance/Movement (DMT) and Equine therapy may be complimentary or covered alternative therapies located under 5160-8 Therapeutic and Diagnostic Services of the Administrative code, specific to “Behavioral health service"- Other licensed Professionals under rule 5160-8-05 and/or “Skilled Therapy Services" under rule 5160-8-35.

Art Therapy

Art therapy combines the knowledge and understanding of human development and psychological theories/techniques with visual arts and the creative process. Art therapists incorporate the use of art media and verbal processing of produced imagery to help clients improve psychological health, cognitive abilities, and sensory-motor functions.

According to the American Art Therapy Association (AATA, 2017), art therapy is used to improve cognitive and sensorimotor functions, foster self-esteem, and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce, and resolve conflicts, and advance societal and ecological change.

Dance Therapy (DMT)

DMT is defined as the psychotherapeutic use of movement to further the emotional, cognitive, physical, and social integration of the individual (American Dance Therapy Association [ADTA], 2015). Dance/movement therapy interventions apply affective, behavioral, motoric, cognitive, and systemic strategies, including the principles of development, wellness, and pathology. The use of specific methods, techniques, modalities, and verbal interventions within the practice of professional dance/movement therapy is restricted to professional dance/movement therapists appropriately trained in the use of such methods, techniques, or modalities.

Dance/movement therapy may be identified by other terms in the research literature, including “dance movement psychotherapy”, “dance therapy”, “body psychotherapy”, or “therapeutic movement”.

Equine Therapy

Equine therapy uses the purposeful manipulation of equine movement to engage sensory, neuromotor, and cognitive systems in achieving functional outcomes (American Hippotherapy Association, 2019). Equine therapy can be conducted by physical therapists or occupational therapists as part of a larger plan of care involving other neuro/sensorimotor techniques. Individual riding centers may also employ “certified path instructors” or “horsemanship instructors”. Equine therapy is identified by other terms in the research literature, including “hippotherapy”, “therapeutic horseback riding”, “horse therapy”, “therapeutic horsemanship”, and “equine-assisted therapy”. Behavioral health conditions for which riding centers promote their services include autism spectrum disorders, attention deficit hyperactivity disorder, post-traumatic stress disorder, and learning disability.

Limitations and Exclusions

Behavioral Health Services-Other Licensed Professionals

- The following services may not be covered under 5060-8-05:
    - Activities, testing, or diagnosis conducted for purposes specifically related to education;
    - Services that are rendered by an unlicensed individual other than a supervised trainee;
    - Activities, testing, or diagnosis conducted for purposes specifically related to education;
    - 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:
        - Encounter groups, workshops, marathon sessions, or retreats;
        - Sensitivity training;
        - Sexual competency training;

        - Recreational therapy (e.g., art, play, dance, music);
        - Services intended primarily for social interaction, diversion, or sensory stimulation; and
        - The teaching or monitoring of activities of daily living (such as grooming and personal hygiene);
        - Psychotherapy services if the patient cannot establish a relationship with the provider because of a cognitive deficit;
        - Family therapy for the purpose of training family members or caregivers in the management of the patient; and
        - Self-administered or self-scored tests of cognitive function.
- Provisions governing payment for behavioral health services as the following service types are set forth in the indicated part of the Administrative Code:
    - Cost-based clinic services, Chapter 5160-28; and
    - Medicaid school program services, Chapter 5160-35.
- 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.

Skilled Therapy Services

“Skilled Therapy Services" under rule 5160-8-35: is a collective term encompassing physical therapy, occupational therapy, speech-language pathology, and audiology.
Two types of skilled therapy service:

- "Developmental service" is a skilled therapy service rendered, in accordance with developmental milestones established by the American academy of pediatrics, to enable individuals younger than seven years of age to attain a level of age-appropriate functionality that they have not yet achieved but are expected to achieve.
- "Rehabilitative service" is a skilled therapy service rendered to individuals for the purpose of improving functionality.
    - Services must be delivered by eligible providers as set forth on 5160-8-35
- The following services may be covered under 5160-8-35:
    - The service is medically necessary, in accordance with rule 5160-1-01 of the Administrative Code.
    - The amount, frequency, and duration of service is reasonable. For rehabilitative services, reevaluation may be performed not more frequently than every thirty days nor less frequently than every sixty days; for developmental services, reevaluation may be performed not more frequently than every thirty days nor less frequently than every six months.
    - The service is rendered on the basis of a clinical evaluation and assessment and in accordance with a treatment or maintenance plan. The performance of a clinical evaluation and assessment and the development of a treatment or maintenance plan are discrete services; payment for them is made separately from payment for skilled therapy. Copies of the clinical evaluation and assessment and the treatment or maintenance plan must be kept on file by the provider.
    - The service is rendered in response either to a prescription (in the case of physical therapy or occupational therapy) or to a referral (in the case of speech-language pathology and audiology) issued by a licensed practitioner of the healing arts, in accordance with 42 C.F.R. 440.110 (October 1, 2017) and rule 5160-1-17.9 of the Administrative Code.
    - This condition does not apply to services rendered through the Medicaid school program, which is described in Chapter 5160-35 of the Administrative Code.
- The following services may not be covered under 5160-8-35:
    - Services that do not meet current accepted standards of practice;
    - Consultations with family members or other non-medical personnel; and
    - Services that are rendered in non-institutional settings but are listed as non-covered in rule 5160-1-61 or in Appendix DD to rule 5160-1-60 of the Administrative Code.
- Providers shall adhere to documentation requirements set forth in rules 5160-1-27 and 5160-8-35 of the Administrative Code.
- A clinical evaluation and assessment of the need for skilled therapy services includes the following elements:
    - A diagnosis of the type and severity of the disorder or a description of the deficit in physical or sensory functionality;
    - A review of the individual's current physical, auditory, visual, motor, and cognitive status;
    - A case history, including, when appropriate, family perspectives on the individual's development and capacity to participate in therapy;

- The outcomes of standardized tests and any non-standardized tests that use age-appropriate developmental criteria;
- Other test results and interpretation;
- An evaluation justifying the provision of skilled therapy services, which may be expressed as one of two prognoses of the patient's rehabilitative or developmental potential:
  - The patient's functionality is expected to improve within sixty days after the evaluation because of the delivery of rehabilitative skilled therapy services or within six months after the evaluation because of the delivery of developmental skilled therapy services, and the patient is expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months; or
  - The patient is not expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months, but a safe and effective maintenance program may be established; and
- Any recommendations for further appraisal, follow-up, or referral.

- A treatment or maintenance plan for skilled therapy services is based on the clinical evaluation and assessment. It should be coordinated, when appropriate, with services provided by non-Medicaid providers or programs (e.g., child welfare, child care, or prevocational or vocational services), and it should provide a process for involving the patient or the patient's representative in the provision of services. A complete treatment or maintenance plan includes the following elements:
  - The patient's relevant medical history;
  - Specification of the amount, duration, and frequency of each skilled therapy service to be rendered; the methods to be used; and the areas of the body to be treated;
  - A statement of specific functional goals to be achieved, including the level or degree of improvement expected within the appropriate time period;
  - The date of each skilled therapy service;
  - The signature of the practitioner responsible for the treatment or maintenance plan;
  - Documentation of participation by the patient or the patient's representative in the development of the plan;
  - Specific timelines for reevaluating and updating the plan;
  - A statement of the degree to which the patient has made progress; and
  - A recommendation for one of several courses of action:
  - The development of a new or revised treatment plan;
    - The development of a new or revised maintenance plan; or
    - The discontinuation of therapy.

Naturopathic Detoxification & Sauna/Niacin Detoxification

Refer to the Optum Policy: BH727CAM_0622 regarding the following complementary and alternative treatments for BH and SUD:

- Naturopathic Detoxification
  - Naturopathic detoxification therapy (also known as “All-Natural Detox Therapy”, “Natural IV Therapy”, “Nicotinamide Adenine Dinucleotide (NAD) IV Therapy”, “Amino Acid Therapy”, “Neurotransmitter Restoration Therapy”, “Brain Restoration+”, “Gentle Detox”, “Easy Detox”, etc.)
- Sauna/Niacin Detoxification
  - Sauna/niacin detoxification for substance use disorders (also known as “New Life Detoxification”, “sauna detoxification”, “Purification Rundown/Program”, “Purif”, “Effective Purification Program”, etc.)

