Optum

Optum Behavioral Health Solutions
Medicaid State-Specific
Supplemental Clinical Criteria

Ohio Medicaid Supplemental Clinical Criteria

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➲ Instructions for Use

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Related UnitedHealthcare® Community Plan of Ohio

- Medical and Drug Policies for Community Plan of Ohio

Application

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.

UnitedHealthcare Community Plan of Ohio has adopted for use the Ohio Department of Medicaid (ODM) Behavioral Health (BH) Provider Manual for Community Mental Health Center (type 84/95) providers. All providers rendering services to UnitedHealthcare Community Plan of Ohio members shall adhere to the requirements in the ODM BH Provider Manual, with evolving limited exceptions that will be outlined in separate written communications to providers from UnitedHealthcare Community Plan of Ohio or ODM.

To clearly reflect that MCOs, MCOPs, and/or delegated entities are utilizing the correct definition of medical necessity when making prior authorization and coverage determinations, MCOs and MCOPs must cite OAC rule 5160-1-01(A), at a minimum, as the supporting regulation for their decision.

Please see the Optum Behavioral Health Services National Provider Network Manual for additional information: Optum Behavioral Health Services National Manual.

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.
- For additional details: Clinical Practice Guidelines

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 medical necessity of services and treatments.
- **Optum Psychological and Neuropsychological Testing Guidelines**: Criteria used to make determinations related to psychological and neuropsychological testing.
- **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.
- For additional details: Clinical Criteria and Guidelines

Additional information can be found here: Clinical Criteria and Guidelines

Benefit Considerations

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

State Specific Rules, Coverage Rationale and Limitations

Ohio Medicaid Specific Rules, Coverage and Limitations

Medical Necessity

- Medical necessity for individuals covered by early and periodic screening, diagnosis and treatment (EPSDT) is 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 is 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.
- 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 of the Ohio Administrative Code.

Documentation of Services for Behavioral Health and Substance Use Treatment Services

- The patient's medical record must substantiate the medical necessity of services performed, and each record is expected to bear the signature and indicate the discipline of the professional who recorded it.
  - All relevant diagnoses pertaining to medical or physical conditions as well as to behavioral health;
  - A treatment plan which must be completed within five sessions or one month of admission, whichever is longer and must specify mutually agreed upon treatment goals, track responses to ongoing treatment, and present a prognosis that documents that the plan has been reviewed with the patient and, as appropriate, with family members, parents, legal guardians or custodians or significant others;.
  - The inability or refusal of the patient to participate in treatment planning or services must be documented and the reason given.
  - Test results, if applicable, with interpretation;
  - Evidence that the patient has sufficient cognitive capacity to benefit from treatment; and
  - Discharge summaries which include date of admission, date of last service, outcome of the service and recommendations and referrals made to the patient.
- The following items must be included as progress note documentation and shall be completed at a minimum on a per provision basis, or on a daily or weekly basis:
  - The type, description, date, time of day, duration, location and, if documenting weekly services, the frequency of treatment, with dates of service;
  - A description of the patient's current symptoms and changes in functional impairment;
  - Changes in medications taken by or prescribed for the patient when applicable;
  - The amount of time spent by the provider with the patient;

- The amount of time spent by the provider in interpreting and reporting on procedures represented by "Central Nervous System Testing" codes, when applicable;
- Assessment of the patient's progress or lack of progress and a brief description of the progress made, if any, significant changes in symptoms, functioning, or events in the life of the patient and recommendation for modifications to the treatment plan, if applicable;
- Evidence of clinical supervision, as required; and
- The clinician's signature, date of signature, and credentials; the clinician must be credentialed to provide all services documented.
- Documentation may be completed using narratives or structured formats (e.g., checklists), provided all required elements are captured
- Must indicate when services are provided via telehealth
- Termination Treatment Summary must be completed within 30 days after a client is determined inactive.
  - It must include:
    - Admission date and last service date
    - Outcome of services (progress/level of care)
    - Final diagnosis
    - ASAM level at admission and discharge (if applicable)
    - Recommendations, referrals, and crisis guidance
    - Medications prescribed at discharge
    - Documentation of appeal rights if involuntarily terminated
    - Provider signature, date, and credentials and evidence of clinical supervision

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 Ohio Administrative Code and Chapter 5160-27 of the Ohio 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): one per code, per recipient, per billing provider, per calendar year. Prior authorization is required for additional service. Cannot be billed by provider type 95. See the Ohio Department of Medicaid Community Behavioral Health Rehabilitative Services Authorization Request Form to request additional units.
  - **Assertive community treatment (ACT):** as defined in rule 5160-27-04 of the Ohio Administrative Code is available on or after the date as determined by prior authorization approval. See the Ohio Department of Medicaid Community Behavioral Health Rehabilitative Services Authorization Request Form to Request Service. Additional assessment results that may need to be provided for this service.
  - Medicaid School Program (MSP): The managed care organization (MCO) is not responsible for payment of services provided through the Medicaid school program (MSP) pursuant to Chapter 5160-35, 5160-35-04, and 5160-26-03 of the Ohio Administrative Code.
- Psychiatric diagnostic evaluation and psychiatric diagnostic evaluation with medical services one of each encounter per recipient, per billing provider, per billing agency, per calendar year. Prior authorization is required for additional service. See the Ohio Department of Medicaid Community Behavioral Health Rehabilitative Services Authorization Request Form to Request additional units.
- The "Ohio children's initiative brief CANS assessment" and the "Ohio children's initiative comprehensive CANS assessment" are covered as defined in rules 5160-59-01, 5160-59-02 of the Ohio 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 of the Ohio Administrative Code.

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 Ohio Administrative Code is limited to two assessments per recipient, per billing agency, per calendar year. Prior authorization is required for
  - additional service. See the Ohio Department of Medicaid Community Behavioral Health Rehabilitative Services Authorization Request Form to Request additional units.

- Substance use disorder **urine drug screening** as referenced in rule 5160-27-09 of the Ohio Administrative Code, is limited to one per day, per recipient. See the Ohio Urine Drug Screen Prior Authorization Request Form to request additional units.
- Additional Information can be found in rule 5160-1-01 of the Ohio Administrative Code.
- 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 Ohio Administrative Code are covered by ODM when rendered and billed by an eligible provider as described in rule 5160-27-01 of the Ohio 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 Ohio Administrative Code or the opiate treatment service section of appendix DD to rule 5160-1-60 of the Ohio Administrative Code are reimbursed by the department when rendered and billed:
  - by an opiate treatment program as described in Chapter 5122-40 of the Ohio 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 Ohio Administrative Code.
- Medical and evaluation and management services stated in the appendix to rule 5160-27-03 of the Ohio Administrative Code or appendix DD to rule 5160-1-60 of the Ohio 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 Ohio Administrative Code and operating within their scope of practice; or
  - A pharmacist, rendering services in accordance with rule 5160-8-52 of the Ohio 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, 5122-27-23, and 5160-8-05 of the Ohio Administrative Code.
    - Medicaid providers are required to keep such records as are necessary to establish that conditions of payment for Medicaid covered services have been met, and to fully disclose the basis for the type, frequency, extent, duration, and delivery setting of services provided to Medicaid recipients, and to document significant business transactions. Medicaid providers are required to provide such records and documentation to the Ohio department of Medicaid (ODM) or its designee
    - Services billed to and reimbursed by the department, which are not validated in the recipients' records, are subject to recoupment through the audit and review process described in this rule.
  - 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 Ohio 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 Ohio Administrative Code.
  - All activities that comprise Medicaid-reimbursable behavioral health services must be directly related to and intended to achieve the goals and objectives identified in the client's **individualized treatment plan**.
  - Providers shall maintain treatment records and progress notes in accordance with rules 5160-01-27 and 5160-8-05 of the Ohio Administrative Code. Records must be sufficient to establish that all conditions of payment for Medicaid-covered services have been met and must fully disclose the basis for the type, frequency, extent, duration, and delivery setting of services provided. Documentation must be made available to the Ohio Department of Medicaid (ODM) or its designee upon request. Services billed and reimbursed that are not supported by documentation in the client record are subject to recoupment.
  - A provider required to maintain an individualized client record shall develop a **comprehensive individualized treatment plan** for each client.
  - An **initial individualized treatment plan** may be developed to address immediate client needs but is not required. If utilized, the initial individualized treatment plan must document immediate needs, include required service and needs information, and be signed and dated by the responsible staff member and supervising clinician, or include documentation of clinical supervision. The initial individualized treatment plan must be

completed within seven days of the client's initial assessment or at the first face-to-face contact following the assessment, whichever occurs later. Face-to-face contact may occur via telehealth.
    - The **comprehensive individualized treatment plan** must be developed by a qualified practitioner meeting applicable requirements for mental health or substance use disorder services under rule 5160-27-01 of the Ohio Administrative Code.
- At a minimum, the comprehensive individualized treatment plan shall include:
    - A description of the client's assessed mental health or substance use disorder needs and recovery supports, including how services will be provided or referred;
    - Mutually agreed upon treatment goals and objectives developed collaboratively with the client, or documentation of the reason agreement was not reached;
    - The specific services to be provided;
    - The frequency and duration of services;
    - Documentation that the plan has been reviewed with the client and, when appropriate, family members or other supports;
    - Documentation of the client's inability or refusal to participate, if applicable, including the reason;
    - The signature, date of signature, and credentials of the staff member developing the plan and the supervising clinician, or documentation of clinical supervision;
    - The ASAM level of care, when applicable to substance use disorder treatment.
- The comprehensive individualized treatment plan must be completed no later than the fifth session or within one month of admission, whichever occurs sooner, unless the service provided is crisis intervention.
- The individualized treatment plan shall be reviewed and updated when services are added or discontinued, when clinically indicated, when there is a change in level of care, upon client request, or at least annually. For clients receiving residential or withdrawal management substance use disorder services or substance use disorder case management, the plan shall be reviewed at least every ninety days.
- The provider shall include the client and, when appropriate, family members or other supports in treatment plan reviews and document all participants. The results of each review must be documented, including any changes made or that no changes were necessary. If the client or others are unable or unwilling to participate, the reason must be documented. All reviews must be signed and dated by the staff member completing the review and the supervising clinician.
- A provider is to determine level of care at admission, for continued stay, for change in level of care recommendation, and at discharge by conducting a multi-dimensional assessment utilizing the American society of addiction medicine criteria third edition (2013), also known as the "ASAM patient placement criteria."

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 Ohio 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, 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 rules 5160-1-01, 5160-1-61, and 5160-27-02 (K) of the Ohio Administrative Code.

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 Healthchek (EPSDT Benefit).
- Additional Information can be found in rules 5160-1-01 and 5160-1-14 of the Ohio Administrative Code.

Telehealth Services

- Medicaid Managed Care Organizations (MCOs), MyCare Ohio Plans (MCOPs) and the OhioRISE plan (hereinafter referred to collectively as managed care entities or MCEs) will use the guidelines outlined in this link: Ohio Department of Medicaid Telehealth Services: Guidelines for Managed Care Entities (version 4.0) to allow their Ohio Department of Medicaid (ODM) members to continue using telehealth In addition to this guidance, the Telehealth Billing Guidelines outline how FFS processes telehealth services and identify all covered telehealth procedure codes.
- Telehealth means the use of real-time audiovisual communications of such quality as to permit accurate and meaningful interaction between at least two persons, one of which is a certified provider of the service being provided pursuant to Chapter 5122-25 of the Ohio Administrative Code. Asynchronous modalities that do not have both audio and video elements are considered telehealth.
- The decision to provide services via telehealth shall be based on client choice, clinical appropriateness, and the professional judgment and responsibility of the provider.
- Must document client's physical location every telehealth session
- A provider's physical site is to conform to the standards in rule 5122-25-02 of the Administrative Code
- The following are the services that may be provided via telehealth:
  - General services as defined in rule 5122-29-03 of the Ohio Administrative Code;
  - CPST service as defined in rule 5122-29-17 of the Ohio Administrative Code;
  - Therapeutic behavioral services and psychosocial rehabilitation service as defined in rule 5122-29-18 of the Ohio Administrative Code;
  - Peer recovery services as defined in rule 5122-29-15 of the Ohio Administrative Code;
  - SUD case management service as defined in rule 5122-29-13 of the Ohio Administrative Code;
  - Crisis intervention service.as defined in rule 5122-29-10 of the Ohio Administrative Code;
  - Assertive community treatment service as defined in rule 5122-29-29 of the Ohio Administrative Code; and,
  - Intensive home based treatment service as defined in rule 5122-29-28 of the Ohio Administrative Code.
  - Mobile response and stabilization service as defined in rule 5122-29-14 of the Ohio Administrative Code.
  - Individuals receiving residential and withdrawal management substance use disorder services as defined in rule 5122-29-09 of the Ohio Administrative Code or mental health day treatment service as defined in rule 5122-29-06 of the Ohio Administrative Code may receive any of the component services listed above through telehealth.
  - Progress notes as defined in rule 5122-27-04 of the Ohio Administrative Code must include documentation to reflect that the service was provided by telehealth.
  - Providers are prohibited from delivering telehealth services in a group format to individuals residing in recovery housing or class II or class III residential facilities.
  - General services delivered via telehealth do not include the collection of urine specimens for urinalysis.

Additional Information can be found in rule 5160-1-18 of the Ohio Administrative Code.

- Telehealth is the direct delivery of health care services to a patient related to diagnosis, treatment, and management of a condition.

- Telehealth is the interaction with a patient via synchronous, interactive, real-time electronic communication comprising both audio and video elements; or
- The following activities that are asynchronous or do not have both audio and video elements:
  - Telephone calls;
  - Remote patient monitoring; and
  - Communication with a patient through secure electronic mail or a secure patient portal.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/resources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.

