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

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

(1) A mental health service performed in an inpatient or outpatient hospital setting is treated as a hospital service, rules for which are set forth in Chapter 5160-2 of the Administrative Code.

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

(3) Provisions governing payment for mental health services as the following service types are set forth in the indicated part of the Administrative Code:

(a) Cost-based clinic services, Chapter 5160-28; and

(b) Medicaid school program services, Chapter 5160-35.

(B) Definitions for the purposes of this rule.

(1) "Mental health service" is a service or procedure that is performed for the diagnosis and treatment of mental, behavioral, or emotional disorders by a licensed professional or under the supervision of a licensed professional. As it is used in this rule, the term includes neither psychiatry nor medication management.

(2) "Licensed psychologist" has the same meaning as in section 4732.01 of the Revised Code.

(3) "Independent practitioner" is a collective term used in this rule to designate the following persons who hold a valid license to practice in accordance with the indicated portion of the Revised Code:

(a) Licensed professional clinical counselor, section 4757.22;

(b) Independent social worker, section 4757.27; and

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

(4) "Supervised practitioner" is a collective term used in this rule to designate the following persons who hold a valid license to practice in accordance with the indicated portion of the Revised Code:

(a) Licensed professional counselor, section 4757.23;

(b) Social worker, section 4757.28; and

(c) Marriage and family therapist, section 4757.30.

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

(a) Registered counselor trainee, defined in rule 4757-13-09 of the Administrative Code;

(b) Registered social work trainee, defined in rule 4757-19-05 of the Administrative Code;

(c) Marriage and family therapist trainee, defined in rule 4757-25-08 of the Administrative Code; and

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

(6) "Independent practice" is a business arrangement in which a professional is not subject to the administrative and professional control of an employer such as an institution, physician, or agency. In particular, a professional working from an office that is located within an entity is considered to be in independent practice when both of the following conditions are met:

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

(b) The professional maintains a private practice (i.e., offers services to the general public as well as to the customers, residents, or patients of the entity), and the practice is not owned, either in part or in total, by the entity.

(C) Provider requirements.

(1) A licensed psychologist or independent practitioner must be enrolled in the medicaid program as an eligible provider, even if services are rendered under the supervision of an eligible provider.

(2) A licensed psychologist in independent practice or independent practitioner in

independent practice who can participate in the medicare program either must do so or, if the practice is limited to pediatric treatment, must meet all requirements for medicare participation other than serving medicare beneficiaries.

(D) Coverage.

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

(a) Diagnostic evaluation, one unit;

(b) Psychological and neuropsychological testing;

(c) Assessment and behavior change intervention:

(i) Alcohol or substance (other than tobacco) abuse, structured assessment and brief intervention, fifteen to thirty minutes;

(ii) Alcohol or substance (other than tobacco) abuse, structured assessment and intervention, greater than thirty minutes;

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

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

(d) Therapeutic services:

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

(a) Psychotherapy, thirty minutes with patient and/or family member;

(b) Psychotherapy, forty-five minutes with patient and/or family member;

(c) Psychotherapy, sixty minutes with patient and/or family member;

(d) Psychotherapy for crisis, first sixty minutes;

(e) Psychotherapy for crisis, each additional thirty minutes; and

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

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

(a) Family psychotherapy without patient present;

(b) Family psychotherapy with patient present;

(c) Group psychotherapy;

(d) Multiple-family group psychotherapy; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Constraints.

(1) Every mental health service reported on a claim must be within the scope of practice of the licensed professional who renders or supervises it and must be performed in accordance with any supervision requirements established in law, regulation, statute, or rule.

(2) Neither a supervised practitioner nor a supervised trainee can be reported on a claim as the rendering provider.

(3) No payment will be made under this rule for the following items:

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

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

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

(d) Services that are unrelated to the treatment of a specific mental health complaint but serve primarily to enhance skills or to provide general information, examples of which are given in the following non-exhaustive list:

(i) Encounter groups, workshops, marathon sessions, or retreats;

(ii) Sensitivity training;

(iii) Sexual competency training;

(iv) Recreational therapy (e.g., art, play, dance, music);

(v) Services intended primarily for social interaction, diversion, or sensory stimulation; and

(vi) The teaching or monitoring of activities of daily living (such as grooming and personal hygiene);

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

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

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

(F) Documentation of services.

The patient's file must substantiate the medical necessity of services performed, and each record is expected to bear the signature and indicate the discipline of the professional who entered it. The following items must be included as documentation if applicable:

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

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

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

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

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

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

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

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

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

(10) Summaries of psychotherapy sessions; and

(11) Any psychotherapy notes that are kept.

(G) Claim payment.

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

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

(2) For a mental health service other than testing, the percentage differs according to the provider who rendered it:

(a) For a service rendered by a physician, an advanced practice registered nurse, a physician assistant, or a licensed psychologist, it is one hundred per cent; and

(b) For a service rendered by an independent practitioner or a supervised practitioner, it is eighty-five per cent.

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