Centers for Medicare and Medicaid Services

Medicare does not have a National Coverage Determinations (NCDs) for the following complementary and alternative medicine modalities used in treating behavioral disorders and/or substance use:

- Art therapy
- Dance/movement therapy (DMT)
- Equine therapy
- Music therapy
- Naturopathic detoxification
- Sauna/niacin detoxification (also known as “New Life Detoxification”, “sauna detoxification”, “Purification Rundown/Program”, “Purif”, “Effective Purification Program”, etc.)

Medicare does not cover acupuncture as an anesthetic or as an analgesic or for other therapeutic purposes. Refer to the following NCDs (www.CMS.gov):

- NCD for Acupuncture (30.3)
- NCD for Acupuncture for Fibromyalgia (30.3.1)
- NCD for Acupuncture for Osteoarthritis (30.3.2)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply. Please refer to state specific guidance and authorization processes below.

Procedure Codes	Description	Prior Authorization
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	Not required OPH* Service
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles(s). (List separately in addition to code for primary procedure.)	Not required OPH Service
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	Not required OPH Service
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles(s). (List separately in addition to code for primary procedure.)	Not required OPH Service
90899	Unlisted psychiatric service or procedure	Required
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	Not a covered code-Ohio Medicaid
H2032	Activity therapy, per 15 minutes	Not a covered code-Ohio Medicaid
S8940	Equestrian/hippotherapy, per session	Required

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**OPH (Outpatient Hospital Setting)*

Prior Authorization

Pursuant to Ohio Revised Code 5160.34, the Ohio Department of Medicaid (ODM) has consolidated links to Medicaid prior authorization requirements.

- All changes to prior authorization requirements for ODM-administered services and Managed Care Organization-administered services can be accessed via links here: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements .
- Skilled therapy (physical therapy, occupational therapy, speech- language pathology, and audiology) Rule 5160-8-35.
- Payment for additional skilled therapy visits in a non-institutional setting can be requested through the prior authorization process.
- Acupuncture Rule 5160-8-51 Payment for more than thirty acupuncture visits per benefit year requires prior authorization.
- https://medicaid.ohio.gov/static/Resources/Publications/Guidance/MedicaidPolicy/NonInst/Non-Institutional-PolicyLinks.pdf.

Community Psychiatric Support and Treatment (CPST)

Purpose

Community psychiatric supportive treatment (CPST) service provides an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents, and families and will vary with respect to hours, type, and intensity of services, depending on the changing needs of each individual.

The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

Services

- Activities of the CPST service shall consist of one or more of the following:
    - Ongoing assessment of needs;
    - Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian;
    - Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian;
    - Coordination of the Individualized Service Plan, including:
        - Services identified in the ISP;
        - Assistance with accessing natural support systems in the community; and
        - Linkages to formal community service/systems;
    - Symptom monitoring;
    - Coordination and/or assistance in crisis management and stabilization as needed;
    - Advocacy and outreach;
    - As appropriate to the care provided to individuals, and when appropriate, to the family, education, and training specific to the individual's assessed needs, abilities, and readiness to learn;
    - Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment; and
    - Activities that increase the individual's capacity to positively impact his/her own environment.

Admission Criteria

- The Member has a DSM diagnosis which has created a reduced level of functioning and subjective distress.
- Less intensive services would not be adequate to assist the member in reaching identified treatment goals.
- Co-occurring mental health and substance use disorders and/or co-morbid physical conditions can be safely managed.
- In collaboration with the CPST provider, the member is willing and able to connect with individual natural supports, community resources and activities that will enable community integration.

Service Delivery

- The methods of CPST service delivery shall consist of:
    - Service delivery to the person served and/or any other individual who will assist in the person's mental health treatment.
    - Service delivery may be face-to-face, by telephone, and/or by video conferencing; and
    - Service delivery may be to individuals or groups.
- CPST services are not site specific. However, they must be provided in locations that meet the needs of the persons served. When a person served is enrolled in a residential treatment or residential support facility setting, CPST services must be provided by staff that are organized and distinct and separate from the residential service as evidenced by staff job descriptions, time allocation or schedules, and development of service rates.
    - There must be one CPST staff who is clearly responsible for case coordination. This staff person must be an employee of an agency that is certified to provide CPST services. This person may delegate CPST services to eligible providers internal and/or external to the certified agency as long as the following requirements and/or conditions are met:
        - All delegated CPST activities are consistent with this rule in its entirety;

        - The delegated CPST services may be provided by an entity not certified by ODMH to provide CPST services as long as there is written agreement between the certified agency and the non-certified entity that defines the service expectations, qualifications of staff, program and financial accountability, health, and safety requirements, and required documentation; and
        - An entity that is not certified by ODMH for CPST service may seek reimbursement for CPST services through a certified agency and with a written agreement as required in this paragraph.
    - Providers of CPST service shall have a staff development plan based upon individual needs of CPST staff. Evidence that the plan is being followed shall be maintained. The plan shall address, at a minimum, the following:
        - An understanding of systems of care, such as natural support systems, entitlements and benefits, inter- and intra-agency systems of care, crisis response systems and their purpose, and the intent and activities of CPST;
        - Characteristics of the population to be served, such as psychiatric symptoms, medications, culture, and age/gender development; and
        - Knowledge of CPST purpose, intent, and activities
    - Community psychiatric support treatment (CPST) service shall be provided and supervised by staff that are qualified according to rule 5122-29-30 of the Administrative Code.

Limitations and Exclusions

- Community psychiatric supportive treatment (CPST) services as defined in rule 5122-29-17 of the Administrative Code and meet the following requirements:
    - All CPST services provided in social, recreational, vocational, or educational settings are allowable only if they are documented mental health service interventions addressing the specific individualized mental health treatment needs as identified in the recipient's individualized service plan.
    - A billable unit of service for CPST may include contact between the mental health professional and the recipient or an individual essential to the mental health treatment of the recipient.
    - CPST services are not covered under this rule when provided in a hospital setting, except for the purpose of coordinating admission to the inpatient hospital or facilitating discharge from an inpatient hospital.

References

- Please refer to BH workgroup limits on the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals.
- Additional Information can be found in rule 5160-29-17, 5122 and 5119.

Day Treatment/Intensive Outpatient

Purpose

Mental health day treatment is an intensive, structured, goal-oriented, distinct and identifiable treatment service that utilizes multiple mental health interventions that address the individualized mental health needs of the client. Mental health day treatment services are clinically indicated by assessment with clear admission and discharge criteria. The environment at this level of treatment is highly structured, and there should be an appropriate staff-to-client ratio in order to guarantee sufficient therapeutic services and professional monitoring, control, and protection.

The purpose and intent of mental health day treatment is to stabilize, increase or sustain the highest level of functioning and promote movement to the least restrictive level of care.
The outcome is for the individual to develop the capacity to continue to work towards an improved quality of life with the support of an appropriate level of care.

Mental health day treatment “program day" means the total amount of hours an individual receives mental health day treatment service during a twenty-four hour calendar day.

Services

Mental health day treatment must be an intense treatment service that consists of high levels of face-to-face mental health interventions that address the individualized mental health needs of the individual as identified in their individualized treatment plan.

The minimum program length of this service shall be in accordance with the appropriate behavioral health standards of the agency's national accrediting body(ies). Such accrediting bodies are identified in rule 5122-25-02 of the Administrative Code and 5160-27-09.

- For purposes of this rule, a mental health day treatment program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities that may include, but are not limited to, the following:
    - Determination of needed mental health interventions;
    - Skills development;
        - Interpersonal and social competency as age, developmentally, and clinically appropriate, such as:
        - Functional relationships with adults;
        - Functional relationship with peers;
        - Functional relationship with the community/schools;
        - Functional relations with employer/family; and
        - Functional relations with authority figures.
        - Problem solving, conflict resolution, and emotions/behavior management.
        - Developing positive coping mechanisms;
- Managing mental health and behavioral symptoms to enhance vocational/school opportunities and/or independent living; and
- Psycho-educational interventions including individualized instruction and training of persons served in order to increase their knowledge and understanding of their psychiatric diagnosis(es), prognosis(es), treatment, and rehabilitation in order to enhance their acceptance of these psychiatric disabilities, increase their cooperation and collaboration with treatment and rehabilitation, improve their coping skills, and favorably affect their outcomes. Such education shall be consistent with the individual's ITP and be provided with the knowledge and support of the interdisciplinary/intersystem team providing treatment in coordination with the ITP.