Applied Behavior Analysis

Purpose

Applied Behavior Analysis (ABA)

The Council of Autism Service Providers [CASP], (2024) provides the following description of ABA:

> ABA is a well-developed scientific discipline that focuses on analyzing, designing, implementing, and evaluating social and other environmental modifications to produce meaningful changes in human behavior. This treatment approach has proven effective across the lifespan and for a variety of disorders and conditions. ABA's success remediating deficits associated with a diagnosis of ASD, as well as developing, restoring, and maintaining skills, has been documented in hundreds of peer-reviewed studies over the past 50 years. ABA is the leading evidence-based, validated treatment for ASD. The success of this treatment approach has made ABA the standard of care for treating ASD. It is widely recognized by several authorities, including the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the National Institute of Mental Health. (p.3)

Services

- If the provider is not enrolled with Medicaid, a single case agreement would be needed, see Ohio Administrative Code for list of eligible practitioners and prior authorization requirements, if applicable.
- Certified Ohio Behavior Analyst (COBA) Providers must be enrolled with Ohio Medicaid as Provider Type 19, Specialty Type 190 and have a National Provider Identifier ("NPI") for both the rendering provider and group provider.
- For additional information, or to enroll in our ABA Provider Network, see Ohio Medicaid ABA Program: https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/autismABA/ohMedicaid.html.
- Please see The Council of Autism Service Providers (CASP, 2021) for additional telehealth guidance: https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/scc/PracParamsTMH-ABA-AMA-Refs.pdf.
- ABA is available through telehealth under the current guidelines effective June, 2018.
  If the modality for ABA services is telehealth a member will need to have certain basic and advanced prerequisite skills to benefit from telehealth services. The caregiver must also be willing and able to support telehealth. Finally, the provider must do a thorough assessment of the environment and address any safety concerns.

Initial Coverage Criteria

Applied Behavior Analysis (ABA) **is covered when the following conditions are met and demonstrated through appropriate clinical documentation:**

- A valid diagnosis of ASD (or other applicable diagnosis as required by governing laws) must be issued by a state licensed physician, psychologist, or other state licensed clinician qualified to make such diagnosis according to the diagnostic criteria based on the DSM-5-TR™ (5th ed.; DSM-5-TR; APA, 2022).
- **The DSM-5 diagnosis and severity level are confirmed and documented by the diagnosing clinician using at least one clinically validated screening tool and one formal diagnostic tool (not an all-inclusive list):**
  - First Level Screening Tools (indicating further evaluation):
    - Autism Behavior Checklist [ABC]
    - Checklist for Autism in Toddlers [CHAT; M-CHAT]
    - Communication and Symbolic Behavior Scales Developmental Profile Infant-Toddler Checklist [CSBS-DP-IT-Checklist]
    - Autism Screening Questionnaire [ASQ]
    - Autism Quotient [AQ]
    - Childhood Autism Screening Test [CAST]
  - Second Level Screening Tools (diagnostic aids indicating further evaluation)
    - Childhood Autism Rating Scale [CARS] [CARS-2]
    - Rapid Interactive Test For Autism in Toddlers (RITA-T)
    - Screening Tool for Autism in Toddlers and Young Children (STAT)
- **Formal Diagnostic Tools (used as part of comprehensive diagnostic evaluation)**
  - Autism Diagnostic Interview-Revised [ADI]
  - Autism Diagnostic Observation Schedule [ADOS] [ADOS-2]
  - Diagnostic Interview for Social and Communication Disorders [DISCO].
- **Once an ASD diagnosis is confirmed, a credentialed ABA provider is identified for the member according to the following requirements:**
  - A Master- or Doctoral-level provider that is a Board-Certified Behavior Analyst (BCBA)
  - A licensed behavioral health clinician who has attested to having sufficient expertise and has been credentialed to provide ABA services.
  - A Board-Certified Assistant Behavior Analyst (BCaBA) or non-licensed individual under the direct supervision of a BCBA or licensed behavioral health clinician who takes responsibility for the individual's care that does either of the following:
    - Technicians must be under the applicable supervision of a BCBA or licensed behavioral health clinician. Technicians should be registered behavior technicians (RBT) or another appropriately certified behavior technician as allowable by state mandate. It is not recommended that parents serve in an RBT role due to numerous ethical and conflicting relationships issues. In addition, BCBAs® acting in a supervisory role for a parent serving as an RBT® for their own child would also be in violation of their ethics code and would have a duty to self-report and to report the RBT.
    - Assist in the initial or concurrent assessment of the individual's deficits or adaptive behaviors.
    - Implement a treatment plan that has been developed by a BCBA or licensed behavioral health clinician.
- **The identified credentialed ABA provider completes the following:**
  - One of the following assessments;
    - Standard Functional Assessment and/or
    - Functional Behavioral Assessment when maladaptive behaviors are present; and
  - Interviews with caregivers, direct observation data, and attention to coexisting medical conditions; and
  - Record review of the individual's history, response to prior interventions, current treatments, cultural and familial considerations, spoken language, and any prior assessments also helps inform the treatment goals; and
  - Baseline skills assessment; and
  - Norm referenced instruments to assess individuals functioning levels in comparison to age-matched neurotypical peers, to assist in goal development, and to assess developmental gains as a result of interventions; and
    - ABA providers may need to collaborate with other qualified health professionals on assessments if there are comorbid conditions that increase an individual's risk of harming themselves or others.
- Skills-based assessments to assist in developing treatment goals as appropriate.

Treatment Plan Criteria

- **The Comprehensive Diagnostic Evaluation and Functional Assessment form the basis for the treatment plan. Documentation must be provided that demonstrates the following:**
  - Treatment goals and objectives that are comprehensive and clearly stated.
  - Outcome-oriented interventions targeting specific baseline behaviors.

- Each intervention has defined frequency, intensity, duration and progress measurement methods.
- Treatment intensity is chosen according to baseline measurement with the use of at least one of the following validated measurement tools:
  - The Autism Treatment Evaluation Checklist (ATEC)
  - Verbal Behavior Milestones and Assessment Placement Program (VB-MAPP)
  - Assessment of Basic Language and Learning Skills (ABLLS, ABLLS-R)
  - Assessment of Functional Living Skills (AFLS)
  - Promoting the Emergence of Advanced Knowledge Generalization (PEAK)
  - Social Skills Improvement System (SSIS)
  - Repetitive Behavior Scale-Revised (RBS-R)
  - Social Responsiveness Scale (SRS)
  - Vineland Adaptive Behavior Scales (VABS)
  - Child and Family Quality of Life, Second Edition (CFQL-2)
    - Measurement tools should be individualized and will not be the same for all individuals or programs. Tools should be selected based on skill development, quality of life and skills of adaptive change.
- Consideration for parent/caregiver participation and training in management of skills that can be generalized to the home.
  - If a parent/caregiver is unable to participate, documentation should include the reason and identify an alternate plan to provide management skills in the home.
- The treatment plan is coordinated with other professionals to ensure appropriate client progress. This may include coordination with the school and applicable Individualized Family Service Plan (IFSP)/ Individualized Education Program (IEP), outpatient behavioral clinicians, medical doctors, speech/occupational therapists and others.
- Consistent with CASP standards of care, direct case supervision is required 1-2 hours for every 10 hours of direct treatment per week.
- All components of the individual's care are tracked and updated throughout the duration of services and regular updates occur throughout authorization periods.

ABA Service Delivery Criteria
Clinical documentation must demonstrate:
- ABA is provided at the least restrictive and most clinically appropriate level to safely, effectively, and efficiently meet the needs of the individual.
- ABA is needed for reasons other than the convenience of the individual, family, physician, or other provider.
- The number of service hours requested is justified by the member's documented clinical need according to an individual's level of impairment, symptom severity, treatment history and response.
- Treatment is a systematic approach, based on the principles of comprehensive Applied Behavior Analysis.
- Treatment targets the core deficits of an autism spectrum disorder, as outlined by the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, Text Revision (DSM-5-TR™), American Psychiatric Association (APA), 2022.

Continued Treatment

With each clinical review for continued ABA treatment, the provider must submit updated documentation demonstrating:

- There is a reasonable expectation that:
  - The individual's behavior and skill deficits will continue to improve to a clinically meaningful and standardized extent if ABA is continued; or
  - Continued ABA treatment is clinically necessary to maintain skills and prevent deterioration of functioning.

- The individual's skills generalize and maintain outside of the treatment environment into the natural settings. (Examples include the home and community). ABA treatment is not making the symptoms or behaviors persistently worse and treatment protocol modifications have been effective at improving progress, or necessary to maintain the individual's skillset or prevent deterioration in their skillset.
- Progress is assessed and documented for each targeted symptom and behavior, including progress toward defined goals, including the same modes of measurement that were utilized for baseline measurement of specific symptoms and behaviors.
    - Progress should include rate and percentage of mastered programs, rates of mastered targets, change scores for any outcome measures, updated standardized adaptive measures, and change scores for skills-based assessments.
- Documentation reflects movement from baseline in skill deficits and problematic behavior using validated and norm referenced assessments of functioning.
- When applicable, documentation of parent/caregiver involvement and progress in their own implementation of behavioral interventions.
- When there has been inadequate or no demonstrable progress with targeted symptoms or behaviors within a 6-month period, or specific goals have not been achieved within the estimated timeframes, there should be an assessment of the reasons for inadequate progress, and treatment interventions should be modified or in order to achieve adequate progress or maintenance of skillset.
- The clinical review will address specific challenges of utilization of prior authorization period hours below 80% over a 2-week period.
    - Supporting documentation demonstrates barriers to services and how these are addressed going forward.
- To support continued coverage of ABA, documentation of includes:
    - Increased time when applicable and/or frequency working on targets
    - Change in treatment techniques
    - If applicable, increased parent/caregiver training
    - Identification of barriers to full participation in treatment and corresponding solutions
    - Any newly identified co-existing disorders (e.g., anxiety, psychotic disorder, mood disorder)
    - How generalization and maintenance are targeted across the individual's environments
    - Goals reconsidered (e.g., modified or removed)
        - Progress should be documented in standardized assessment of norm referenced, adaptive functioning. Lack of progress or where services are no longer maintaining skillset needs to be addressed via changes in treatment, behavior plans and/or caregiver engagement.
- When goals have been achieved, either new goals should be identified based on targeted symptoms and behaviors.
    - These new goals demonstrate how the symptoms and behaviors are preventing the individual from adequately participating in age-appropriate home, school or community activities, or are presenting a safety risk to self, others, or property.
    - When goals have been met and ABA is no longer clinically appropriate to improve, maintain, or prevent deterioration in skillset, the treatment plan should be revised to include a transition to less intensive interventions.

Transition and Discharge

- "Transition" is a coordinated set of individualized and results-oriented activities designed to move the patient through treatment toward discharge or other more intensive services as clinically indicated. Transition and discharge planning are not single events that occurs at the end of the treatment period. With the goal of providing ABA services to bring about significant, lasting, and generalized behavior, the plan should include how care will be coordinated with other supports and how to transition to least restrictive services as clinically indicated. Transitioning may include moving from a 1:1 model to a group model, moving from a comprehensive plan to a focused plan, or shifting from a center model to a community-based program.
    - The transition plan should also specify monitoring and evaluation details. Monitoring may entail:
        - assessing generalization across environments and people
        - assessing maintenance of treatment gains
        - monitoring the effectiveness of interventions for challenging behavior
        - measuring skill maintenance
- "Discharge" is defined as the end of services between a provider and a patient. Discharge can be initiated by the provider or the patient for a multitude of reasons and should occur in compliance with any state laws or regulations pertinent to discharge.

Transition and/or discharge may be appropriate if one or more of the following are present:

- The individual demonstrates improvement from baseline in targeted skill deficits and behaviors to the extent that goals are achieved, or maximum benefit has been reached (i.e., the individual has reached generalized behavioral change and maintains targeted skills outside of the treatment environment into the natural settings).
- The individual is no longer benefiting from services as demonstrated by lack of substantive progress towards goals (e.g., declining or no progress on standardized adaptive measures of functioning such as the Vineland) for successive authorization periods in one or more of the following areas, and ABA is no clinically appropriate to maintain or prevent deterioration in targeted skillset:
  - Communication Skills
  - Social Skills
  - Behavior Challenges
- The treatment is making the skill deficits and/or behaviors persistently worse and protocol modification did not make notable improvements or otherwise demonstrate medical necessity to maintain or prevent deterioration in skillset.
- Caregivers and provider are unable to reconcile important issues in treatment planning and delivery that prevent delivering medically necessary care.
- Caregivers refuse treatment recommendations or are not following through on treatment recommendation to an extent that compromises the effectiveness of care.
- The individual's physical and psychological well-being, independence and relationships with others has improved to the extent possible and continued treatment is not needed to maintain or prevent deterioration of skillset.
  - If an individual no longer displays significant symptoms on standardized assessments compared to their cognitive functioning, they may no longer need the intensity of ABA services.
  - The provider should continually monitor for any demonstrated change in intensity of behaviors necessitating a step up or step down in services.

Limitations and Exclusions

ABA is not covered for:

- Services that are not ABA therapy, such as 1:1 aid delivered simultaneously during classroom instruction, or services covered under the Individuals with Disabilities Education Act (IDEA). School ABA services do allow for coordination of services and would cover services such as teacher training, meetings with school personnel, and observations in the school setting.

Diagnosis Codes

The following list(s) of diagnosis code(s) 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. For additional billing and coding information, please see the Optum Autism/Applied Behavior Analysis (ABA) Reimbursement Policy.

Diagnosis Codes	Description
F84.0	Autistic Disorder

Evidence-Based Treatment Recommendations

The following are evidence-based treatment recommendations highlighting best practices for ABA services. This information below is not used to make coverage determinations.