Services for SUD

- Substance use disorder treatment services shall be defined by and shall be 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).
- Day Treatment/IOP services are provided under the following ASAM levels of care:
    - LOC 1: outpatient services. LOC 1 services are designed to treat the recipients 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, 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.
    - LOC 2: intensive outpatient/partial hospitalization including LOC 2 withdrawal management (WM).
        - LOC 2 services are capable of meeting the complex needs of people with addiction and co-occurring conditions.
        - They can be rendered during the day, before or after work or school, in the evening, and/or on weekends.
        - Prior authorization is required for LOC 2.5 (partial hospitalization) which requires a minimum of twenty hours of services per week. If, after the first four consecutive weeks of treatment, the amount of services provided is less than twenty hours, the prior authorization will be rescinded but services may still be reimbursed at a lower level of care not to exceed 19.9 hours per week.
- Providers of mental health day treatment services shall have a staff development plan based upon identified individual needs of mental health day treatment program staff. Evidence that the plan is being followed shall be maintained.
- Mental health day treatment service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code and 5160-27-09.
- The patients' medical record must substantiate the medical necessity of services performed. Providers shall adhere to documentation requirements set forth in rules 5160-1-27 and 5160-8-05 of the Administrative Code.

References

- Please refer to BH workgroup limits on the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals .

- Additional Information can be found in rules 5160-27-09, 5122 and 5119.

Healthchek (EPSDT Benefit)

Purpose

Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for all Medicaid recipients younger than twenty-one years of age, described in 42 U.S.C. 1396d(r) (as in effect 10/2017).

Services

- Screening services:
    - Healthchek screening services include, but are not limited to, all of the following procedures:
        - A comprehensive health and developmental history, including assessment of both physical and mental health development, as well as substance abuse disorders;
        - A comprehensive unclothed physical exam, when appropriate;
        - Immunizations appropriate to age and health history;
        - Laboratory tests, including lead blood level assessment appropriate to age and risk factors, as required by the centers for Medicare and Medicaid services (CMS);
        - Nutritional status assessment; and
        - Health education, counseling, anticipatory guidance, and risk factor reduction intervention provided to an individual younger than twenty-one years of age and, as applicable, to another person responsible for the individual younger than twenty-one years of age.
- Healthchek screening services are covered with specific frequencies. See 5160-1-14
- For other screening services, at ages and intervals in accordance with the bright futures guidelines;
- For all screening services, at such other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions.
    - All medically necessary services and items set forth in agency 5160 of the Administrative Code.
    - All medically necessary screenings, health care, diagnostic services, treatment, and other measures described in 42 U.S.C. 1396d(a) (as in effect 10/2017) to correct or ameliorate defects and physical and mental illnesses and conditions, regardless of whether such measures are addressed in agency 5160 of the Administrative Code.
- Additional provisions.
    - Coverage limits that have been established may be exceeded, with prior authorization, for medically necessary services rendered to Medicaid-eligible individuals younger than twenty-one years of age.
    - In accordance with guidance issued by CMS in "EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents" (June 2014, found at http://www.medicaid.gov), when a screening examination indicates the need for further evaluation of a childs health, the child must be appropriately referred without delay for diagnosis, necessary treatment, and follow-up.

References

- Additional Information can be found in rules 5160-1-14 and 5160-1-01.
- See Recommendations for Preventive Pediatric Health Care Bright Futures here: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/multi/Bright-Futures-Periodicity-Schedule.pdf.
- See Ohio EPSDT Coding: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/oh/forms/OH-EPSDT-Coding-Guidelines.pdf.

Inpatient & Institutions for Mental Disease

Purpose

Acute Inpatient is a structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the

member's condition can be safely, efficiently, and effectively treated in a less intensive level of care.

INSTITUTIONS FOR MENTAL DISEASE: An IMD is a hospital, nursing facility, or other institution of more than sixteen beds which primarily provides diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services intended to provide members with improved access to timely, medically appropriate, and cost-effective services by allowing IMDs to be utilized in lieu of otherwise covered settings, such as inpatient psychiatric units in general medical hospitals.

Admission Criteria

- For IMD settings, the member must be 21 to 64 years old.

Continuing Stay Criteria

- For IMD settings, there is a limit of 15 days per month as long as inpatient psychiatric or substance use disorder treatment is being provider per 42 CFR 438.6(e).

Limitations and Exclusions

Ohio Medicaid does not cover services to individuals that meet the following criteria: CFR 42 § 435.1009 Institutionalized individuals.

- Federal Financial Participation (FFP) is not available in expenditures for services provided to;
    - (1) Individuals who are inmates of public institutions as defined in § 435.1010; or
    - (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter. (As authorized in 42 CFR 438.6, a managed care plan may cover a short-term IMD stay for a member aged 21-64. This may not be covered through fee-for-service Medicaid).
- The exclusion of FFP described in paragraph above, does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.
- An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.
- Additional Information can be found in rule 5160-1-01, 5160-1-61, and 5160-27-02 (K).

Intensive Home-Based Treatment Services

See OhioRISE

Mobile Response and Stabilization Service

Purpose

Mobile response and stabilization service (MRSS) is a structured intervention and support service provided by a mobile response and stabilization service team that is designed to promptly address a crisis situation; with young people who are experiencing emotional symptoms, behaviors, or traumatic circumstances that have compromised or impacted their ability to function within their family, living situation, school, or community.

Families with youth and young adults up to age 21 who are experiencing difficulties or distress can receive assistance within 60 minutes after contacting MRSS. You may also receive up to 42 days of intensive, in-home services and linkage to on-going supports.

Services provided by the MRSS team may include: safety assessments, de-escalation, peer support, and skill building, among others. Access to MRSS is available 24 hours per day, seven day a week. Ohio MRSS state line: (888) 418-MRSS (6777).

Admission Criteria

- MRSS is provided to people who are under the age of twenty-one.

- MRSS is intended to be delivered in-person where the young person or family is located, such as their home or a community setting. There are instances where MRSS can be delivered using a telehealth modality. Common times that telehealth would be appropriate are:
    - When the young person or family requests MRSS service delivery using telehealth modalities,
    - There is a contagious medical condition present in the home, or
    - Inclement weather that prevents or makes it dangerous for the MRSS team to travel to the young person or family.
- The initial mobile response is expected to occur within sixty minutes from the end of the initial call and immediate linkage of the caller to the MRSS provider, with a de-escalation period up to seventy-two hours and a stabilization period for up to six weeks. If the caller requests mobile response later than sixty minutes, the response will occur within forty-eight hours. The de-escalation period begins when the initial mobile response occurs. In instances where the initial mobile response occurs greater than 60 minutes from the time of dispatch, the MRSS team will maintain documentation that supports the extended response time was an appropriate response.
- Ohio MRSS state line: (888) 418-MRSS (6777).

Services

MRSS Team

- A MRSS team will consist of at least:
    - A clinician identified in rule 5122-29-30 of the Ohio Administrative Code who holds a valid and unrestricted certification or license issued by any of the Ohio professional boards that includes a scope of practice for behavioral health conditions. This provider will also demonstrate and maintain competency in the under twenty-one years of age population. The independently licensed supervising practitioner will also be considered a member of the MRSS team. A qualified behavioral health specialist (QBHS) as defined in rule 5122-29-30 of the Administrative Code does not meet the standards of this paragraph; and
    - One of the following:
        - A family peer or youth peer supporter who holds a valid and unrestricted certification from OhioMHAS issued in accordance with rule 5122-29-15.1 of the Ohio Administrative Code. The peer supporter will also demonstrate competency in the care and services of individuals in the under twenty-one years of age population and has scope of practice for persons aged twenty-one and under with mental health disorders and substance use disorders.
        - A QBHS as defined in rule 5122-29-30 of the Administrative Code. This QBHS will also demonstrate competency in the care and services of individuals in the under twenty-one years of age population and has scope of practice for persons aged twenty-one and under with mental health disorders and substance use disorders.
    - The MRSS team will have ready access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes as needed, and this person is not necessarily a member of the MRSS team. The psychiatrist or certified nurse practitioner or clinical nurse specialist will hold a valid and unrestricted license to practice in Ohio.