Treatment

- Effective ABA services should focus on socially significant behaviors, meaning skills and behavior that lead to more opportunity for the individual and their family, including leading to great autonomy, and reduced levels of treatment.
- ABA interventions include the following elements:
  - Mitigate the core features of ASD
    - ABA is an intensive treatment, if an individual needs a less intensive treatment, other services may be more appropriate, such as individual or family therapy, speech therapy, occupational therapy, etc.
  - Target specific deficits related to appropriate social imitation, attending and social referencing, observational learning, play skills, social relationships, and reducing challenging behaviors.
  - The specific behaviors that are to be incrementally taught and positively reinforced tie to objective and quantifiable treatment goals that have baseline data, measurable progress, and projected timeframes for completion. Include the individual's caregiver's in parent/caregiver training and the acquisition of skills in behavior modification to promote management and generalization of skills within the home.
  - ABA treatments will differ in scope, intensity, staffing, and duration of treatment. Treatment should be aligned with the breadth and depth of behaviors targeted for the individual.
    - Caregiver/parent-mediated ABA produces greater outcomes in the socialization domain of the Vineland and increased caregiver/parent self-efficacy, supporting the inclusion of caregiver/parent-led ABA treatment. It is not recommended that parents/caregivers serve in an RBT role due to numerous ethical and conflicting relationships issues.
    - ABA should be rendered in multiple settings to support transition and generalization. If ABA is not occurring in multiple locations the plan should indicate why and how that is being addressed via other services.
  - Treatment plans are usually reviewed/updated twice annually, as appropriate per state mandate and/or clinical presentation of individual. This allows for ongoing re-assessment and documentation of treatment progress. Data should be analyzed ongoing and treatment plans updated as needed throughout care.
  - Treatment goals are prioritized in to address behaviors that threaten the safety of the client or others or create a barrier to quality of life. Goals are also prioritized to increase skills fundamental to maintaining health and social inclusion.
  - Descriptions of any needed replacement behaviors and skill acquisition goals based on the reported behaviors and assessments.
  - Treatment goals identified are best addressed by intensive 1:1 intervention or group intervention versus being learned by incidental teaching.
  - Train family individuals and other caregivers to manage problem behavior and interact with the individual in a therapeutic manner.
  - As indicated, include referrals to psychotherapy (e.g., cognitive behavioral therapy), outpatient or family therapy for higher functioning individuals to treat conditions such as anxiety, anger management, attention, and depression.
  - Have an appropriate level of intensity and duration driven by factors such as:
    - Changes in the targeted behavior(s)/response to treatment
    - The demonstration and maintenance of management skills by the parents/caregivers
    - Whether specific issues are being treated in a less intensive group format (e.g., social skills groups or group ABA format)
    - The individual's ability to participate in ABA, given participation in other therapies and engagements, should be considered
    - The impact of co-occurring behavioral or medical conditions on skill attainment
    - The individual's overall symptom severity
    - The scope of treatment
    - The individual's progress in treatment related to treatment duration; and
    - The individuals response to treatment, including: ability to benefit and show substantive growth and show developmentally/functionally appropriate response to goals. This can be measured by benchmarking the clients progress to standardized functional and developmentally appropriate assessments.
    - Treatment plan should indicate the treatment setting, instructional methods to be used, hours requested, schedule, and clinical justification of those hours.
    - Treatment should not be restricted to specific settings but instead should be delivered in the settings that

maximize treatment outcomes for the individual patient;
    - When group ABA services are included, the treatment plan must include clearly defined, measurable goals for the group therapy that are specific to the individual's needs. Treatment review takes into consideration when group services are appropriate for the individual to gain or practice skills in a small group. Social behaviors are often best delivered in small group settings.
    - According to current research there is a lack of high-quality clinical evidence to suggest that a higher number of hours results in improved outcomes, including outcomes regarding substantial difficulties.
        - Researchers have acknowledged there is minimal support for comprehensive high hour ABA in producing overall positive outcomes. In addition, there is no predictive relationship between number of treatments hours and positive outcomes. According to current research no difference was noted in outcomes between 15 hours versus 25 hours per week.
    - According to recent research, there is limited evidence to show those individuals receiving very low intensity services make as much progress as those receiving a higher volume of hours. Treatment should evaluate if focused or comprehensive treatment is more appropriate based on the severity of symptoms presented by the individual.
    - Treatment takes into consideration the developmental level of each individual, and treatment schedule considers the needs of the individual including rest and nutrition breaks and interactions with peers.
    - Behavior analysts identify their services accurately and include all required information on reports, bills, invoices, requests for reimbursement, and receipts. They do not implement or bill nonbehavioral services under an authorization or contract for behavioral services. Examples include, but not limited to:
        - Naps, extended recreational reinforcement, meals without active goals and treatment, extended breaks in active intervention.
- Treatment methodologies utilized as part of intensive behavior therapies should be considered established by the National Autism Centers Standards Projects.
- Parent/Caregiver involvement in treatment is strongly recommended/encouraged to achieve optimal clinical outcomes for the individual. Parent/caregiver support is encouraged as a component of the ABA program, as they will need to provide additional hours of behavioral interventions. Parents or caregivers involvement and engagement is strongly recommended/encouraged in training and follow through on treatment recommendations beyond that provided by licensed or certified practitioners. Caregivers are engaged to assist with maintenance and generalization of skills and to focus on activities of daily living. Parent support groups are considered not medically necessary.
- Parent and caregiver training include a systematic, individualized curriculum on ABA fundamental concepts. The goal of this training is skills development and support so that parents and caregivers are proficient in implementing treatment strategies in a variety of settings and critical environments. Such training is not accomplished by simply having the caregiver or guardian present during treatment implemented by a technician. Some models of ABA may focus solely on parent/caregiver coaching. A caregiver would not be expected to act as a technician for their child.
- Detailed description of interventions with the parent(s) or caregiver(s), including:
    - Parental or caregiver education, training, coaching and support
    - Overall parent or caregiver goals including a brief summary of progress. As part of the summary of progress the information should also include percentage of planned sessions attended
    - Plan for transitioning ABA interventions identified for the child to the parents or caregivers
    - How parents will be supported in assisting with increases in skills, such as communication or routines that help maintain good health.
- ABA programs typically fall into either focused or comprehensive ABA treatment. The type of treatment may lend itself to different intensity of services. Total intensity of services includes both direct and indirect services (e.g., caregiver training and supervision). Hours may be increased or decreased based on the client's response to treatment and current needs. Comprehensive services are typically rendered when the individual is early in his or her development. Comprehensive services commonly focus on most areas of functioning and are intended to improve multiple skills. Focused intervention is intended to reduce dangerous or maladaptive behavior and strengthen more appropriate functional behavior.
- When individuals display significant challenging behaviors a higher staff to patient ratio and on-site direction by the supervisor may be needed.
- Relying on a single treatment methodology, procedure, or setting is unlikely to achieve the desired generalization and maintenance of behavior change.

- When adolescents and young adults are receiving ABA services, it is important to include a focus on transition to adulthood. Including ensuring goals focus on steps to independence, are patient centered, and include caregivers (when appropriate) in creating a plan Interventions to support independence may include things such as:
    - Self-management and/or token economy systems
    - Working with caregivers to modify current environment and create supports within the environment
    - Creating visual schedules to support individuals ability to navigate the day independently
    - Teaching self-reinforcement
    - Parent/Caregiver guided interventions
- According to current research, supporting individuals with ASD across the lifespan includes ethical considerations. Behavior analysts should consider prioritizing skills with meaningful current and future outcomes for individuals transitioning into adulthood.
- Examples of other behavioral interventions as a treatment for ASD include, but not limited to:
    - Joint attention interventions (e.g., pointing to objects, showing, etc.)
    - Modeling (both real-life and video-based modeling)
    - Peer training package (including, but not limited to, peer networks, peer initiation training, and peer-mediated social interventions)
    - Story-based intervention package (including the Socials Stories approach)
    - The social skills package (e.g., social and pragmatic groups)
- These steps can increase the number of adolescents with ASD who receive recommended transition to adulthood planning:
    - Healthcare providers consider recommendations for healthcare transitioning and use them when providing care for adolescents, beginning at age 12 years, and modifying to meet the unique needs of each adolescent.
    - Parents/caregivers can address transition planning with pediatric healthcare providers.
    - Healthcare professionals can utilize strategies for moderating gaps in health service utilization by:
        - Providing interdisciplinary training to professionals that endorses the programs with positive outcomes and increases provider confidence in treating adolescents with ASD and other developmental disorders;
        - Improving multidisciplinary care delivery services to be timely, coordinated, and family-centered; and
        - Promoting programs with successful healthcare transitions for adolescents, including those with ASD and other developmental disorders.
    - Supervision is responsive to individual client needs, up to two hours for every ten hours of direct treatment is the general standard of care. Other factors may increase or decrease case supervision, such as barriers to progress, issues of client health and safety, and transitions with implications for continuity of care. The BCBA or other supervisor may also engage in adaptive behavior treatment with protocol modification where the individual is being observed for changes in the behavior and/or troubleshoot treatment protocols. This would include adjustments to specific protocols or determinations if protocols are functional for the individual. Adjustments to treatment should occur throughout care, and especially when the individual is not making adequate progress, CASP (2024) indicates if inadequate progress occurs over 3 sessions there must be a review to determine causes. Unanticipated utilization shortfalls of services require attention by the supervisor to determine if there are barriers that can be addressed or are likely to persist.
        - Supervision can involve direct and indirect activities. Case supervision typically involves monitoring the delivery of services, monitoring and reporting on progress, adapting plans and modifying protocols, and supporting/training staff. Please refer to the definitions of ABA CPT codes in the Optum Autism/Applied Behavior Analysis (ABA) Reimbursement Policy to determine which specific activities are billable. The supervisor also monitors the reliability of the collected data by evaluating interobserver agreement and procedural fidelity.
        - Case supervision needs should be individualized to each individual and case support team; the same percentage of clinical supervision should likely not be used for all individuals.
- Individuals with autism can benefit from other less intensive services, such as individual, group and family therapies, occupational therapy, speech therapy, medication management, etc. ABA services do not duplicate the services provided to or available to the individual by other medical or behavioral services.
- Overall, the available clinical evidence reveals that the younger the age at treatment induction is associated with superior outcomes.
    - if an individual needs a less intensive treatment, other services may be more appropriate, such as individual or family therapy, speech therapy, occupational therapy, etc. Very young children may not be able to manage a high intensity or full time ABA programs.
    - Any child receiving active treatment for more than 6+ hours per day also needs rest breaks, lunch, snacks, family time, and time for play and/or non-learning opportunities. Full time ABA programs are rare and should be specific, focused on intensive behavioral challenges and addressing short term behavioral goals.
    - Discussion with caregivers should include how service hours and intensity of services were determined; this will allow families to make informed decisions about what amounts might be both beneficial and feasible.

Coordination of Care

If applicable, documentation of communication and coordination with other service providers and agencies, (i.e., day care, preschool, school, early intervention services providers) and/or other allied health care providers (i.e., occupational therapy, speech therapy, physical therapy and any other applicable providers) to reduce the likelihood of unnecessary duplication of services. Coordination of care is meant to support generalization, maintenance of skills, and consistency across environments. According to CASP (2024) and the Behavioral Health Center of Excellence (2020), collaborating between all professionals engaged with a child will ensure consistency, as better consistency leads to better outcomes. Documentation should include the following:

- Types of therapy provided
- Number of therapies per week
- Behaviors/deficits targeted
- Progress related to the treatment/services being provided
- Measurable criteria for completing treatment with projected plan for continued care after discharge from ABA therapy
- Total number of days per week and hours per day of direct services to individual and parents/caregivers to include duration and location of requested ABA therapy
- Dates of service requested
- Licensure, certification and credentials of the professionals providing ABA services
- Documentation that parents/caregivers have been trained and consulted about the treatment plan, following all appropriate treatment recommendations.
    - Documentation should indicate those actively participating and their relationship to the individual receiving ABA services.

Documentation

ABA providers are required to have a separate record for each individual that contains the following documentation:

- Comprehensive assessment establishing the autism diagnosis, or other diagnosis appropriate by that state's mandates
- All necessary demographic information
- Complete developmental history and educational assessment
- Functional behavioral assessment including assessment of targeted risk behaviors
- Behavioral/medical health treatment history including but not limited to:
    - known conditions
    - dates and providers of previous treatment
    - Currently treating clinicians
    - current therapeutic interventions and responses
- Individualized treatment plan and all revisions to the treatment plan, including objective and measurable goals, as well as parent/caregiver training, barriers to progress, response to interventions
- Daily progress notes include:
    - place of service
    - start and stop time
    - who rendered the service
    - the specific service (e.g., parent/caregiver training, supervision, direct service)
    - who attended the session
    - interventions that occurred during the session
    - licensure or credentials of those in the session
- All documentation must be legible
- All documentation related to coordination of care; including with school related services rendered via an IEP. Attempts to coordinate care are acceptable if other providers will not collaborate
- All documentation related to supervision of behavior technicians
- If applicable and available, a copy of the individual's Individualized Education Plan (IEP)
- If applicable and available, progress notes related to Early Intervention Plan or Pre-school/Special Education Program or allied health services
- Certification and credentials of the professionals providing and supervising the ABA therapy.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/resources-for-providers/billing/billing.

References

- For additional information, see Ohio Medicaid ABA Program: https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/autismABA/ohMedicaid.html.
- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
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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. ACT Team service providers shall be certified as outlined in the Ohio Administrative Code 5122-29-29.

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 is eighteen years of age or older at the time of ACT enrollment;
- 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.

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

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

- 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 Ohio 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 Ohio 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 rules 5160-1-27 and 5160-8-05 of the Ohio 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 Ohio 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 Ohio 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.

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.
- SUD services above ASAM level 1 must be prior authorized for ACT enrollees.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/resources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5122-29-29 and 5160-27-04 of the Ohio Administrative Code.

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 a registered nurse or licensed practical nurse as defined in section 4723.01 of the Ohio Revised Code 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 and Licensed practical nurse (LPN) as defined in Ohio Administrative Code rules 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 is in enrolled in assertive community treatment (ACT) or in a SUD residential treatment facility;
- Services must be provided within the practitioner's scope of practice and in authorized settings in accordance with applicable state regulations.

- All services must be documented in the client record in accordance with applicable Ohio Administrative Code requirements.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

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

Behavioral Health Peer Support

Purpose

Peer support services are services for individuals with a mental illness, intellectual or developmental disabilities, or substance use disorders and their caregivers and families.

Peer support services consist of activities that promote resiliency and recovery, self-determination, advocacy, well-being, and skill development. Peer support services are individualized, resiliency and recovery focused and based on increasing knowledge and skills through a peer relationship that supports an individual's or family's ability to address needs, navigate systems and promote recovery, resiliency, and wellness. They promote family driven, youth guided, trauma informed care and cultural humility, encourage partnership with individuals and families, and advocate for informed choice.