Screening/Triage

- MRSS provides immediate de-escalation, delivers rapid community-based assessment, and stabilization services to help the young person remain in their home and community. MRSS consists of three activities: screening/triage, mobile response, and stabilization. Some young people do not need all three MRSS activities but are still considered MRSS participants.
- MRSS will be initiated through screening/triage and progress in the following order and at a minimum:
    - The MRSS service may be initiated through direct connection with the MRSS provider or the statewide MRSS call center. When the service is initiated through direct connection with the provider:
        - An initial triage screening is done to gather information on the crisis or crises, identify the parties involved, and determine an appropriate response or responses. The initial triage screening is performed remotely
        - All calls with a young person or family in crisis where 911 is not indicated, are responded to with a mobile response.
        - If a young person or family is already involved with an intensive home-based service (i.e., IHBT, wraparound) the mobile response team is dispatched to de-escalate the presenting crisis. Once the family is stabilized, the family is re-connected with the existing service.

Mobile Response

- The mobile response team will mobilize to arrive at the location of the crisis, or a location specified by the young person or family within the designated response time, as determined by the end of the triage assessment. If the initial response is done by a single team member, that team member will meet the standards.
- The MRSS mobile response team will provide de-escalation services for up to seventy-two hours until the young person and family are stable; de-escalation services will include the following:
    - An urgent assessment of the following elements for de-escalation: Understanding what happened to initiate the crisis and the young person's and their family's response or responses to it; risk assessment of lethality, propensity for violence, and medical/physical condition including alcohol or drug use, mental status, and information about the young person's and family's strengths, coping skills, and social support network.
    - Development of an initial safety plan to be provided to the youth and family at the end of the first face-to-face contact.
    - Crisis intervention and de-escalation with the young person or family using strategies as appropriate to meet the unique needs of the youth and family. Such strategies may include but are not limited to ongoing risk assessment and safety planning, teaching of coping and behavior management skills, mediation, parent support, and psychoeducation.
    - Telephonic psychiatric consultation initiated when indicated.
    - Administration of the Ohio children's initiative brief child and adolescent needs and strengths (CANS) tool prior to entry into the ongoing stabilization phase of services, and for youth who do not continue into stabilization, complete the CANS when adequate information is known. This will be performed by a provider who is a qualified CANS assessor.
    - Consult with the young person or family to define goals for preventing future crisis and the need for ongoing stabilization.
    - Initiate an individualized MRSS plan, prior to the stabilization phase, which is inclusive of the safety plan. An individualized MRSS plan is valid for up to forty-two days or until the end of the MRSS episode of care and should be updated or modified as indicated during this time period.

Stabilization

- Stabilization services are provided by the MRSS team as documented in the individualized MRSS plan. The stabilization services immediately follows the seventy-two hours of mobile response.
- Continued monitoring, coordination, and implementation of the individualized MRSS plan.
- The MRSS team provides stabilization services that are defined in the individualized MRSS plan to achieve goals as articulated by the young person or family. Stabilization services are to build skills of the young person and family, to strengthen capacity to prevent future crisis, facilitate an ongoing safe environment, link the young person and family to natural and culturally relevant supports and build or facilitate building the young person and family's resilience.
- Stabilization activities include but are not limited to:
    - Psychoeducation: Young person or family individual coping skills; behavior management skills, problem solving and effective communication skills;
    - Referral for psychiatric consultation and medication management if indicated;
    - Advocacy and networking by the provider to establish linkages and referrals to appropriate community-based services and natural supports;
    - Coordination of services to address the needs of the young person or family.
- Linkage to the natural and clinical supports and services to maintain engagement and sustain the young person's or their family's stabilization post MRSS involvement.
- Convene or participate in planning meeting(s) with the young person, family, and cross system partners for the purpose of developing and coordinating linkages to ongoing services and supports when family need indicates.

Service Transition

- The MRSS team and the young person or their family will work on moving from stabilization to ongoing support through identified supports, resources, and services, which are consistent with their unique needs and documented in the individualized MRSS plan.
- With the young person's or family's permission, the MRSS team will share the most recent individualized MRSS plan and supporting information with other service providers in person, including by video or telephone, and with the young person or family present when possible.
- Review with the young person or their family newly formed coping skills and how future crisis can be managed; emphasizing the role of the young person and the family.

- Prepare and finalize a transition plan with the young person and their family. The transition plan will include the most recent version of the individualized MRSS plan with safety plan.

References

- Ohio MRSS state line: (888) 418-MRSS (6777).
- Additional Information can be found in rule 5122-29-14 & 5160-27-13.
- OhioRISE website for additional information: https://managedcare.medicaid.ohio.gov/managed-care/ohiorise.
- Please refer to the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals.
- Ohio Wraparound MRSS: https://wraparoundohio.org/mobile-crisis-response-and-stabilization-services/.

Neurofeedback/Biofeedback For Behavioral And Substance Use Disorders

Purpose

Neurofeedback/biofeedback therapy use real-time physical sign monitors, such as electroencephalographs (EEGs), heart-rate variability/respiratory sinus arrhythmia (HRV/RSA), and functional real-time functional magnetic resonance imaging (rtfMRI) to teach individuals how to control physiologic functions and mental states. As the individual's EEG pattern or other physiological process improves or is learned through the feedback, symptoms of ADHD or other behavioral disorders are expected to improve (Begemann et al., 2016).

In some instances, neurofeedback and quantitative electroencephalography (qEEG) are used in combination. When this occurs, the individual's EEG pattern is analyzed by qEEG, and an individualized feedback protocol is defined for the individual based on the reported findings (Begemann et al., 2016).

Refer to Optum Policy: BCP - Neurofeedback/Biofeedback For Behavioral And Substance Use Disorders (providerexpress.com) for additional information, clinical evidence, rationale and references regarding each of the categories below.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply. Please refer to state specific guidance and authorization processes below.

Procedure Codes	Description	Prior Authorization
90875	Psychophysiological Therapy	PA required OPH* Service
90876	Psychophysiological Therapy	PA required OPH Service
90911	Biofeedback/peri/uro/rectal	PA Not Required

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**OPH (outpatient Hospital Setting)*

- 90911, 90912, 90913 are discontinued or non covered codes. Please visit: 5160-1-60 (Non-Institutional Fee Schedule) https://codes.ohio.gov/assets/laws/administrative-code/pdfs/5160/0/1/5160-1-60_PH_FF_A_APP1_20211215_1151.pdf
- See FFS Schedule and covered services here: https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

Prior Authorization

- Pursuant to Ohio Revised Code 5160.34, the Ohio Department of Medicaid (ODM) has consolidated links to Medicaid prior authorization requirements.

- All changes to prior authorization requirements for ODM-administered services and Managed Care Organization-administered services can be accessed via links here: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements.

OhioRISE

Purpose

OhioRISE (Resilience through Integrated Systems and Excellence) provides behavioral health services such as:

- Intensive and Moderate Care Coordination
- Mobile Response and Stabilization Services (MRSS)
- Intensive Home-Based Treatment (IHBT)
- Psychiatric Residential Treatment Facility (PRTF)
- Behavioral Health Respite to enrollees

OhioRISE System of Care focuses on community-based services, care coordination, reduction of out-of-home placements, and identification and implementation of evidence-based services.

Admission Criteria

- Be enrolled in Ohio Medicaid
- Be under age 21
- At risk for or may have had a behavioral health hospitalization
- Emergency department visits with a psychiatric diagnosis
- Meet Child and Adolescent Needs and Strengths (CANS) criteria

Once the individual meets criteria and is enrolled in OhioRISE, Aetna Better Health of Ohio will be responsible for Behavioral Health management of member. See below regarding Mixed Services protocol.

CANS Criteria

- OhioRISE uses the Child and Adolescent Needs and Strengths (CANS) assessment to determine if a child or youth qualifies for OhioRISE.
- CANS assessors gather information about the child or youth and their family and caregivers to understand their strengths and needs.
- The CANS steps are:
    - Referral* from UnitedHealthcare to CANS assessors (1 business day)
    - Assessment to take place within 72 hours
    - Assessment is reviewed within 10 business days

      *There are many ways to get a referral for a CANS assessment. It may be through UnitedHealthcare, OhioRISE, the Medicaid Consumer Hotline, a local Care Management Entity (CME), a behavioral health provider, a Mobile Response Stabilization Services (MRSS) provider, or others.
- Enrollment in OhioRISE for eligible children and youth begins on the submission date of their CANS assessment.
- In urgent cases, enrollment into OhioRISE can be:
    - The date of admission for an inpatient hospital stay for mental illness or substance use disorder or
    - The date of admission into a Psychiatric Residential Treatment Facility (PRTF).