Service Delivery

- An eligible rendering provider of peer support services is:
  - A person who is eligible to provide peer support services in accordance with rule 5122-29-15.1 of the Ohio Administrative Code; and
  - An eligible provider of behavioral health services in accordance with rule 5160-27-01 of the Ohio Administrative Code.
- An eligible billing provider is:
  - An eligible behavioral health provider that meets the conditions in paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Ohio Administrative Code; and
  - Employs or contracts with an eligible rendering provider of peer support services as described in this rule.
- The peer support service is covered when:
  - Provided in accordance with the activities as described in rule 5122-29-15 of the Ohio Administrative Code.
  - Rendered as a component of behavioral health treatment for the purpose of addressing the individual's behavioral health care needs relating to a mental health or substance use disorder.
  - Intended to achieve goals or objectives based on and documented in a current individualized treatment plan meeting the requirements in rule 5122-27-03 of the Ohio Administrative Code.
- Peer support services may include, but are not limited to:
  - Ongoing exploration of recovery, resiliency, and wellness needs;
  - Supporting individuals and their caregivers and families in achieving goals through increased knowledge, skills and connection as identified by the individual or family;
  - Encouraging hope;

- Supporting the development of life skills;
- Developing and working toward achievement of individualized recovery, resiliency, and wellness goals;
- Modeling personal responsibility for resiliency, recovery and wellness;
- Teaching and coaching skills to effectively navigate systems to effectively and efficiently utilize services;
- Addressing skills or behaviors, through processes that assist an individual, caregiver, or family in eliminating barriers to achieving or maintaining recovery, resiliency, and wellness;
- Assisting with accessing and developing natural support systems;
- Promoting coordination and linkage among providers;
- Coordinating or assisting in crisis interventions and stabilization;
- Conducting outreach and community education;
- Attending and participating in team decision making or specific treatment team; or,
- Assisting individuals, caregivers, or families in the development of empowerment skills through advocacy and activities that mitigate discrimination and inspire hope.
- Providing services in a culturally inclusive and competent manner which includes not practicing, condoning, facilitating, or collaborating in any form of discrimination on the basis of ethnicity, race, gender, sexual orientation, age, religion, national origin, marital status, political belief, or mental or physical disability.
- Peer support services are not site specific but shall be provided in locations that meet the needs of the individual, caregiver, or families.
- Peer support services may be facilitated to individuals, families, or groups.
- Peer support services shall be provided a person certified in accordance to rule 5122-29-15.1 of the Ohio Administrative Code.
- Peer support services providers shall report for any certified peer supporter employed by or volunteering with the provider to the Ohio department of mental health and addiction services any events that would disqualify the certified peer supporter pursuant to rule 5122-29-15.1 of the Ohio Administrative Code.

- 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 Ohio 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 Ohio Administrative Code, is limited to one per day, per recipient.
  - **Peer recovery support** as referenced in rules 5160-27-09, 5160-43-04, and 5160-27-14 of the Ohio Administrative Code is limited to four hours per day per recipient.
    - Peer recovery services defined as peer support services in rule 5122-29-15 of the Ohio Administrative Code are covered when delivered:
    - Through the specialized recovery services program in accordance with rule 5160-43-04 of the Ohio Administrative Code; or
    - As a component of assertive community treatment as defined in rule 5160-27-04 of the Ohio Administrative Code: or
    - As a component of substance use disorder residential treatment as defined in rule 5160-27-09 of the Ohio Administrative Code; or
    - As a substance use disorder outpatient treatment service in accordance with rule 5160-27-09 of the Ohio Administrative Code; or
    - As a component of intensive home-based treatment service as defined in rule 5122-29-28 of the Ohio Administrative Code; or
    - As a component of mobile response and stabilization service in accordance with rule 5122-29-14 of the Ohio Administrative Code.
    - Substance use disorder **partial hospitalization** as described in rule 5160-27-09 of the Ohio Administrative Code.
    - Substance use disorder **residential** level of care as described in rule 5160-27-09 of the Ohio Administrative Code.

Limitations and Exclusions

- Peer support services, whether provided in individual or group or combined format, must be prior authorized when units exceed sixteen units (four hours) for the same individual on the same date of service.
- Transportation activities that do not include the provision of a peer support service are not covered.
- Provision of a peer support service is reimbursed in accordance with this rule and may not be reimbursed as another covered Medicaid service, including, but not limited to, the following:
  - Community psychiatric supportive treatment.

    - Therapeutic behavioral services.
    - Psychosocial rehabilitation.
    - Substance use disorder target case management.
- Payment is not allowable when a peer support service is provided in a group setting and the certified peer supporter to client ratio exceeds one to twelve.
- When peer support service is delivered to caregivers or family members of the individual, it is reimbursable when the purpose of the service is to address the behavioral health needs, goals, and objectives as documented in the individual's treatment plan.
- Reimbursement
    - The Medicaid reimbursement rate for the peer support service is stated in the appendix to rule 5160-27-03 of the Ohio Administrative Code.
    - The peer support service is not reimbursable when covered as part of another Medicaid reimbursable service. Reimbursement will not be made for peer support services when an individual is:
        - Receiving intensive home-based treatment as described in rule 5122-29-28 of the Ohio Administrative Code.
        - Receiving assertive community treatment as described in rule 5160-27-04 of the Ohio Administrative Code.
        - Receiving mobile response and stabilization service as described in rule 5160-27-13 of the Ohio Administrative Code.
        - Receiving substance use disorder residential treatment services as described in rule 5160-27-09 of the Ohio Administrative Code, except when the peer support service is necessary to support admission to and discharge from the substance use disorder residential treatment. Payment for the services provided during a substance use disorder residential treatment stay is made in accordance with rule 5160-27-09 of the Ohio Administrative Code.
        - Receiving inpatient hospital psychiatric services as described in Chapter 5160-2 of the Ohio Administrative Code, except when the peer support service is necessary to support admission to and discharge from the hospital. Payment for the services provided during an inpatient hospital stay is made in accordance with Chapter 5160-2 of the Ohio Administrative Code.
        - Receiving psychiatric residential treatment facility (PRTF) services as described in Chapter 5122-41 of the Ohio Administrative Code and rule 5160-59-03.6 of the Ohio Administrative Code, except when the peer support service is necessary to support admission to and discharge from the PRTF. Payment for the services provided during a PRTF stay is made in accordance with rule 5160-59-03.6 of the Administrative Code.

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.
- Per Ohio Medicaid authorization is required if more than 16 units/4 hours combined group and/or individual peer support per day. See the Ohio Department of Medicaid Community Behavioral Health Rehabilitative Services Authorization Request Form to request additional units.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

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

OhioRISE Behavioral Health/Short-Term Respite

Purpose

OhioRISE 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.

OhioRISE Behavioral Health Respite

- Coverage of behavioral health respite is subject to authorization by the OhioRISE plan in accordance with rule 5160-59-03.4 of the Ohio Administrative Code. Refer to the OhioRise Manual Here: OhioRISE Program 2026 Provider Manual.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Aetna OhioRise Provider Manual OhioRISE Program 2026 Provider Manual
- Ohio Department of Behavioral Health: OhioRISE (Resilience through Integrated Systems and Excellence) | Ohio Medicaid Managed Care.

Complementary And Alternative Medicine (CAM) for BH and SUD

Purpose

According to the National Center for Complementary and Integrative Health (NCCIH, 2021) 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 Ohio Administrative Code.

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

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

Acupuncture

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 Ohio Administrative Code; and
  - It is performed in accordance with section 4762.10 or 4762.01 of the Ohio 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.

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

Art therapy, Dance/Movement (DMT), Equine therapy, and Music Therapy may be complimentary or covered alternative therapies located under 5160-8 Therapeutic and Diagnostic Services of the Ohio 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 of the Ohio Administrative Code.

Animal-Assisted Therapy

According to the Association of Animal-Assisted Intervention Professionals (AAAIP, 2022), Animal-assisted interventions consist of objective goals with structured interventions that integrate animals in health, education, and human service for a therapeutic role in improved health and wellness. While dogs are the most common animal utilized, a variety of animals and species can provide animal-assisted interventions.

Art Therapy

According to the American Art Therapy Association (AATA, 2023), 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 communicate beyond verbal expression.

Brainspotting Therapy

Brainspotting (BSP) is a type of therapy that purports to assist individuals in coping with emotional pain, trauma, anxiety, and depression. During a session, the therapist helps the person find a specific eye position, called a "brainspot," that is connected to a troubling memory or feeling. By focusing on that spot while staying aware of their current thoughts and body sensations, people can begin to process deep emotional stress (Horton et al, 2023).

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], 2020). 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, 2022). 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.

Music Therapy

Music therapy is the clinical use of music interventions to accomplish individualized goals within a therapeutic relationship and is typically conducted by an individual completing an approved music therapy program. Therapists may assess emotional well-being and social functioning through musical responses and develop music sessions based on specific client needs. According to the American Music Therapy Association (AMTA), music therapy allows exploration of personal feelings and promotes positive changes in mood and emotional states (AMTA, 2025).

Naturopathic Detoxification & Sauna/Niacin Detoxification

- 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.)

Treatment programs may be delivered at varying levels of care, depending on the individual patient. The purpose of sauna/niacin detoxification is to eliminate from the body any drug residues and other toxic substances that remain locked in fatty tissues and may be present in the blood stream.

Reiki Therapy

Reiki originates from ancient Japanese healing practices. The theory is that it involves channeling energy to promote balance and well-being across physical, emotional, and psychological levels. It is believed to activate the parasympathetic nervous system, fostering harmony between the body, mind, and spirit. Reiki can be performed in person or remotely, often focusing on the body's seven main chakras, such as those in the head, chest, and abdomen, through either light touch or non-contact methods, typically dedicating a few minutes to each area (Guo et al, 2024).

Limitations and Exclusions

Behavioral Health Services-Other Licensed Professionals

- The following services may not be covered under Ohio Administrative Code 5160-8-05:
  - 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 rendered by an unlicensed individual other than a supervised trainee;
  - 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 Ohio 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 of the Ohio Administrative Code: 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 of the Ohio Administrative Code.
- The following services **may be covered** under 5160-8-35 of the Ohio Administrative Code:
  - The service is medically necessary, in accordance with rule 5160-1-01 of the Ohio 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 Ohio Administrative Code.
  - This condition does not apply to services rendered through the Medicaid school program, which is described in Chapter 5160-35 of the Ohio Administrative Code.
- The following services **may not be covered** under 5160-8-35 of the Ohio Administrative Code:
  - 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 Ohio Administrative Code.
- Providers shall adhere to documentation requirements set forth in rules 5160-1-27 and 5160-8-35 of the Ohio 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, childcare, 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.

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:

- Animal-assisted therapy
- Art therapy
- Brainspotting therapy
- Dance/movement therapy (DMT)
- Equine therapy
- Music therapy
- Naturopathic detoxification
- Reiki therapy
- 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
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 of the Ohio Administrative Code.
- Payment for additional skilled therapy visits in a non-institutional setting can be requested through the prior authorization process.
- ***Acupuncture*** rule 5160-8-51 of the Ohio Administrative Code, payment for more than thirty acupuncture visits per benefit year requires prior authorization.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

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Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT) for SUD

Purpose

Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT) is not medically necessary as outpatient therapy to treat substance use disorders. A review of the clinical literature does not support CBTCBT as a significant intervention in treating substance use disorders. While short-term benefits have been observed, replication through rigorously designed trials is needed to establish its efficacy and identify durable outcomes.

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with evidence-based clinical guidelines. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Description of Service

Using technology such as the computer, internet, or cell phone to deliver outpatient cognitive behavioral therapy is considered computer-based treatment cognitive behavioral therapy (CBTCBT). This policy addresses CBTCBT for the outpatient treatment of substance use disorders. Examples of this technology are:

- reSET® is a 12-week duration, FDA-cleared Prescription Digital Therapeutic offered by PursueCare to be used in conjunction with standard outpatient treatment for substance use disorder related to stimulants, cannabis, cocaine, and alcohol. The application is not intended as a stand-alone treatment or to be used to treat opioid dependence.
- The reSET-O® is an FDA-cleared mobile application offered by PursueCare that is a prescription cognitive behavioral therapy intended to be used in addition to outpatient treatment under the care of a health care professional, combined with treatment that includes buprenorphine and contingency management. Contingency management is a behavior modification intervention that establishes a connection between new, targeted behavior and the opportunity to obtain a preferred reward. The reSET-O is an application that is downloaded directly to a mobile device after a prescription is received from the treating physician. It is intended to be used while participating in an outpatient Opioid Use Disorder treatment program.

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
A9291	Prescription digital cognitive and/or behavioral therapy, FDA-cleared, per course of treatment

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Diagnosis Codes	Description
F10.10	Alcohol abuse, uncomplicated
F10.20	Alcohol dependence, uncomplicated
F11.1 – F11.9	Opioid abuse and dependence
F12.10	Cannabis abuse, uncomplicated
F12.20	Cannabis dependence, uncomplicated
F14.10	Cocaine abuse, uncomplicated
F14.20	Cocaine dependence, uncomplicated
F15.10	Other stimulant abuse, uncomplicated
F15.20	Other stimulant dependence, uncomplicated
F19.10	Other psychoactive substance abuse, uncomplicated
F19.20	Other psychoactive substance dependence, uncomplicated

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 of the Ohio Administrative Code.
- Payment for additional skilled therapy visits in a non-institutional setting can be requested through the prior authorization process.
- ***Acupuncture*** rule 5160-8-51 of the Ohio Administrative Code, payment for more than thirty acupuncture visits per benefit year requires prior authorization.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

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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.

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 Ohio Administrative Code.

Limitations and Exclusions

- Community psychiatric supportive treatment (CPST) services as defined in rules 5160-27-02 and 5122-29-17 of the Ohio 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 reimbursable when provided in a hospital setting, except for the purpose of coordinating admission to an inpatient hospital or facilitating discharge from an inpatient hospital.

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.

Utilization Management Requirements

- See the Ohio Department of Medicaid information here: https://content.govdelivery.com/accounts/OHMEDICAID/bulletins/416eeb5.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Please refer to BH workgroup limits on the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals.
- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5160-27-02 and 5122-29-17 of the Ohio Administrative Code.

Therapeutic Behavioral Services - Group Day Treatment

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 delivered as a group treatment service. 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 staff-to-client ratio for mental health day treatment shall not exceed one staff to twelve individuals.

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 rules 5122-25-02 and 5160-27-09 of the Ohio Administrative Code.

- 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 recipient's level of clinical severity and function:
        - These services may be delivered in a variety of settings. Addiction, mental health, or general health care treatment personnel provide professionally directed screening, 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 rules 5122-29-30 and 5160-27-09 of the Ohio Administrative Code.
- 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 Ohio Administrative Code.

Limitations

- Mental health day treatment services are not reimbursable when the individual is receiving assertive community treatment (ACT) or substance use disorder residential treatment services.
- Day Treatment Group Therapeutic Behavioral Services, Per Diem: Authorization required after 30 units per calendar year.
- When services are provided for less than 2.5 hours in a day, the hourly billing code shall be used. When services are provided for 2.5 hours or more in a day, the per diem billing code shall be used.
- Reimbursement for other behavioral health or substance use treatment services provided on the same day as mental health day treatment is limited to no more than one hour, unless prior authorized.
- Reimbursement by more than one provider for mental health day treatment services on the same day requires prior authorization.

- Mental health day treatment hourly and per diem services may not be billed on the same for the same individual. Only one per diem mental health day treatment service may be billed per individual per day per provider.

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

Prior Authorization

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Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

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References

- Please refer to BH workgroup limits on the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals.
- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5160-27-09, 5122-29-06 of the Ohio Administrative Code.