CANS Resources

- Click for contacts to request a CANS assessment or Request additional OhioRise information.
- Learn more about CANS at www.managedcare.medicaid.ohio.gov/managed-care/ohiorise/4-cans-resources.

Services Available Under OhioRISE

MRSS Services

- See MRSS Services Section

Psychiatric Residential Treatment Facility (PRTF)

- See PRTF Section
    - Youth who meet the criteria are automatically eligible for OhioRise:
        - Be twenty years of age or younger at the time of enrollment;
        - Be determined eligible for Ohio Medicaid in accordance with Chapters 5160:1-1 to 5160:1-6
        - Not be enrolled in a MyCare Ohio plan as described in Chapter 5160-58

- Be an inpatient in a hospital, as defined in in Chapter 5160-2 of the Administrative Code, with a primary diagnosis of mental illness or substance use disorder or
- Be an inpatient in a psychiatric residential treatment facility (PRTF), as described in 42 CFR 441.150 to 42 CFR 441.184 (October 1, 2021).

OhioRISE Behavioral Health Respite

Purpose

Behavioral health respite services are services that provide short-term, temporary relief to the primary caregiver of an OhioRISE plan enrolled youth, in order to support and preserve the primary caregiving relationship.

Admission Criteria

- Coverage of behavioral health respite is subject to authorization by the OhioRISE plan in accordance with rule 5160-59-03.1 of the Administrative Code.
- Behavioral health respite services may be authorized in an amount, scope, and duration consistent with the youth's needs and behavioral health history.
- Coverage of the behavioral health respite services is based on a determination that the youth's primary caregiver has a demonstrated need for temporary relief from the care of the youth as a result of the youth's behavioral health needs.
- Behavioral health respite is identified on a youth's child and family-centered care plan developed by the care management entity or the OhioRISE plan.

Services

- Components of the behavioral health respite service may include:
  - Assistance with activities of daily living;
  - Transportation; and
  - Supports in home and community-based settings.

Limitations and Exclusions

- Reimbursement may be made for behavioral health respite when rendered to youth enrolled in the OhioRISE plan in accordance with rules 5160-59-02, 5160-59-02.1, and 5160-59-04 of the Administrative Code who:
  - Resides:
    - With the youth's primary caregiver in a home that is not owned, leased, or controlled by a provider of any health-related treatment or support services; and
      - In a foster home licensed by the Ohio department of job and family services (ODJFS);
      - In the home of kin; or
      - In a medically fragile or treatment foster home; and
      - Have behavioral health needs for the behavioral health respite as determined by the OhioRISE plan.
- Respite services may be provided either during normal awake hours or overnight. The provider of the behavioral health services will be awake when the youth is awake during the provision of behavioral health respite services. The child and family-centered care plan will document when a provider will need to be awake during overnight hours dependent on a youth's assessed needs.
- The behavioral health respite service may be provided on a planned or emergency basis. An emergency behavioral health respite service may be provided to address either a primary caregiver's unexpected need for behavioral health respite or to address an urgent need related to the youth's behavioral health diagnosis.
- Respite services delivery may occur in the following locations:
  - The primary caregiver's home that is not owned, leased, or controlled by a provider of any health-related treatment or support services;
  - A qualifying provider's place of residence when approved by the youth's legal guardian;
  - A foster home licensed by ODJFS;
  - In the home of kin;
  - In a treatment foster home certified by ODJFS; or
  - A community setting in which the general public has access.
- Reimbursement is allowed for behavioral health respite delivered in a foster home or treatment foster home when:
  - The behavioral health respite need is determined to meet the provisions set forth in this rule for behavioral health respite;

- The behavioral health respite does not duplicate reimbursement for otherwise available respite services in a foster home or treatment foster home;
- The Medicaid reimbursement does not cover room and board costs; and.
- Title IV-E funding is not used for coverage of the OhioRISE behavioral health respite service.

References

- Additional information can be found at 5160-59-03.4.

OhioRise Intensive Home-Based Treatment (IHBT)

Purpose

Intensive home-based treatment (IHBT) service is a comprehensive behavioral health service provided to a child/adolescent with serious emotional disturbance (SED) and their family, designed to treat mental health conditions that significantly impair functioning. IHBT may also be utilized for the treatment of children and adolescents that have co-occurring substance use or neurodevelopmental needs when these needs co-occur with a mental health condition.

IHBT is provided for the purpose of preventing out of home placement or facilitating a successful transition back home. IHBT integrates trauma-informed and resilience-focused assessment, crisis response, individual and family psychotherapy, service and resource coordination, and rehabilitative skill development with the goal of either preventing the out-of-home placement or facilitating a successful transition back to home. These intensive, time-limited behavioral health services are provided in the child/adolescent's natural environment with the purpose of stabilizing and improving their behavioral health functioning as documented using the Ohio specific child and adolescent needs and strengths (CANS) tool.

The purpose of IHBT is to enable a child/adolescent with SED to function successfully in the least restrictive, most normative environment. IHBT services are culturally, ethnically, racially, developmentally, and linguistically appropriate, and respect and build on the strengths of the child/adolescent and family's race, culture, and ethnicity.

For OhioRISE Intensive Home-Based Treatment also includes Multisystemic Therapy (MST) and Functional Family Therapy (FFT). These criteria should be applied for those services as well.

Admission Criteria

- Eligibility for IHBT will be determined by the IHBT team in collaboration with the youth and family and other cross systems partners by documenting the following criteria:
  - Is clinically determined to meet the "person with serious emotional disturbance" (SED) criteria in rule 5122-24-01 of the Administrative Code and the child or adolescent;
  - Is under twenty-one years of age;
  - Has a mental health need;
  - Has an Ohio specific CANS assessment that indicates marked to severe behavioral/emotional impairment and at least one of the following:
    - Impairment that seriously disrupts life functioning; or
    - Risk behaviors that are rated as actionable on the CANS.
  - Meets one or more of the following criteria as documented in the ICR:
    - Is at risk for out-of-home placement due to their behavioral health conditions;
    - Has returned within the previous thirty days from an out-of-home placement or is transitioning back to their home within thirty days; or
    - Requires a high intensity of behavioral health interventions to safely remain in or return home.

Services

- The following describes the activities and components of IHBT:
  - IHBT is an intensive service that consists of multiple face-to-face contacts per week with the child/adolescent and family, which includes collateral contacts related to the mental health needs of the child/adolescent as documented in the ICR. The frequency of contacts may fluctuate based on the assessed needs and unique circumstances of the child, adolescent, and family.
  - IHBT is strength-based and family-driven, with both the child/adolescent and family regarded as equal partners with the IHBT staff in all aspects of developing the service plan and service delivery;
  - IHBT is provided in the home, school, and community where the child/adolescent lives and functions;

- Crisis response is available twenty-four hours a day, seven days a week. Crisis response may be provided through written agreement with another agency, if at least one agency IHBT staff is accessible to the provider agency, and is available to the client and family as needed;
- Each child/adolescent and family receiving IHBT is assessed for risk and safety issues. When clinically indicated, a jointly written safety plan shall be developed that is provided to the child/adolescent and family;
- Collaboration occurs with other child-serving agencies or systems, e.g., school, court, developmental disabilities, job and family services, and health care providers that are providing services to the child/adolescent and family, as well as family and community supports identified by the child/adolescent and family;
- The service is flexible and individually tailored to meet the needs of the child/adolescent and family. Appointments are made at a time that is convenient to the child/adolescent and family, including evenings and weekends if necessary; Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment.

References

- Additional information See 5122-29-28 and 5160-59-03.3.