Electroconvulsive Therapy

Purpose

- Electroconvulsive therapy (ECT) is a treatment device used for treating severe psychiatric illness by applying a brief intense electrical current to precise locations on the head to induce a seizure that lasts less than one minute. ECT is delivered in inpatient or outpatient settings and administered by a skilled psychiatrist privileged to perform ECT along with an anesthesiologist, and a nurse or physician assistant. ECT has been extensively studied with the longest history of use.

Services

- Prior Authorization and Pre-Service Notification for Inpatient Admissions
  - For inpatient admissions that require prior authorization or notification for pre-service scheduled treatment, these notifications must occur at least five (5) business days before admission. Notification of unscheduled treatment (including Emergency admissions) should occur as soon as is reasonably possible. In the event that Optum is not notified of an inpatient admission with ECT, benefits may be reduced. Check the member's specific benefit plan document for the applicable penalty and allowance of a grace period before applying a penalty for failure to notify Optum as required.
- ECT is medically necessary to treat severe, treatment-resistant depression, and may also be useful in treating individuals with bipolar disorder and schizophrenia that have not responded to other treatments.
- ECT is not medically necessary for any of the following:
  - Multiple-seizure electroconvulsive therapy (MECT). The efficacy of ECT for these indications has not been verified by in well-designed controlled trials. In addition, studies have demonstrated an increased risk of adverse effects with multiple seizures.
  - Other diagnoses in the absence of major depressive disorder, bipolar disorder, or schizophrenia disorder, including, but not limited to any of the following:
  - Substance use disorders;
  - Autism spectrum disorders;
  - Obsessive-compulsive disorder;
  - Posttraumatic stress disorder.
- The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.
- Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with evidence-based clinical guidelines.

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

Prior Authorization

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Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

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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 January 1, 2025).

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, appropriate to age and risk factors;
    - 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 Ohio Administrative Code 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 Ohio 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 Ohio 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 child's health, the child must be appropriately referred without delay for diagnosis, necessary treatment, and follow-up.

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

Prior Authorization

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Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5160-1-14 and 5160-1-01 of the Ohio Administrative Code.
- See Recommendations for Preventive Pediatric Health Care Bright Futures here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.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. A facility is an IMD, whether or not it is licensed as such if it is operated primarily for the care and treatment of individuals with mental diseases. An institution for persons with cognitive impairments or other developmental disabilities is not an IMD.

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 Title 42 Code of Federal Regulations (CFR) 438.6(e).

Limitations and Exclusions

Ohio Medicaid does not cover services to individuals that meet the following criteria: CFR 42 § 435.1009 (effective October 1, 2023):

- An individual who is an inmate of a public institution, except as outlined in paragraph (D) of this rule; or
- An individual who is a patient in an institution for mental diseases (IMD), as defined in rule 5160:1-1-01 of the Administrative Code, who is age twenty-two or older, but under age sixty-five, except:
  - As permitted in 42 C.F.R. 438.6(e) (as in effect October 1, 2023); or
  - As permitted under a demonstration waiver approved by the centers for Medicare and Medicaid services (CMS) under section 1115 of the Social Security Act (as in effect October 1, 2023)
- In accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. No. 115-271), medical assistance for the following individuals will be suspended, not discontinued, when the individual becomes an inmate of a public institution on or after October 24, 2019. Prior to the individual's release from the public institution a redetermination of eligibility will be processed without a new application from the individual.
  - Individuals under the age of twenty-one; or
  - Former foster care children up to the age of twenty-six as described in 42 C.F.R. 435.150(b) (as in effect October 1, 2023).

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

Prior Authorization

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Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5160-1-01, 5160-1-61, 5160-27-02 (K), 5160-3-06.1, 5160:1-1-03, 5160-3-16.4, 5160-8-05 of the Ohio Administrative Code.
- Code of Federal Regulations. (2006). Institutionalized individuals. Code of Federal Regulations website: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-K/subject-group-ECFR87e8ed6bfd3adb9/section-435.1009.

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 a young person who is experiencing emotional or behavioral symptoms, traumatic circumstances, or any distressing situation as identified by the young person, the young person's family, or another person responsible for the welfare of the young person that has compromised or impacted the young person's 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 days 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;
  - When there is a contagious medical condition present in the home; or
  - When there is 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 both of the following:
  - A clinician who demonstrates and maintains competency in the care and provision of services to young people.
  - and
  - One of the following:
    - A certified family peer or youth peer supporter. The certified peer supporter will also demonstrate competency in the care and provision of services to young people and have a scope of practice that includes young people with mental health disorders and substance use disorders.
    - A QBHS as defined in rule 5122-29-30 of the Ohio Administrative Code. This QBHS will also demonstrate competency in the care and provision of services to young people and have a scope of practice that included young people 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 call center designated by the department. When the service is initiated through direct connection with the provider, all of the following are to be the case:
    - 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, their family, or the other individual responsible for the welfare of the young person within the designated response time, as determined by the end of the triage assessment. The initial response may be scheduled outside of the designated response time if requested by the caller. If a call for mobile response is made after the MRSS provider's operational hours, the mobile response is to occur within forty-eight hours of the call or the next business day, whichever occurs first.
- The initial response will be conducted by:
  - A clinician;
  - A clinician and either a QBHS, certified family peer supporter, or certified youth peer supporter as described in paragraph (G)(1)(b) of this rule; or
  - (A combination of at least one QBHS and either another QBHS or a certified family peer supporter or certified youth peer supporter as described in paragraph (G)(1)(b) of this rule.
- If a clinician is unable to be present in person at the location described in paragraph (L)(2)(a) of this rule, the QBHS, certified family peer supporter, or certified youth peer supporter is to contact the MRSS team's clinician before leaving the premises of the site of the response so that the clinician can participate in the initial response by telehealth. If a telehealth connection cannot be made and sustained at the site of the response, the clinician is to be available for telephone consultation or is to go to the site of the response.
- The MRSS 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 young person and family at the end of the first face-to-face contact;
  - Crisis intervention and de-escalation with the young person or their 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) assessment performed by an MRSS team member who is a certified CANS assessor if one of the following is the case;
    - The young person is not enrolled in the Ohio resilience through integrated systems and excellence (OhioRISE) program for children and youth involved in multiple state systems or children and youth with other complex behavioral health needs;
    - A CANS assessment has not been administered to the young person in the ninety days prior to the MRSS team providing de-escalation to that young person; or
    - There has been a significant change in the young person's circumstances as determined by the clinician.
  - 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.
  - Identification of the young person's established behavioral health providers, notifying such providers of the crisis response and assisting with coordination of services.

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;
- There is to be 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 and/or their family. Stabilization services are to build skills of the young person and their family, to strengthen capacity to prevent future crisis, facilitate an ongoing safe environment, link the young

person and their 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 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 MRSS team members 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 their family.
- There is to be 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;
- There is to be the convening of or participation in one or more in planning meeting(s) with the young person, the young person's family, and cross system partners for the purpose of developing and coordinating linkages to ongoing services and supports when family need indicate that such activities are appropriate.

Service Transition

- The MRSS team and the young person and/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 their family's permission, the MRSS team will share the most recent individualized MRSS plan and supporting information with other service providers and/or family-identified natural supports in person, including by video or telephone, and with the young person or their family present when possible.
- The MRSS team will 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.
- The MRSS team will 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. With the permission of the young person or their family, the transition plan will be shared with the other service providers and/or family-identified natural supports.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio MRSS state line: (888) 418-MRSS (6777).
- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5122-29-14 and 5160-27-13 of the Ohio Administrative Code.
- 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: Mobile Response and Stabilization Services (MRSS) | Department of Behavioral Health.

Neurofeedback/Biofeedback For Behavioral And Substance Use Disorders

Purpose

Neurofeedback/biofeedback therapy is a non-invasive technique that uses real-time physical sign monitors, such as electroencephalographs (EEGs), heart-rate variability/respiratory sinus arrhythmia (HRV/RSA), magnetic

encephalography (MEG), and functional real-time functional magnetic resonance imaging (rtfMRI). These modalities provide feedback to individuals on how to control physiologic functions and mental states. The real-time feedback such as the individuals' EEG pattern and other physiological processes allows the individual to correct and enhance a mental and behavioral strategy for symptom improvement.

The reviewed evidence, including randomized controlled trials and systematic reviews, does not clearly demonstrate a treatment effect of neurofeedback/biofeedback on behavioral or substance use disorders. Many of these reviewed studies contain a number of significant limitations. Additionally, there is a lack of well-designed clinical trials with sufficient sample sizes, randomization, and blinding demonstrating the effectiveness of neurofeedback/biofeedback in the treatment of behavioral and substance use disorders.

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)*

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.
- 90911, 90912, 90913 are discontinued or non-covered codes. Please visit: 5160-1-60 of the Ohio Administrative Code (Non-Institutional Fee Schedule): https://www.registerofohio.state.oh.us/pdfs/5160/0/1/5160-1-60_PH_RV_A_APP1_20231121_0947.pdf.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
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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
- Inpatient substance use disorder, Inpatient psychiatric services, Opioid Treatment Program (OTP) services, please see detailed information here: https://codes.ohio.gov/ohio-administrative-code/rule-5160-59-03.
- 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. For additional information: OhioRISE Program 2026 Provider Manual.
- Coverage of OhioRISE services are subject program eligibility and authorization by the OhioRISE plan in accordance with rule 5160-59 of the Ohio Administrative Code.
- Refer to the OhioRise Manual Here: OhioRISE Program 2026 Provider Manual and the Ohio Department of Behavioral Health OhioRISE (Resilience through Integrated Systems and Excellence) | Ohio Medicaid Managed Care.

Admission Criteria

- Be determined eligible for Ohio Medicaid;
- Be under age 21;
- Not be enrolled in a MyCare Ohio plan
  - Have one of the following:
  - Certain needs for behavioral healthcare, identified by the Ohio Children's Initiative (OCI) and the Child and Adolescent Needs and Strengths (CANS) assessment, or
  - A recent inpatient hospital stay for mental illness or substance use disorder, or
  - A recent inpatient stay in a Psychiatric Residential Treatment Facility (PRTF).
  - Those enrolled in a MyCare Ohio plan and have qualifying needs for OhioRISE services, Please contact the Medicaid Consumer Hotline for options1-800-324-8680 (TTY: 711)
- For additional information, see Rule 5160-59-02 - Ohio Administrative Code | Ohio Laws and Plan Overview | OhioRISE - Aetna Better Health

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 OhioRISE 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. For additional information, see Rule 5160-59-02 - Ohio Administrative Code | Ohio Laws
- 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)

- Psychiatric residential treatment facility (PRTF) service in accordance with 5160-59-03.6. Provides intensive treatment for young people with behavioral health needs. PRTFs work with the member and their family to develop the knowledge and skills to safely manage their needs in the community.
- Please refer to the OhioRise manual here for eligibility and benefit information https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/ohio-rise/providers/pdf/abhohiorise_provider_manual.pdf for additional information: OhioRISE Program 2026 Provider Manual.

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. For additional information, see the OhioRISE Program 2026 Provider Manual.

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 Ohio Administrative Code.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional information can be found at 5160-59-03.4 of the Ohio Administrative Code.

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.

- Please refer to the OhioRise manual here for eligibility and benefit information: OhioRISE Program 2026 Provider Manual.

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.
- See The OhioRISE Mixed Services Protocol

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.

Opioid Treatment Program

Purpose

"Opioid treatment program" or "program" means a community addiction services provider that engages in supervised assessment and treatment, dispensing any form of medication assisted treatment for individuals who have opioid use disorders. Services include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.

Medication assisted treatment administration

- Medication administration shall consist of face-to-face interactions with patients, and methadone medication shall only be administered or dispensed in oral, liquid doses.
- Medication administration shall be provided in a manner to ensure privacy.
- Methadone medication shall only be administered orally.
- Opioid treatment programs are permitted to establish medication units following the guidelines of 42 CFR part 8 subsection 8.11(i)(1).
- Medication is to be administered only by the following individuals:
  - A physician;
  - A pharmacist who is authorized to manage drug therapy pursuant section 4729.39 of the Ohio Revised Code but only if specifically authorized by a consult agreement and to the extent specified in the agreement;
  - Registered nurse;
  - Licensed practical nurse; or
  - Physician assistant
- Dispensing medication is only to be performed by pharmacists in accordance with Chapter 4729. of the Revised Code. Personally furnishing medication is to be performed in accordance with rules adopted by the state of Ohio board of pharmacy and may only be done by the following individuals:
  - A physician;
  - A pharmacist pursuant to section 4729.39 of the Ohio Revised Code;
  - Certified nurse practitioner
  - physician assistant; or
  - An individual to whom a program prescriber has delegated the act of personally furnishing as authorized by the state of Ohio board of pharmacy in accordance with Chapter 4729:5-21 of the Administrative Code.
- A provider of medication administration is to be supervised in their medication administration if such supervision is required by statute or rules adopted by the Ohio licensing board that issued such provider's license or certification.