Resources and References

- OhioRISE, Aetna Better Health of Ohio: AetnaBetterHealth.com/OhioRISE.
- Ohio Medicaid OhioRISE page to learn more.
- Ohio Medicaid OhioRISE FAQ pdf page
- The OhioRISE FamilyConnect Portal is where members can get the most from their behavioral health care.
- For more information about billing for the new and enhanced services for youth enrolled in OhioRISE, please refer to the OhioRISE Provider Enrollment and Billing Guidance: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/a81a1aee-e68e-40ae-8b12-14aabb3cfa7a/OhioRISE+Provider+Enrollment+and+Billing+Guidance.pdf?MOD=AJPERES&CVID=o3tVsyN

OhioRISE Mixed Services Protocol

- The OhioRISE Mixed Services Protocol clarifies responsibility for behavioral health services provided to children and youth who are:
  - Enrolled in the OhioRISE plan.
  - Become enrolled in the OhioRISE plan as of the date of admission to an inpatient behavioral health stay on or after OhioRISE program implementation (July 1, 2022).
- It excludes the enhanced or new services that are only covered by the OhioRISE plan.
- Services that are not behavioral health (dental, transportation, etc.) are not OhioRISE covered services and remain the responsibility of the individual's MCO (or fee-for-service (FFS) Medicaid).
- Responsibility for behavioral health services provided to children and youth who are not enrolled in the OhioRISE plan remain the responsibility of the recipient's managed care organization or fee-for-service Medicaid.
- https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/66beb0f3-0b72-482e-8c17-1c981c175842/OHR+Mixed+Services+Protocol.pdf?MOD=AJPERES&CVID=o2WaD-Y.

Psychiatric Residential Treatment Facility (PRTF)

Purpose

Psychiatric Residential Treatment Facility (PRTF) is a sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to child or adolescent members who have significant functional impairments resulting from a behavioral health condition.

A child or youth (referred to here as 'child') needs a PRTF level of care when their psychiatric symptoms cause danger to themselves, or others and intensive community services have failed to keep the child and others safe and have failed to improve their psychiatric condition or prevent regression.

Admission Criteria

- PRTF services for individuals under age 21 must be:

    - Provided under the direction of a physician;
    - Provided by:
        - A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or a hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.
        - A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.
- Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following:
    - The date the individual no longer requires the services; or
    - The date the individual reaches 22; and
- Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances).
- Inpatient psychiatric services furnished in a psychiatric residential treatment facility must satisfy all requirements governing the use of restraint and seclusion.
- A team must certify that:
    - Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
    - Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be needed.
- The certification satisfies the utilization control requirement for physician certification.
- Certification must be made by terms specified as follows:
    - For an individual who is a beneficiary when admitted to a facility or program, certification must be made by an independent team that:
        - Includes a physician;
        - Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
        - Has knowledge of the individual's situation.
    - For an individual who applies for Medicaid while in the facility of program, the certification must be -
        - Made by the team responsible for the plan of care; and
        - Cover any period before application for which claims are made.
        - For emergency admissions, the certification must be made by the team responsible for the plan of care within 14 days after admission.

OhioRISE Eligibility

- Youth who meet the criteria are automatically eligible for OhioRISE:
    - Be twenty years of age or younger at the time of enrollment;
    - Be determined eligible for Ohio Medicaid in accordance with Chapters 5160:1-1 to 5160:1-6;
    - Not be enrolled in a MyCare Ohio plan as described in Chapter 5160-58;
    - Be an inpatient in a hospital, as defined in in Chapter 5160-2 of the Administrative Code, with a primary diagnosis of mental illness or substance use disorder; or
    - Be an inpatient in a psychiatric residential treatment facility (PRTF), as described in 42 CFR 441.150 to 42 CFR 441.184 (October 1, 2021).

Continued Stay Criteria

- Inpatient psychiatric services must involve “active treatment”, which means implementation of a professionally developed and supervised individual plan of care that is:
    - Developed and implemented no later than 14 days after admission; and
    - Designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time.

Individual Plan of Care

"Individual plan of care" means a written plan developed for each beneficiary to improve his condition to the extent that inpatient care is no longer necessary.

- The plan of care must:
    - Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the beneficiary's situation and reflects the need for inpatient psychiatric care;
    - Be developed by a team of professionals in consultation with the beneficiary; and his parents, legal guardians, or others in whose care he will be released after discharge;
    - State treatment objectives;
    - Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
    - Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.
- The plan must be reviewed every 30 days by the team to:
    - Determine that services being provided are or were required on an inpatient basis, and
    - Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an inpatient.
- The development and review of the plan of care as specified in this section satisfies the utilization control requirements for:
    - Recertification; and
    - Establishment and periodic review of the plan of care
    - The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.
    - Based on education and experience, preferably including competence in child psychiatry, the team must be capable of
        - Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
        - Assessing the potential resources of the beneficiary's family;
        - Setting treatment objectives; and
        - Prescribing therapeutic modalities to achieve the plan's objectives.
    - The team must include, as a minimum, either -
        - A Board-eligible or Board-certified psychiatrist;
        - A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
        - A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.
    - The team must also include one of the following:
        - A psychiatric social worker.
        - A registered nurse with specialized training or one year's experience in treating mentally ill individuals.
        - An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
        - A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

References

- Additional Information can be found in rule 5160-59.
- OhioRISE website for additional information https://managedcare.medicaid.ohio.gov/managed-care/ohiorise
- inpatient psychiatric services to individuals under age 21: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-D
- Additional Information can be located at 5160-59, 5160-59-02 thru 5160-59-2.1.

Psychological and Neuropsychological Testing

Purpose

Psychological testing includes the administration, interpretation, and scoring of tests designed to measure areas of intellectual, cognitive emotional, and behavioral functioning, in addition to identifying psychopathology, personality style, interpersonal processes, and adaptive skills. Service activities can include test selection, review of records, consultation with referral source, integration of clinical data, clinical decision making, preparation of the testing report, and reviewing the results of testing with member and/or caregivers.

Neuropsychological testing procedure differs from that of psychological testing in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.). These procedures are objective and quantitative in nature and require the patient to directly demonstrate his/her level of competence in a particular cognitive domain.

Refer to Optum Policy: BH803PNTG0222 for additional information, clinical evidence, rationale and references regarding each of the categories below.

Refer to the medical policy for Neuropsychological Testing Under Medical Benefits 2022T0152X for additional information, clinical evidence, rationale and references.

Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary. Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing. See BH Manual v 1_24.pdf (ohio.gov).

Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, a report may be requested to indicate the medical necessity for extended testing.

Admission Criteria

- Psychological and Neuropsychological Testing is located under 5160-8 Therapeutic and Diagnostic Services of the Administrative code, specific to “Behavioral health service"- Other licensed Professionals under rule 5160-8-05
- 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.
- Includes neither psychiatry nor medication management.
    - Provider requirements.
        - A licensed psychologist or licensed independent practitioner must be enrolled in the Medicaid program as an eligible provider, even if services are rendered under the supervision of another eligible provider.
        - 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.

Limitations and Exclusions

- Psychological and Neuropsychological testing may be a covered benefit under Healthchek/EPSDT 5160-1-14 and/or the Medicaid School Program (MSP) 5160-35-05.
- 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.
    - Coverage/Payment may be made for the following behavioral health services:

        - Psychiatric diagnostic evaluation;
        - Psychological and neuropsychological testing;
        - Assessment and behavior change intervention:
    - 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.
        - 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;
        - For psychological testing a maximum of twelve hours per recipient, per calendar year; and
        - For neuropsychological testing, a maximum of eight hours per recipient, per calendar year;
    - No payment will be made under this rule for the following activities:
        - Services that are rendered by an unlicensed individual other than a supervised trainee;
        - Activities, testing, or diagnosis conducted for purposes specifically related to education;
        - 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:
        - Encounter groups, workshops, marathon sessions, or retreats;
        - Sensitivity training;
        - Sexual competency training;
        - Recreational therapy (e.g., art, play, dance, music);
        - Services intended primarily for social interaction, diversion, or sensory stimulation; and
        - The teaching or monitoring of activities of daily living (such as grooming and personal hygiene);
        - Psychotherapy services if the patient cannot establish a relationship with the provider because of a cognitive deficit;
        - Family therapy for the purpose of training family members or caregivers in the management of the patient; and
        - Self-administered or self-scored tests of cognitive function.
    - Psychological and Neuropsychological Testing will require Prior Authorization past 20 hours/encounters per calendar year: https://bh.medicaid.ohio.gov/Portals/0/BH%20Manual%20v%201_24.pdf .

Prior Authorization

- Pursuant to Ohio Revised Code 5160.34, the Ohio Department of Medicaid (ODM) has consolidated links to Medicaid prior authorization requirements.
- All changes to prior authorization requirements for ODM-administered services and Managed Care Organization-administered services can be accessed via links here: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements.

Specialized Recovery Services/Recovery Management

Purpose

"Specialized recovery services program" means the home and community-based services (HCBS) program jointly administered by ODM and the Ohio department of mental health and addiction services (OhioMHAS) or only administered by ODM to provide services to individuals with qualifying diagnoses of severe and persistent mental illness or diagnosed chronic conditions.

Specialized Recovery Services program includes:

- Peer Recovery Support
- Recovery Management
- Individualized Placement Support
- Supported Education

Specialized Recovery Services is the coordination of all specialized recovery services program services received by an individual and assisting him or her in gaining access to needed Medicaid services, as well as medical, social, educational, and other resources, regardless of funding source.

The Recovery Manager is the person responsible for performing the needs-based assessment and monitoring the provision of services included in the person-centered care plan to ensure the individual's needs, preferences, health, and welfare are supported.

Services

Recovery Management

- Recovery Management is the coordination of all SRSP services:
    - Administration of the "ANSA";
    - Verification of the individual's residence in an HCBS setting;
    - Verification of the individual's qualifying behavioral health diagnoses or diagnosed chronic conditions as described in the qualifying diagnosis appendix which is available on the ODM website at https://Medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/srs; and
    - Evaluation of all other eligibility criteria.
        - Evaluations may be conducted by video conference or telephonically in lieu of face-to-face unless the individual's needs require a face-to-face visit.
    - Person-centered care planning and updating the individual's service plan;
    - Facilitation of transitioning to the community for individuals who receive Medicaid-funded institutional services.
        - Recovery management activities for individuals leaving institutions shall be coordinated with, and shall not duplicate, institutional, Mycare and managed care plan discharge planning, and other community resources.
    - Informing the individual about services, person centered planning, resources for recovery, and individual rights and responsibilities;
        - Supporting the review and approval of the individual's person-centered service plan;
        - Monitoring the individual's service plan;
        - Identifying and resolving issues that impede access to needed services;
        - Identifying resources in the person-centered service plan to support the individual's recovery goals, including non-HCBS Medicaid, Medicare, private insurance, and community resources;
    - Coordinating with other service providers and systems;
        - Assisting with accessing resources necessary to complete Medicaid redetermination and retain HCBS and Medicaid eligibility;
    - Responding to and assessing emergency situations and incidents and assuring that appropriate actions are taken to protect the health, welfare, wellness, and safety of the individual and assist in meeting the needs of the individual in those situations;
    - Evaluating the individual's progress in meeting his or her goals;
    - Participating in quality oversight activities and reporting activities;
        - Participating in case consultations regarding an individual's progress with a trans-disciplinary care team.
        - When an individual is assigned to or enrolled in a comprehensive care management program operated by an accountable entity (e.g., patient centered medical home or managed care plan), the recovery manager will support access to the individuals full set of Medicaid and Medicare benefits and community resources across the continuum of care, including behavioral, medical, LTSS and social services;
    - Updating the assessment at least annually, making revisions to the individual's service plan, and making recommendations to the accountable care management entity, as appropriate;
    - Educating the individual about hearing and appeal rights; and
    - Assisting the individual with preparing and submitting a hearing request, as needed.

Individualized Placement Support – Supported Employment (IPS-SE)

- There are eight core principles to the IPS model:
    - Zero Exclusion
    - Integrated Employment & Treatment
    - Competitive Jobs
    - Rapid Job-Search
    - Systematic Job Development
    - Time-Unlimited Support

    - Consumer Preferences
    - Benefits Planning
- Individualized placement and support - supported employment (IPS-SE) is the implementation of evidence-based practices allowing individuals to obtain and maintain meaningful employment by providing training, ongoing individualized support, and skill development to promote recovery.
- IPS-SE is an evidence-based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness to obtain, maintain, and advance within competitive community integrated employment positions.
    - IPS-SE activities include:
        - Benefits planning;
        - Development of a vocational plan;
        - General consultation, including advocacy and building and maintaining relationships with employers;
        - Individualized job supports, including regular contact with the individual's employer(s), family members, guardians, advocates, treatment providers, and other community supports;
        - Job coaching;
        - Job development and placement;
        - Job seeking skills training;
        - On-the-job training and skill development;
        - Vocational rehabilitation guidance and counseling;
        - Time unlimited vocational support; and
        - Vocational assessment.
    - IPS-SE activities may include the following when provided in conjunction with an IPS-SE activity:
        - Facilitation of natural supports;
        - Peer services; and/or
        - Transportation.
    - The responsible service provider in conjunction with the treatment team and, whenever possible, the member develops a person-centered service plan that includes a description of the following:
        - The member’s recovery and resiliency goals;
        - Strengths;
        - Problems;
        - Specific and measurable goals for each problem;
        - Interventions that will support the member in meeting the goals.
        - The services plan must reflect the services and supports that are important for the member to meet the needs identified through the assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
    - The provider also completes a comprehensive employment assessment in order to establish a vocational profile and individual employment support plan.
    - The person-centered service plan and employment plan are updated or revised at least quarterly, or as necessary to document changes in the member's service needs.
    - Discharge Planning
        - Prevocational services are designed to be provided for a limited time in order to prepare a member for employment. If a member has been receiving prevocational services for more than one year and is not ready for regular employment, the interdisciplinary team should re-evaluate the necessity of prevocational services and explore other service options to meet the member’s vocational needs, if necessary.

Supported Employment (SE)

- Supported Employment activities include:
    - Vocational Assessment
    - Development of a Vocational Plan ;
    - On-the-job Training and skill development;
    - Job seeking skills training (JSST);
    - Job development and placement;
    - Job coaching;

- Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports;
- Benefits planning;
- General consultation, advocacy, building and maintaining relationships with employers;
- Rehabilitation guidance and counseling; or,
- Time unlimited vocational support.

Supported Employment can be provided in conjunction with any of the following services:

- Facilitation of natural supports;
- Transportation; or,
- Peer services.
- The outcome of an employment service is that individuals will obtain and maintain a job of their choosing through rapid job placement which will increase their self-sufficiency and further their recovery. Employment services should be coordinated with mental health services and substance use treatment and services.

Peer Recovery Support (PRS)

- Peer recovery support provides community-based supports to an individual with a mental illness with individualized activities that promote recovery, self-determination, self-advocacy, well-being, and independence through a relationship that supports the person's ability to promote his or her own recovery.
- Peer recovery supporters use their own experiences with mental illness to help individuals reach their recovery goals.
  - Peer Recovery Support activities include:
    - Assisting the individual with accessing and developing natural support systems in the community;
    - Attending and participating in care team meetings;
    - Conducting outreach to connect individuals with resources;
    - Coordinating and/or assisting in crisis interventions and stabilization as needed;
    - Developing and working toward achievement of the individual's personal recovery goals;
    - Facilitating development of daily living skills;
    - Modeling personal responsibility for recovery;
    - Promoting coordination among similar providers;
    - Providing group facilitation that addresses symptoms, behaviors, and thought processes to assist an individual in eliminating barriers to seeking and maintaining recovery, employment, education, and housing;
    - Supporting individuals in achieving personal independence as identified by the individual; and
    - Teaching skills to effectively navigate the health care delivery system to utilize services.
  - Peer Recovery Support activities does not include:
    - Assistance with activities of daily living as defined in rule 5160-3-05 of the Administrative Code;
    - Management of medications; and
    - Performance of activities covered under other services.

Admission Criteria

- The member is 21 years of age or older
- Has a current behavioral health diagnosis
  - Or a diagnosis listed in the qualifying diagnosis appendix: https://Medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/srs
  - Or be active on the solid organ or soft tissue waiting list
- Participate in an initial assessment using the "Adult Needs and Strengths Assessment (ANSA)" and obtain a qualifying score of either:
  - Two or greater on at least one item in the "mental health needs" or "risk behaviors" sections; or
  - Three on at least one item in the "life domain functioning" section.
- The member demonstrates needs related to the management of his or her behavioral health as documented in the "ANSA";
- The member has at least one of the following risk factors prior to enrollment in the program:
  - One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or
  - A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment while residing in that correctional facility; or
  - Two or more emergency department visits with a psychiatric diagnosis or diagnosis chronic condition; or

    - A history of treatment in an intensive outpatient rehabilitation program for greater than ninety days.
    - One or more hospital inpatient admissions due to a diagnosed chronic condition as listed in the qualifying diagnosis appendix available at https://Medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/srs
- The member meets at least one of the following:
    - Currently have a need for one or more of the specialized recovery services to maintain stability, improve functioning, prevent relapse, maintain residency in the community, and be assessed and found that, if not for the provision of home and community-based services (HCBS) for stabilization and maintenance purposes, he or she would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning); or
    - Previously have met the needs-based criteria within two years of the date of initial assessment, and be assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, he or she would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).
- Reside in an HCBS setting;
- Demonstrate a need for specialized recovery services, and not otherwise receive those services;
- Have needs that can be safely met through the program in an HCBS setting; and
- Participate in the development of a person-centered care plan.