- A written, signed, and dated order from a program prescriber is for all medication administered, personally furnished, or dispensed. A copy of each order is to be maintained in the patient's record.
- Labels for dispensing or personally furnishing medication are to be prepared in accordance with 21 C.F.R. 1306.14 and section 3719.08 of the Ohio Revised Code and in accordance with agency 4729 of the Ohio Administrative Code.
- Medication orders are to be written by a program prescriber who is appropriately licensed and registered with the U.S. drug enforcement administration to order medications for opioid use disorder. The following procedures are to be followed in writing prescriber orders for these medications.
  - A prescriber's order for medication shall be valid for a maximum time period of ninety days.
  - A prescriber's order for medication shall be reviewed at least every ninety days and adjusted, reordered, or a notation made that the medication is to be discontinued.
- Opioid treatment programs are to be open and administer medication at least six days per week, except that programs may close on federal holidays indicated in rule 5122-40-06 of the Ohio Administrative Code. Upon approval of an exception request from the state authority and SAMHSA, opioid treatment programs may close for one business day twice per year for administrative planning purposes. Closure dates may not be within the same sixth month period.
- An opioid treatment program will enter into agreements with one or more alternate programs under which the opioid treatment program arranges for such programs to administer medication used in medication-assisted treatment in the event the opioid treatment program is closed due to emergency and unable to administer medication as required by paragraph (I) of this rule. Such agreements will cover any costs associated with the patient receiving the medication at the alternate site and are not to lead to any additional costs incurred by the patient.
- The take-home supply of medications for medication-assisted treatment for patients enrolled in an opioid treatment program receiving partial opioid agonist is limited to a one month supply. The take-home supply of such medication for patients enrolled in an opioid treatment program receiving methadone is limited to a one month supply and is to be in accordance with federal regulations.
- If the opioid treatment program is closed for any of the federal holidays set forth in 5 U.S.C. 6103 including, but not limited to, the following holidays, all patients receiving methadone may be given a one-day take-home dose at the discretion of the medical director:
  - Thanksgiving day.
  - Christmas day.
  - New year's day.
  - Martin Luther King day.
  - President's day
  - Memorial day
  - Juneteenth national independence day
  - Fourth of July
  - Labor day
  - Columbus day
  - Veteran's day
- The opioid treatment program is to have written procedures for take-home medication doses that include:
  - Statement that the opioid treatment program decisions on dispensing take-home doses of medication are to be determined by the medical director or other authorized program prescriber;
  - Statement that the dispensing of medication for home administration is permitted only when such dispensing is found to be safe, outweighs potential risks, and is beneficial for the patient. Such dispensing is not a right and is not automatic. Rather it is subject to medical-legal considerations on an individual case by case basis.
  - Requirement that take-home doses of medication are to be given only to:
    - A patient, who, in the opinion of the medical director or other authorized prescriber, is responsible in handling medication;
    - A trusted third party in accordance with federal drug enforcement administration regulations, when the pickup is approved in advance by the SOTA.
- A statement that prescriber orders for take-home doses of medication expire every ninety days;
- A requirement that education on the proper safe storage and disposal of take-home dose of medication be provided to patients prior to the first take-home dose.
  - Requirement that child-resistant packaging or caps be used for take-home doses of medications; and,
    - If a take-home bottle or other form of packaging is returned by a patient for refills, the opioid treatment program is to accept the bottle or other form of packaging and dispose of it.
    - If a take-home bottle or other form of packaging is utilized for take home doses, the medication bottles - are only to be used once.
    - Under no circumstance is medication to be placed in a container provided by a patient (including previous take-home bottle).

- Requirement that each take-home bottle or other form of medication packaging used have a label that contains the following information:
  - The name and address of the prescriber;
  - Name of patient for whom the drug is intended;
  - The name and strength dangerous drug
  - The dosing instructions and schedule;
  - Date furnished; and
  - If a compounded drug, the statement "Compounded Drug" or other similar statement shall also be displayed prominently on the label.
  - A requirement that any take-home policies and procedures be individualized to each patient's treatment needs.
- An individual is to be a patient of an opioid treatment program licensed by the department in order to receive medication under the provisions of this rule except as otherwise provided in this rule.
- A patient may attend a different opioid treatment program if prior approval is obtained from the patient's medical director or program prescriber to receive services on a temporary basis from another opioid treatment program licensed under this chapter or by SAMHSA. The approval is to be noted in the patient's record and included in the following documentation:
  - The patient's signed and dated consent for disclosing identifying information to the program which will provide services on a temporary basis;
  - A medication change order by the referring medical director or prescriber permitting the patient to receive services on a temporary basis from the other program for a length of time not to exceed thirty days; and,
  - Evidence that the medical director or prescriber for the program contacted to provide services on a temporary basis has accepted responsibility to treat the visiting patient, concurs with his or her dosage schedule, and supervises the administration of the medication.
- A patient may receive medication at a community mental health services or addiction services provider certified for the residential and withdrawal management substance use disorder services as defined in rule 5122-29-09 of the Ohio Administrative Code, long-term care provider, or skilled nursing provider from an opioid treatment program. A temporary medication request will be submitted through the SAMHSA extranet and approved by the state authority. Medication orders are to be renewed every seven days. Medication approval will be noted in the patient's record and will include the following documentation:
  - The patient's signed and dated consent for disclosing identifying information to the program which will provide services on a temporary basis; and
  - A chain of custody document showing that any medication used for medication assisted treatment is transferred from medical staff of the opioid treatment program to medical staff of the partnering provider or appropriate law enforcement staff.
- The provision of interim maintenance with medication is prohibited under this rule unless the opioid treatment program has a waiver from the department in addition to authorization from SAMHSA in accordance with 42 C.F.R. 8.11(g).
  - All of the requirements for comprehensive maintenance treatment apply to interim maintenance treatment with the following exceptions for patients receiving methadone: no take-home doses are permitted except on Sundays and federal holidays if the program is closed on those days; a primary counselor is not required; and the rehabilitative and other services described in 42 C.F.R. 8.12(f)(4), (f)(5)(i), and (f)(5)(iii) are not required.
  - Interim maintenance cannot be provided to an individual for more than one hundred and eighty days in any twelve month period.
  - To receive interim maintenance, a patient must be fully eligible for admission to comprehensive maintenance.
  - Interim maintenance treatment is for those patients who cannot be enrolled in comprehensive maintenance treatment in a reasonable geographic area within fourteen days of application for admission.
  - During interim maintenance, the initial toxicology and at least two additional toxicology screening tests should be obtained.
  - Programs offering interim maintenance must develop clear policies and procedures governing the admission to interim maintenance and transfer of patients to comprehensive maintenance.
- Each opioid treatment program shall have written procedures for pregnant patients that include at least the following:
  - Requirement that each pregnant person admitted to the opioid treatment program be informed of the possible risks to themselves or to their unborn child from the use of medication assisted treatment, and be informed that abrupt withdrawal from these medications may adversely affect the unborn child;
  - Statement that a pregnant person, regardless of age, who has a documented opioid use disorder and who may be in direct jeopardy of resuming illicit opioid use with all of its attendant dangers during pregnancy, may be placed on a regimen of medications used in medication-assisted treatment.
- Statement that for such pregnant patient, evidence of current physiological dependence on opioid drugs is not needed if the medical director or other authorized prescriber certifies the pregnancy, determines and documents that the

person may resort to the use of opioid drugs and determines that medications used in medication-assisted treatment is justified in their clinical opinion;
    - Requirement that the admission of each pregnant patient to an opioid treatment program be approved by the medical director or other authorized prescriber prior to admitting the person to the program;
    - Requirement that opioid treatment programs develop a form for release of information between themselves and the healthcare provider providing obstetrical care. This voluntary form should be offered for coordination of medical care;
    - Requirement that each pregnant patient be given education on recognizing the symptoms of neonatal abstinence syndrome near the time of delivery;
    - Procedures for prenatal care that include:
        - Provisions for providing prenatal care by the program or by referral to an appropriate health care provider. If appropriate prenatal care is neither available on-site or by referral, or if the pregnant patient cannot afford care or refuses prenatal care services on-site or by referral, an opioid treatment program, at a minimum, should offer basic prenatal instruction on maternal, physical, and dietary care as part of its counseling services. If a pregnant patient refuses the offered on-site or referred prenatal services, the medical director or treating prescriber must use informed consent procedures to have the person formally acknowledge, in writing, refusal of these services;
        - Requirement that if a person is referred to prenatal care outside the agency, the name, address and telephone number of the health care provider shall be recorded in the woman's clinical record;
        - If prenatal care is provided by the opioid treatment program, the clinical record shall include documentation to reflect services provided;
        - Requirement that if a person is referred outside of the agency for prenatal services, the provider to whom they have been referred is to be notified that the person is taking medication for an opioid use disorder; however, such notice shall only be given after the patient has signed a release of information;
        - Requirement that any changes in medication be communicated to the appropriate healthcare provider if the person has prenatal care outside the agency and if the person allows communication among providers;
        - Requirement that the program monitor the medication dose carefully throughout the pregnancy, moving rapidly to supply increased or split dose if it becomes necessary;
        - Recommendation that blood serum levels of methadone be monitored once a trimester prior to delivery. Post-partum, the patient's withdrawal symptoms and clinical status should be re-evaluated every three days for two weeks to determine the appropriate dose of medication-assisted treatment by the appropriate healthcare professional. The medical director or other authorized prescriber shall request and review serum levels to determine whether any changes to treatment are indicated; and,
        - Requirement that the program offer on-site parenting education and training to all patients who are parents or refer interested patients to appropriate alternative services for the training.
- Statement that if a person refuses prenatal service by the opioid treatment program and by an outside provider:
    - The medical director or other authorized prescriber shall note this in the clinical record; and,
    - The patient will be asked to sign a statement that says "I have been offered the opportunity for prenatal care by the opioid treatment program or by a referral to a prenatal clinic or by a referral to the physician of my choice. I refuse prenatal counseling by the opioid treatment program. I refuse to permit the opioid treatment program to refer me to a physician or prenatal clinic for prenatal services." If the patient refuses to sign the statement, the medical director or other authorized prescriber is to indicate in the signature block that "patient refused to sign" and affix their signature and the date on the statement.
- If a patient desires to be permanently transferred, medication administration shall continue until the patient completes the admission process at the admitting program.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5122-40 Opioids of the Ohio Administrative Code.

Substance Use Disorder Intensive Outpatient and Partial Hospitalization

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 recipient's level of clinical severity and function:
    - These services may be delivered in a variety of settings. Addiction, mental health, or general health care treatment personnel provide professionally directed screening, 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.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5160-27-09 Substance use disorder treatment services of the Ohio Administrative Code.

Ohio RISE 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.

Please refer to the OhioRise manual here for eligibility, benefit, and additional information: OhioRISE Program 2026 Provider Manual.

Admission Criteria

- PRTF services for individuals under age 21 are to be:
  - Provided under the direction of a physician;
  - Provided by a psychiatric facility that is not a hospital and is accredited by the joint commission, the commission on accreditation of rehabilitation facilities, or the council on accreditation as a behavioral health residential treatment facility.

Psychological and Neuropsychological Testing

Purpose

Psychological Test Evaluation Services is a set of formal procedures utilizing reliable and validated 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 Test Evaluation Services is a set of formal procedures utilizing reliable and validated tests specifically focused on identifying the presence of brain damage, injury, or dysfunction, and any associated functional deficits. Service activities can include tests 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.

Refer to the 2024 Psychological and Neuropsychological Testing Billing and Coding Guide for additional information.

Refer to the medical policy for Neuropsychological Testing and Monitoring Medical Policy 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).

Automated Testing and Result

- Automated Testing and Result is primarily a method of screening for potentially clinically significant intellectual, cognitive, emotional, and behavioral symptoms or functional deficits that utilizes a single reliable and validated instrument that has fully automated administration, scoring and interpretation.
- Automated Testing may also be used to quickly estimate changes in clinical status over time either as a method of obtaining an objective measure of progress in treatment or periodic objective surveillance of known risk issues.
- Automated Testing and Result is within the scope of the provider's professional training and licensure when the provider is any of the following:
  - A doctoral-level psychologist who is licensed to practice independently and demonstrates sufficient training and experience.
  - A masters-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.
    - The masters-degreed provider has professional expertise in the types of tests/assessments being administered.

        - The masters-degreed provider is conducting test administration, scoring and interpretation in accordance with licensing standards and psychological testing professional and ethical standards.
- A credentialed psychiatrist who meets the following requirements:
    - Recognized certification in neurology through the American Board of Psychiatry and Neurology;
    - Accreditation in behavioral neurology and neuropsychiatry through the American Neuropsychiatric Association;
    - State medical licensure specifically allowing for the provision of neuropsychological testing service(s);
    - Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
    - Physician and supervised psychometrician(s) adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

Developmental, Cognitive and Brief Emotional Assessment

- Assessment of Aphasia (96105) is the evaluation of expressive and receptive speech and language function, language comprehension, speech production ability, spelling or writing with interpretation and report per hour. This procedure is often conducted by a speech language therapist. It is not considered a form of psychological testing and is not typically covered under the behavioral health benefit.
- Standardized cognitive performance testing (96125) is an occupational therapy assessment used to assess capacity to function in activities of daily living. It is not considered a form of psychological or neuropsychological testing and is not typically covered under the behavioral health benefit.
- Developmental Testing (96110, 96112, 96113) is an adjunct to the routine surveillance for developmental delays in young children. This procedure is often conducted by a developmental pediatrician, or a speech, language, physical or occupational therapist. It is not considered a form of psychological testing and is not typically covered under the behavioral health benefit unless contractually required to manage as a behavioral health service.
- Brief emotional/behavioral assessment (96127) is typically used in primary care settings for early detection of potential conditions or disorders, to monitor progress in treatment or track changes in symptoms over time. Results of brief self-report screening assessments can also be used to inform decisions about whether to refer for psychological or neuropsychological testing. Brief screening assessments should not be used for making definitive diagnostic decisions and are not considered to be psychological or neuropsychological testing. This service code is not typically included on behavioral contracts or fee schedules and most often is managed under medical benefits.

Psychological Tele-Assessment

- Tele-assessment is typically not covered unless required by regulation or contract. Member-specific benefit plan documents and any federal or state mandates should be consulted, The use of tele-assessment should not contradict federal, state, or local laws overseeing the practice of psychologists providing assessment services including applicable licensure requirements.
- Face-to-face assessment is the standard of care, but there may be case-by-case circumstances where tele-assessment is indicated and an exception could be made (e.g., to extend geographical reach to isolated populations, areas where there are no available providers who can render the required testing, or to lessen the number of visits to specialist clinics).
- Adapting traditional assessment practices to the remote delivery of services must maintain professional and ethical standards and ensure the integrity and accuracy of psychological assessments conducted via telecommunication platforms. Remote testing should not override typical and standardized practice. Teleassessment is not covered when:
    - In person testing is available.
    - The provider is not sufficiently proficient in the use of telehealth to deliver care.
    - The provider is not actively licensed or credentialed to practice in the state where the member will receive testing.
    - HIPAA compliant platform will not be used. Examples of HIPAA compliant include:
        - Doximity
        - Doxy.me
        - GoToMeeting
        - Healthie
        - Kareo
        - Teladoc
        - Thera-LINK
        - TherapyNotes
        - Zoom for Healthcare
    - Test materials are not adequately secured (e.g., sending physical materials).
    - Adequate monitoring of test administration through audio-visual methods will not occur.

- Member is not a good candidate for remote administration (e.g., due to age, condition or diagnosis, lack of access to a conducive test environment).
- Member does not have technology literacy or access to technology to effectively participate in teleassessment.
- Test selection does not include tests that are medically necessary to answer the referral questions because the test(s) can't be remotely administered or would require modification to such an extent as to undermine test score reliability.
- Standard administration procedures must be modified to such an extent as to undermine test validity.
- Informed consent has not been secured for telehealth testing and/or risks and limitations of remote assessment have not been plainly communicated to the member.