Continued Stay Criteria

- To be enrolled in and to maintain enrollment in the specialized recovery services program, an individual shall be determined to meet all of the following requirements:
    - Be determined eligible for the program;
    - Maintain residency in an HCBS setting;
    - Agree to and receive recovery management services in accordance with his or her person-centered service plan including, but not limited to:
        - Participation in reassessments at least annually and ongoing reassessments as needed;
        - Participation in the development and implementation of the person-centered service plan and consent to the plan by signing and dating it; and
        - Participation in quality assurance and participant satisfaction activities during his or her enrollment in the program including, but not limited to, in-person visits.
    - Once enrolled in the program, an individual's level of need shall be reassessed at least annually, and more frequently if there is a significant change in the individual's condition that may impact his or her health and welfare. If the reassessment determines the individual no longer meets the requirements, he or she shall be disenrolled from the program.

Discharge Criteria

- If an individual fails to meet any of the requirements the individual shall be denied enrollment in the program.
- Once enrolled in the program, an individual's level of need shall be reassessed at least annually, and more frequently if there is a significant change in the individual's condition that may impact his or her health and welfare. If the reassessment determines the individual no longer meets the requirements, he or she shall be disenrolled from the program.
- If, at any time, it is determined that an individual enrolled in the program no longer meets the requirements set forth, he or she shall be disenrolled from the program. Reassessment is not required to make this determination.
- If an individual is denied enrollment in the program or is disenrolled from the program, the individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Limitations and Exclusions

- ODM and or designee is sponsible for the ongoing monitoring and oversight of all providers of specialized recovery services (hereafter referred to as providers) and contractors to ensure compliance with program requirements. See 5160-43-07 for details.
- Each activity has varied provider requirements and supervision, please see 5160-43 for specifics.
- Adaptations, assistance, and training used to meet the employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act, 42 U.S.C. 12101 et. seq. (as in effect on January 1, 2021);
- Job placements paying below minimum wage;
- Supervisory activities rendered as a normal part of the business setting;

- Supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business;
- Unpaid internships, unless they are considered crucial for job placement and such experience is vital to the individual achieving his or her vocational goal(s);
- Services which are not provided in integrated settings including sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following:
    - Incentive payments made to an employer to encourage hiring the individual;
    - Payments that are passed through to the individual; or
    - Payments for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business; or payments used to defray the expenses associated with starting up or operating a business.
- Assistance with activities of daily living;
- Management of medications; and
- Performance of activities covered under other services.
- SRS programming is covered when rendered by telehealth

References

- Additional Information can be found in rule 5160-43.
- Please refer to BH workgroup limits on the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals.

Therapeutic Behavioral Services

Purpose

Therapeutic behavioral services (TBS) and psychosocial rehabilitation (PSR) services are an array of activities intended to provide individualized supports or care coordination of healthcare, behavioral healthcare, and non-healthcare services. TBS and PSR may involve collateral contacts and may be delivered in all settings that meet the needs of the individual.

Services

TBS service activities include, but are not limited to the following:

- Consultation with a licensed practitioner or an eligible provider to assist with the individual's needs and service planning for individualized supports or care coordination of healthcare, behavioral healthcare, and non-healthcare services and development of a treatment plan;
- Referral and linkage to other healthcare, behavioral healthcare, and non-healthcare services to avoid more restrictive levels of treatment;
- Interventions using evidence-based techniques;
- Identification of strategies or treatment options;
- Restoration of social skills and daily functioning; and,
- Crisis prevention and amelioration.

PSR service activities include, but are not limited to the following

- Restoration, rehabilitation, and support of daily functioning to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person’s daily functioning;
- Restoration and implementation of daily functioning and daily routines critical to remaining successfully in home, school, work, and community; and,
- Rehabilitation and support to restore skills to function in a natural community environment.

Limitations and Exclusions

- TBS and PSR will not be reimbursed when a patient is enrolled in assertive community treatment (ACT) or receiving residential substance use disorder treatment services. A separate payment will not be made for TBS and PSR while a youth is enrolled in intensive home-based treatment (IHBT) unless the service is prior authorized.
- TBS must be delivered as an individual or group intervention with the individual, family/caregiver and/or other collateral supports.
- PSR must be delivered as an intervention with the individual, not in a group setting.
- TBS Group limit of 1 per day. Prior authorization is required for an additional per diem service to the same client on the same day rendered by a different billing agency.

References

- Additional Information can be found in rule 5122-29-18, 5160-27-08, 5160-27-06.
- Please refer to the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals .

References

Assertive Community Treatment (ACT): https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-29 and https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-04

Behavioral Health Nursing: https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-11

CANS Ohio, Child and Adolescent Needs and Strengths Assessment: https://cansohio.org/

Centers for Medicare and Medicaid, Department of Health and Human Services, Title 42, Chapter IV, Inpatient Psychiatric Services for Individuals Under Age 21 (PRTF): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-D

Community Psychiatric Support Treatment (CPST) Service: https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-17

Complementary and Alternative Medicine (CAM)Treatments, Optum Behavioral Clinical Policy: BH727CAM_0622

Coverage and Limitations of Behavioral Health Services: https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-02

Healthchek/EPSDT: https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-14

Intensive Home-Based Treatment (IHBT) Service: https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-28

Mobile Response and Stabilization Service: https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-14

Medicaid School Program (MSP): https://codes.ohio.gov/ohio-administrative-code/rule-5160-35-05

Medical Necessity: https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-01

Medical Policy for Neuropsychological Testing Under Medical Benefits: 2022T0152X

Mental Health Therapeutic Behavioral Services and Psychosocial Rehabilitation: https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-08

Ohio Medicaid Behavioral Health provider site and manual: https://bh.medicaid.ohio.gov/manuals

OhioRISE: https://codes.ohio.gov/ohio-administrative-code/chapter-5160-59

OhioRISE Managed Care: https://managedcare.medicaid.ohio.gov/managed-care/ohiorise

OhioRISE Mixed Services Protocol: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/66beb0f3-0b72-482e-8c17-1c981c175842/OHR+Mixed+Services+Protocol.pdf?MOD=AJPERES&CVID=o2WaD-Y

OhioRISE website for additional information: https://managedcare.medicaid.ohio.gov/managed-care/ohiorise

OhioRISE, Aetna Better Health of Ohio: AetnaBetterHealth.com/OhioRISE

Ohio Medicaid: OhioRISE page

Ohio Medicaid: OhioRISE FAQ pdf page

OhioRISE: FamilyConnect Portal

OhioRISE Provider Enrollment and Billing Guidance: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/a81a1aee-e68e-40ae-8b12-14aabb3cfa7a/OhioRISE+Provider+Enrollment+and+Billing+Guidance.pdf?MOD=AJPERES&CVID=o3tVsyN

Ohio Telehealth: https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/Telehealth-Billing-Guidelines.pdf

Optum Guidelines and Policies: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies.html

Optum Behavioral Clinical Policy: BCP - Neurofeedback/Biofeedback For Behavioral And Substance Use Disorders (providerexpress.com)

Prior Authorization for ODM-administered services and Managed Care Organization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

Psychological and Neuropsychological Testing Optum Policy: BH803PNTG0222

Specialized Recovery Services Program: https://codes.ohio.gov/ohio-administrative-code/chapter-5160-43

Therapeutic Behavioral Services and Psychosocial Rehabilitation: https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-18

Revision History

Date	Summary of Changes
05/20/2019	Version 1
01/31/2020	Version 2
10/19/2020	Version 3: Addition of PRTF, CCTS and IISS
04/19/2021	Version 4
10/19/2022	Version 5
01/01/2023	Version 6