Admission Criteria

- Psychological and Neuropsychological Testing is located under 5160-8 Therapeutic and Diagnostic Services of the Ohio 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 of the Ohio Administrative Code and/or the Medicaid School Program (MSP) 5160-35-05 of the Ohio Administrative Code.
- 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 based on encounters per calendar year: Ohio Medicaid Authorization Form - Community Behavioral Health

- Neuropsychological testing is not medically necessary for the following:

- Baseline neuropsychological testing in asymptomatic persons at risk for sport-related concussions
- Computerized neuropsychological testing when used alone for evaluating concussions
- blob:https://teams.microsoft.com/44412f53-c2bc-403c-b022-511122a1979fNeuropsychological testing for the following diagnoses alone without other covered conditions as noted above:
- Headaches, including migraine headache;
- History of myocardial infarction;
- Intermittent explosive disorder;
- Computerized cognitive testing, such as Mindstreams® Cognitive Health Assessment, BrainCareTM and QbTest.

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.
- Per Ohio Medicaid: Up to 12 hours per patient per calendar year for psychological testing codes. Up to 8 hours per patient per calendar year for neuropsychological testing codes. Prior authorization is required for additional service. See the Ohio Department of Medicaid Community Behavioral Health Rehabilitative Services Authorization Request Form to Request additional units.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

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Withdrawal Management Services for Substance Use Disorder

Service Delivery

- For the purpose of Medicaid reimbursement, 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).
- Medicaid will reimburse for the services provided under the following ASAM levels of care:
  - LOC 1: outpatient services. LOC 1 services are designed to treat the recipient's level of clinical severity and function. These services may be delivered in a variety of settings. Addiction, mental health, or general health care treatment personnel provide professionally directed screening, 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.
    - LOC 3: residential services/inpatient services including LOC 3 WM. These services are co-occurring capable, co-occurring enhanced, and complexity capable in nature and provided by addiction treatment, mental health and general medical personnel in a twenty four hour treatment setting. Services are provided in Ohio department of mental health and addiction services certified permanent facilities which are staffed twenty four hours a day. The following services are included in the residential treatment service and will not be reimbursed separately:
        - Ongoing assessments and diagnostic evaluations.
        - Crisis intervention.
        - Individual, group, family psychotherapy and counseling.
        - Case management.
        - Substance use disorder peer recovery services.
        - Urine drug screens.
        - Medical services.
- Individuals in residential treatment may receive medically necessary services from practitioners who are not affiliated with the residential treatment program. Examples include, but are not limited to, psychiatry, medication assisted treatment, or other medical treatment that is outside the scope of the residential level of care as defined by the American society of addiction medicine. Medicaid will reimburse providers of these services outside the per diem rate paid to residential treatment programs. All treatment services, regardless of whether they are rendered by the residential treatment program or unaffiliated billing practitioners or agencies must be documented in the client's treatment plan maintained by the residential treatment provider.
- The entity providing a residential service must ensure that the Medicaid recipient has access to the appropriate practitioner for receipt of clinical services as stated in the ASAM treatment criteria.
- Eligible practitioners of substance use disorder treatment services must meet all applicable requirements stated in rule 5160-27-01 of the Ohio Administrative Code. Qualified mental health specialists are not eligible to be a residential treatment team practitioner.
- Residential substance use disorder services shall be provided in accordance with the American Society of Addiction Medicine's (ASAM) level of care three and ASAM's level of care three-withdrawal management (WM), and associated sub levels as appropriate to the needs of the individual being served; as published in the ASAM criteria, third edition, 2013.
- A provider certified to provide this service, may provide ASAM level of care two-withdrawal management.
- For the purposes of this rule "family" means any individual or caregiver related by blood or affinity whose close association with the person is the equivalent of a family relationship as identified by the person including kinship and foster care.
- Each provider shall have written policies and procedures to ensure its referral process to other levels of care is appropriately implemented and managed and shall include, at a minimum, the following:
    - Referral decisions made to the appropriate level of care as determined utilizing the American society of addiction medicine criteria protocols for levels of care. Documentation of referral shall appear in the client record.
    - Discharge plan stipulating specific recommendations and referrals for alcohol and drug addiction treatment. The discharge plan shall be documented in the client record.
    - Follow-up communications with client and the service provider to which client is referred. These contacts shall be documented in the client's record.
    - Provisions for the transition of the client to other SUD treatment providers. Provisions for use of transition communications conducted in person to include staff members of the rendering provider organization, the SUD treatment program to which the patient is being referred, the patient, and family, if present.
- Each provider rendering services pursuant to this rule will be capable of admitting, initiating, and referring clients receiving medication assisted treatment and capable of facilitating the continuity of their pharmacotherapy through care transitions, including but not limited to other levels of care for behavioral health treatment, hospitals, community-based providers, and criminal justice settings.
- Each provider of this service shall provide, in addition to the required ASAM level of care:
    - Food for clients, to include at least three nutritionally-balanced meals and at least one nutritious snack per day, seven days per week;
    - The opportunity for clients to get eight hours of sleep per night; and,
    - Services in facilities that are clean, safe, and therapeutic.

- Time for meals, unstructured activities, free time, or time spent in attendance of self-help groups, such as alcoholics anonymous or narcotics anonymous shall not be considered for the purposes of meeting ASAM level of care requirements for services.
- Providers shall promote interpersonal and group living skills.
  - A service provider may require clients to perform tasks of a housekeeping nature as specified within service provider guidelines.
  - Housekeeping tasks shall not be considered for the purposes of meeting ASAM level of care requirements for services.
- Providers will offer medication assisted treatment on site or through facilitated access off site.
- Providers will connect clients to resources for education, job training, job interviews, employment stabilization and obtaining alternative living arrangements.
- Providers of ASAM level of care 3.1 will:
  - Have a prescriber as part of the interdisciplinary team either through employment or contractual arrangement; however, the prescriber does not provide direct services; and,
  - Offer at least five hours per week of low intensity treatment of substance use disorders.
- Providers of ASAM level of care 3.3 will:
  - Include, in addition to the ASAM specified interdisciplinary team members, peer supporters certified pursuant to rule 5122-29-15.1 of the Ohio Administrative Code as appropriate and available to the range and severity of the residents' problems.
  - Have an appropriately credentialed, licensed addictions clinician manage the program.
  - Have one appropriately certified or licensed addictions clinician on site days and a certified or licensed chemical dependency counselor or similar with telephonic availability during the remaining hours.
  - Offer at least thirty hours per week of a combination of skilled treatment services, clinically managed services and recovery support services focused on individuals where the effects of the substance use or a co-occurring disorder has resulted in cognitive impairment. At least ten of the thirty hours is to include individual, group, or family counseling.
  - Have staff with the knowledge and skills to work with patients with cognitive limitations.
  - Have therapies, for clients with significant cognitive deficits, delivered in a manner to promote engagement and understanding of concepts that is slower paced, more concrete, and more repetitive.
  - Have addiction treatment professionals with sufficient cross-training to recognize the signs and symptoms of co-occurring mental disorders and initiate treatment interventions (treatment within the program or referral to treatment outside the program) to address identified behavioral health needs.
- Providers of ASAM level of care 3.2-WM and 3.5 will:
  - Include, in addition to the ASAM specified interdisciplinary team members, peer supporters certified pursuant to rule 5122-29-15.1 of the Ohio Administrative Code as appropriate and available to the range and severity of the residents' problems.
  - Have an appropriately credentialed, licensed addictions clinician manage the program.
  - Have one appropriately certified or licensed addictions clinician on site days and a certified or licensed practitioner with a declared scope of practice that includes treating people with SUDs in the evenings, with telephonic availability during evenings and nights. A nurse, physician assistant, physician, or emergency services will be available twenty-four hours a day either on site or with telephonic availability.
  - Offer at least thirty hours per week of a combination of skilled treatment services, clinically managed services and recovery and withdrawal (for 3.2-WM programs) support services focused on individuals who have significant social and psychological problems. At least ten of the thirty hours is to include individual, group, or family counseling.
  - Have addiction treatment professionals with sufficient cross-training to recognize the signs and symptoms of co-occurring mental disorders and initiate treatment interventions (treatment within the program or referral to treatment outside the program) to address identified behavioral health needs.
  - If the provider primarily provides this ASAM level of care to adolescents who have not graduated from high school or who have not passed a general education development (GED) test, offer at least twenty hours per week of a combination of skilled treatment services, clinically managed services and recovery and withdrawal (for 3.5-WM adolescent programs) support services focused on individuals who have significant social and psychological problems. At least ten of the twenty hours is to include individual, group, or family counseling. The provider will also provide year round schooling.
- Providers of ASAM level of care 3.7-WM and 3.7 will:
  - Include, in addition to the ASAM specified interdisciplinary team members, peer supporters certified pursuant to rule 5122-29-15.1 of the Ohio Administrative Code as appropriate and available to the range and severity of the residents' problems.
  - Have one appropriately certified or licensed addictions clinician on site days and evenings, with telephonic availability during the remaining hours.

    - Offer at least thirty hours per week of a combination of skilled treatment services, clinically managed services and recovery and withdrawal (For 3.7 WM programs) support services focused on individuals with subacute biomedical and emotional, behavioral, or cognitive problems. At least ten of the thirty hours is to include individual, group, or family counseling.
    - Have addiction treatment professionals with sufficient cross-training to recognize the signs and symptoms of co-occurring mental disorders and initiate treatment interventions (treatment within the program or referral to treatment outside the program) to address identified behavioral health needs.
- All component practitioner services must be provided in accordance with Chapter 5122-29 of the Ohio Administrative Code.
- A health history, including food allergies and drug reactions, shall be completed on or before admission to a provider of this service.
- Each provider of this service organized to serve individuals under the age of eighteen shall provide services in a manner that is developmentally appropriate, addresses educational needs, and promotes family or significant other involvement.
- Services provided pursuant to this rule shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Ohio Administrative Code.

Limitations and Exclusions

- The following services are considered non-covered for individuals in residential treatment:
    - Therapeutic behavioral services.
    - Psychosocial rehabilitation.
    - Community psychiatric supportive treatment.
    - Mental health day treatment.
    - Assertive community treatment.
    - Intensive home based treatment.
- Residential levels of care are mutually exclusive; therefore a patient can only receive services through one level of care at a time.
- 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.
- Prior authorization is required for LOC 3 residential treatment according to the following:
    - Up to thirty consecutive days without prior authorization per Medicaid enrollee for the first and second admission in a calendar year. If the stay continues beyond the thirty days of the first or second stay, prior authorization is required to support the medical necessity of the continued stay. If medical necessity is not substantiated and approved by the ODM designated entity, only the initial thirty consecutive days will be reimbursed.
    - Third and subsequent admissions during the same calendar year must be prior authorized from the first day of admission.
- The patient's 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 Ohio Administrative Code.

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.

Utilization Management Requirements

- See the Ohio Department of Medicaid information here: https://content.govdelivery.com/accounts/OHMEDICAID/bulletins/416eeb5.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5122-29-09, 5122-29-30, 5122-29-15.1 of the Ohio Administrative Code.

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:

- Recovery Management
- Individualized Placement Support
- Supported Employment

Recovery management is the coordination of all specialized recovery services program services received by an individual and assisting him or her in gaining access to 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 activities include:
  - Face-to-face eligibility evaluation, including:
    - 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;
    - At the discretion of ODM or its designee, evaluations may be conducted by video conference or telephonically at the request of the individual, 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 SRSP 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 in accordance with rule 5160-44-02 of the Ohio Administrative Code;
  - 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 in accordance with rule 5160-44-05 of the Ohio Administrative Code 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 as defined in rule 5160-43-01 of the Ohio Administrative Code;
- 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)

- 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; or
  - Transportation.
- The person-centered services plan will document that any modification of the additional conditions for provider-owned or controlled residential settings set forth in rule 5160-44-01 of the Ohio Administrative Code is supported by a specific assessed need and justified in the person-centered services plan. In these cases, the person-centered services plan will:
  - Identify a specific and individualized assessed need;
  - Document the positive interventions and supports used prior to any modifications to the person-centered services plan;
  - Document less intrusive methods of meeting the need that have been attempted but were unsuccessful;
  - Include a clear description of the condition that is directly proportionate to the specific assessed need;
  - Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
  -) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
  - (g) Include informed consent of the individual; and
  - (h) Include an assurance that interventions and supports will not cause any harm to the individual.
- The person-centered services plan will:
  - Be understandable to the individual receiving services and supports, and the people important in supporting him or her. At a minimum, it will be written in plain language and in a manner that is accessible to persons with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b) (as in effect on October 1, 2023).

- Identify the person and/or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all people and providers responsible for its implementation. Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature will be documented on the plan.
- Be distributed to the individual and other people involved in the plan.
- Prevent the provision of unnecessary or inappropriate services and supports.
- Be reviewed and revised upon reassessment of functional need as required by 42 CFR 441.365(e) (as in effect on October 1, 2023), at least every twelve months, when the individual experiences a significant change, or at the request of the individual.

Admission Criteria

An individual may be eligible for enrollment in the specialized recovery services program if they meet all of the following:

- The member is 21 years of age or older;
- Be determined eligible for Ohio Medicaid in accordance with Chapters 5160:1-1 to 5160:1-5 of the Ohio Administrative Code;
- 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 functioning" section.
- The member demonstrates needs related to the management of his or her behavioral health or diagnosed chronic condition 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; or
  - 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 described in the above paragraph 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 as determined by the Ohio department of Medicaid (ODM) or its designee; 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 in accordance with Admission Criteria;
  - Maintain residency in an HCBS setting;
  - Agree to and receive recovery management services in accordance with his or her person-centered service plan from ODM or its designee 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.
- 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 Ohio 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 of the Ohio Administrative Code for details.
- Each activity has varied provider requirements and supervision, please see 5160-43 of the Ohio Administrative Code for specifics.
- The following are not payable under IPS-SE:
    - 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, 2024):
        - Job placements paying below minimum wage;
        - Supervision, training, support, and adaptations typically available to the general workforce filling similar positions in the business;
        - Supervisory activities rendered as a normal part of the business setting;
        - 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.
- Recovery management activities do not include:
    - Travel time incurred by the recovery manager billed as a discrete unit of service;
    - Services that constitute the administration of another program such as child welfare, child protective services, foster care, parole and probation functions, legal services, public guardianship, and special education;
    - Representative payee functions; and
    - Other activities identified by ODM.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

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

Substance Use Disorder Case Management Services

Purpose

Substance use disorder case management services means those activities provided to assist and support individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Case management services may include interactions with family members, other individuals or entities.

Service Delivery

- Case management services shall include, at a minimum, the following activities:
  - Assessment.
  - Referral.
  - Monitoring and follow-up.
- Examples of case management activities include: coordinating: client assessments, treatment planning and crisis intervention services; providing training and facilitating linkages for the use of community resources; monitoring service delivery; obtaining or assisting individuals in obtaining necessary services, for example, financial assistance, housing assistance, food, clothing, medical services, educational services, vocational services, recreational services, etc.; assisting individuals in becoming involved with self-help support groups; assisting individuals in increasing social support networks with family members, friends, and/or organizations; assisting individuals in performing daily living activities; and coordinating criminal justice services.
  - Transportation in and of itself does not constitute case management.
  - Waiting with clients for appointments at social service agencies, court hearings and similar activities does not, in and of itself, constitute case management.
- Case management services do not include the provision of
  - Direct services to which the client has been referred such as medical, educational, or social; or,
  - Internal quality assurance activities, such as clinical supervisory activities and/or case reviews/staffing sessions.

Substance Use Disorder Targeted Case Management

Targeted case management assists an individual receiving alcohol or substance use disorder treatment services from an Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified substance use disorder treatment program to gain access to needed medical, social, educational and other services.

Service Delivery

- Targeted case management services shall include, at a minimum, the following activities:
  - Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. Assessment activities include taking client history; identifying the individual's needs and completing related documentation and gathering information from other sources such as family members, medical providers, social workers and educators to form a complete assessment of the eligible individual.
  - Development and periodic revision of a specific care plan that is based on the information gathered through the assessment. The care plan must include the following requirements:
  - Goals and actions to address the medical, social, educational and other services needed by the individual; and
  - A plan to ensure the active participation of the eligible individual and or their authorized health care decision maker; and
  - A course of action to respond to the assessed needs of the eligible individual.
  - Referral and related activities to help the eligible individual obtain needed services
  - Monitoring and follow-up activities or contacts that are necessary to ensure that the care plan is implemented and adequately addresses the eligible individual's needs. Changes in needs or status must be reflected in the care

plan. Monitoring shall be performed no less frequently than annually. Monitoring may be performed in person or by electronic communication.

- In order to provide targeted case management, practitioners must meet the requirements in rule 5160-27-01 of the Ohio Administrative Code. For the purposes of this rule, the following unlicensed practitioners are excluded: qualified mental health specialists and certified peer supporters.
- The following activities or contacts do not constitute targeted case management and are ineligible for reimbursement as targeted case management:
  - Transportation.
  - Waiting with an individual for appointments at social service agencies, court hearings and similar activities does not, in and of itself, constitute case management.
  - Direct services to which the client has been referred such as medical, educational or social services.
  - Internal quality assurance activities, such as clinical supervisory activities and/or case review/staffing sessions.
- Targeted case management services will not be separately reimbursed when a recipient is enrolled in a substance use disorder (SUD) residential treatment facility.
- Targeted case management services require prior authorization from the Ohio department of Medicaid (ODM) designated entity when a recipient is enrolled in an assertive community treatment (ACT) or intensive home based treatment (IHBT) team.

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5122-29-13, 5160-27-01, 5160-27-10 of the Ohio Administrative Code.

Therapeutic Behavioral Services and Psychosocial Rehabilitation

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

- For the purposes of Medicaid reimbursement, therapeutic behavioral services (TBS) are goal-directed supports and solution-focused interventions.
- Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's treatment plan. Activities include but are not limited to the following:
  - Treatment planning. Participating in and utilizing strengths based treatments/planning which may include assisting the individual and family members or other collaterals with identifying strengths and needs.
  - Identification of strategies or treatment options. Assisting the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness.
  - Developing and providing solution focused interventions and emotional and behavioral management drawn from evidence-based psychotherapeutic treatments.
  - Restoration of social skills. Rehabilitation and support with the restoration of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community

awareness, develop coping strategies, and promote effective functioning in the individual's social environment including home, work and school.
    - Restoration of daily functioning. Assisting the individual to restore daily functioning specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements; and
    - Crisis prevention and amelioration. Assisting the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a community setting or that result in functional impairments. Activities may include, but not be limited to, assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or, as appropriate, seeking other supports to restore stability and functioning.
    - 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.
- For the purposes of Medicaid reimbursement, psychosocial rehabilitation (PSR) assists individuals with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or mental health barriers associated with an individual's mental health diagnosis.
- Activities include:
    - 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.
    - Supporting the individual with restoration and implementation of daily functioning and daily routines critical to remaining successful in home, school, work, and community.
    - Rehabilitation and support to restore skills to function in a natural community environment.
- Eligible providers are unlicensed mental health practitioners in accordance with rule 5160-27-01 of the Administrative Code, are at least eighteen years of age and who have, at a minimum, a high school diploma with appropriate mental health training as determined by the employing agency and documented in the employee's record.
- 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.

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

Prior Authorization

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Utilization Management Requirements

- See the Ohio Department of Medicaid information here: https://content.govdelivery.com/accounts/OHMEDICAID/bulletins/416eeb5.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
- Additional Information can be found in rules 5122-29-18, 5160-27-08, 5160-27-06 of the Ohio Administrative Code.
- Please refer to the Ohio Medicaid Behavioral Health provider site: https://bh.medicaid.ohio.gov/manuals.

Transcranial Magnetic Stimulation

Purpose

Transcranial Magnetic Stimulation is proven and medically necessary for the treatment of individuals with a confirmed diagnosis of major depressive disorder (MDD) when all of the following conditions are met:

Effective 01/01/2026: Individuals 15 years of age and older

Prior to 01/01/2026: Individuals 18 years of age and older

- One of the following psychopharmacologic scenarios applies:
  - For ages 15-17 years of age:
    - A lack of clinically significant response and/or the inability to tolerate two (2) evidence-based depression medication regimen trials* in the current depressive episode.
  - For ages 18 years and older:
    - A lack of clinically significant response and/or the inability to tolerate two (2) evidence-based depression medication regimen trials in the current depressive episode and
    - The evidence-based depression medication regimen trials are from at least two (2) different medication classes*.

    *Medication side effects will be considered intolerable when those side effects are of a nature where they are not expected to diminish or resolve with continued administration of the drug.
- The individual has a documented history of response to transcranial magnetic stimulation (TMS) in a previous depressive episode, as evidenced by a greater than 50% improvement on a standardized rating scale for depression symptoms.
- The individual's current baseline depression measurement score has been documented using an evidence-based validated rating scale (e.g., BDI; HAM-D; MADRS).
- TMS treatment is provided using a device that is approved by the U.S. Food and Drug Administration (FDA) for the treatment of major depressive disorder.
- The order for treatment (or retreatment) must be written by a psychiatrist (MD or DO) who has examined the patient, reviewed the record and is prescribing an evidence-based TMS protocol on an FDA-cleared device the physician is trained to operate. A physician shall oversee the treatment but does not have to personally administer the sessions nor be in the area. A prescribing or covering physician must be immediately reachable and interruptible in case of questions or problems during treatment.
- TMS must be ordered, supervised, and administered by a qualified psychiatrist or a psychiatric mental health nurse practitioner (PMHNP) operating in a state where full practice authority is granted and are practicing within the advanced practice registered nurse state scope of practice. See current list of states granting Full Practice Authority (FPA) to PMHNPs: TMS FPA States
- TMS is considered reasonable and necessary for up to 30 treatment sessions, followed by 6 tapered treatments.

Retreatment

Retreatment may be considered for members that have relapsed 6 months after the most recent treatment and who meet all the following criteria:

- met the guidelines for initial treatment; and

- relapsed despite ongoing treatment strategies which may include psychotherapy, pharmacotherapy, etc.; and
- responded to prior treatments as evidenced by a greater than 50% improvement in standard rating scale measurements for depressive symptoms.

The following are not medically necessary due to insufficient evidence of efficacy:

- TMS for individuals not meeting the above evidence-based coverage criteria
- TMS for individuals who are pregnant or nursing
- TMS for individuals with acute suicidality, acute psychosis or with psychiatric emergencies where a rapid clinical response is needed, such as marked physical deterioration, catatonia, or immediate suicide risk
- TMS maintenance therapy and/or booster treatments
- Accelerated TMS protocols and/or Theta burst stimulation protocols
- Navigated transcranial magnetic stimulation (nTMS) for mapping or treatment planning for any behavioral health diagnosis
- Use of TMS for treating behavioral disorders in which the current focus of treatment is a diagnosis other than major depressive disorder. These disorders include but are not limited to:
  - Child depression ages 14 and younger
  - Alzheimer's disease and other dementia
  - Autism spectrum disorder
  - Bipolar disorder
  - Obsessive-compulsive disorder (OCD)
  - Post-traumatic stress disorder (PTSD)
  - Psychotic disorder (including schizoaffective disorder and major depression with psychotic features)
  - Smoking cessation
  - Individuals with a primary substance abuse, eating disorder, or post-traumatic stress disorder diagnosis whose symptoms are the primary contributors to the clinical presentation.

Contraindications

- Individuals who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30 cm. of the treatment coil. Examples include metal plates, aneurysm coils, cochlear implants, ocular implants, deep brain stimulation devices, and stents.
- Individuals who have active or inactive implants (including device leads), including deep brain stimulators, cochlear implants, and vagus nerve stimulators.
- Individuals with a poor response or serious adverse effects to TMS therapy.
- Individuals with a history of or risk factors for seizures during TMS therapy.

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
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery, and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

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Diagnosis Codes	Description
F32.2	Major depressive disorder, single episode, severe without psychotic features

F33.2	Major depressive disorder, recurrent severe without psychotic features

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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

References

- Ohio Administrative Code and Ohio Revised Code can be found here: https://codes.ohio.gov/.
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Wilderness Therapy

Purpose

Wilderness Therapy is a behavioral health intervention targeted at children and adolescents with emotional, addiction, and/or psychological problems. The intervention typically involves the individual being immersed in the wilderness or a wilderness-like setting, group-living with peers, administration of individual and group therapy sessions, and educational/therapeutic curricula including back country travel and wilderness living skill development. This therapy aims to remove children and adolescents from the negative influences and destructive patterns in their lives and placing them into a more therapeutic environment. These programs include wilderness boot camps, though many have attempted to differentiate themselves from such types of treatment, which rely heavily on punishment, confrontation, and deprivation in order to gain compliance and obedience. Certain wilderness programs may be nationally certified by agencies such as the Council of Accreditation and the Joint Commission on Accreditation of Health Organizations and/or licensed by state agencies. Wilderness Therapy may be identified by other terms in the research literature, including: “Wilderness Treatment,” “Behavior Management Through Adventure,” “Residential Wilderness,” “Adventure Therapy,” “Nature-Assisted Therapy,” “Nature-Based Therapy,” “Adventure-Based Counseling,” “Wilderness Adventure Therapy,” and “Outdoor Behavioral Healthcare.”

Summary of Clinical Evidence

The Wilderness Therapy literature includes several studies suggesting participants show some improvement in behavioral health outcomes and/or reduced recidivism rates for juvenile offenses. However, these results are inconclusive due to significant methodological limitations. Most notably, there is a lack of randomized controlled trials or well-designed cohort studies to draw causal conclusions about the impact of wilderness therapy. Additionally, the durability of effects is not well-demonstrated, as few studies included follow-up measures. There is also extensive variability in the length, design, and fidelity of the programs. The reviewed studies did not show that wilderness therapy is equivalent to or better than current procedures. The field of Wilderness Therapy is still evolving, and there is a need for more rigorous research methodologies to better understand its efficacy and mechanisms of action. Future studies are needed to prioritize various populations and diagnoses, standardize outcome measures, enhance the generalizability of findings, and clarify therapy protocols.

- Wilderness Therapy is not medically necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to:
  - Adjustment Disorders
  - Mood Disorders
  - Anxiety Disorders
  - Conduct Disorders
  - Impulse Disorders
  - Social Functioning Disorders
  - Substance Related Disorders
  - Attention-Deficit Hyperactivity Disorder

- There is inadequate evidence of the safety and efficacy of wilderness therapy for treating these mental health and substance-related conditions. Inadequate study designs, safety concerns, inadequately trained staff, and questions of long-term benefit are key limitations.
- The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

- Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with clinical criteria.
- All services must be provided by or under the direction of a properly qualified behavioral health provider.

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
	There is no specific procedure code for Wilderness Therapy
T2036	Therapeutic camping, overnight, waiver; each session
T2037	Therapeutic camping, day, waiver; each session

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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.

Coding for CPT, HCPCS, EAPG, and Non-Institutional Codes

- https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Fee Schedules and Rates

- https://medicaid.ohio.gov/reources-for-providers/billing/billing.

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- Behavioral Health Nursing: https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-11.
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- Neurofeedback/Biofeedback for BH and SUD. Optum Behavioral Clinical Policy: https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/bh_Clinnical_Policies.html.
- 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.
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- Withdrawal Management Services for SUD: https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-09.

Policy History/Revision Information

Date	Summary of Changes
10/19/2022	• Version 5
01/01/2023	Annual Review
12/12/2023	Interim Update: • updated weblinks throughout document • clarified phrases “Ohio Administrative Code” and “Ohio Revised Code” throughout document • removed outdated language • formatting updates
07/01/2024	Annual Review Integrated Optum Behavioral Clinical Policies Integrated Optum Supplemental Clinical Criteria Updates throughout document per OAC and ORC CQOC approval on 02/20/2024 • ODM approval on 05/02/2024
08/01/2025	Annual Review Updates throughout document per OAC and ORC Updates to integrated Optum Behavioral Clinical Policies: • CAM • CBT4CBT for SUD • Neurofeedback • TMS • Wilderness Therapy Updates to integrated Optum Supplemental Clinical Criteria: • ABA • ECT • Psychological and Neuropsychological Testing CQOC approval on 03/18/2025, 06/17/2025 • ODM approval on 06/27/2025

Date	Summary of Changes
07/01/2026	Annual Review Updates throughout document per OAC and ORC Updates include 05/01/2026 Rule Number Filings: • OAC 5122-27-03, OAC 5122-27-04, OAC 5122 27-05, OAC 5122-27-07, OAC 5122-26-22 Updates to integrated Optum Behavioral Clinical Policies: • CAM • CBT4CBT for SUD • Neurofeedback • TMS • Wilderness Therapy Updates to integrated Optum Supplemental Clinical Criteria: • ABA • ECT • Psychological and Neuropsychological Testing CQOC approval on 05/19/2026 ODM approval on 05/28/2026

Instructions for Use

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.

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.