

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
Provided: No limitations With limitations*
- 2.a. Outpatient hospital services.
Provided: No limitations With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic- (which are otherwise included in the state plan)
 Provided: No limitations With limitations*
 Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
 Provided: No limitations With limitations*
- ~~d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.
~~Provided: No limitations With limitations*~~~~
3. Other laboratory and x-ray services.
Provided: No limitations With limitations*

*Description provided on attachment.

TN No. 92-20
Supersedes Approval Date 10-23-92 Effective Date 9-1-92
TN No. 91-20

HCFA ID: 7986E

State/Territory: Ohio

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations With limitations*

- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

- c. (i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Attachment 2.2-A, B, if this eligibility option is elected by the State.

Provided: No limitations With limitations*

(ii) Family planning-related services provided under the above State Eligibility Option.

- d. Tobacco cessation counseling services for pregnant women (as defined in 1905(bb) of the Social Security Act)

Provided: No limitations With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: No limitations With limitations*

- b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a)(5)(B) of the Act).

Provided: No limitations With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

- a. Podiatrists' services.

Provided: No limitations With limitations*

Not provided.

6/14/13

*Description provided on attachment.

TN: 11-013

Supersedes:

TN: 10-013

Approval Date: 6/14/13

Effective Date: 01/01/2012

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

Provided: No limitations With limitations*
 Not provided

c. Chiropractors' services.

Provided: No limitations With limitations*
 Not provided

d. Other practitioners' services.

Provided: Identified on attached sheet with description of limitations, if any.
 Not provided

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or
by a registered nurse when no home health agency exists in the area.

Provided: No limitations With limitations*

b. Home health aide services provided by a home health agency.

Provided: No limitations With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: No limitations With limitations*

*Description provided on attachment.

TN: 11-009
Supersedes:
TN: 91-20

Approval Date: 11/21/12

Effective Date: 12/2/2011

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided: No limitations With limitations*

Not provided.

8. Private duty nursing services.

Provided: No limitations With limitations*

Not provided.

*Description provided on attachment.

TN No. 91-20
Supersedes 85-41 Approval Date 1-16-92 Effective Date 10/1/91
TN No. 85-41

HCFA ID: 7986E

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

Provided: No limitations With limitations*
 Not provided.

10. Dental services.

Provided: No limitations With limitations*
 Not provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided: No limitations With limitations*
 Not provided.

b. Occupational therapy.

Provided: No limitations With limitations*
 Not provided.

c. Services for individuals with speech, hearing, and language disorders
(provided by or under the supervision of a speech pathologist or
audiologist).

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN No. 85-41

Supersedes

TN No. 26-51

Approval Date 6/23/87

Effective Date 7/1/87

HCFA-179 #

85-41

Date Rec'd

12/3/85

HCFA ID: 0069P/0002P

Supersedes

Date Appr

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided: No limitations With limitations*
 Not provided.

b. Dentures.

Provided: No limitations With limitations*
 Not provided.

c. Prosthetic devices.

Provided: No limitations With limitations*
 Not provided.

d. Eyeglasses.

Provided: No limitations With limitations*
 Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

Provided: No limitations With limitations*
 Not provided.

c. Preventive services.

Provided: No limitations With limitations*
 Not provided.

d. Rehabilitative services.

Provided: No limitations With limitations*
 Not provided..

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided: No limitations With limitations*
 Not provided.

b. Skilled nursing facility services.

Provided: No limitations With limitations*
 Not provided.

c. Intermediate care facility services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TE No. 95-16
Supersedes
TE No. 89-27

Approval Date 5/2/96

Effective Date 6-1-95

HCFA ID: 00692/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided: No limitations With limitations*
 Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided: No limitations With limitations*
 Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided: No limitations With limitations*
 Not provided.

17. Nurse-midwife services.

Provided: No limitations With limitations*
 Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TE No. 95-16
Supersedes
TE No. 90-22

Approval Date 5/7/95

Effective Date 6-1-95

HCFA ID: [REDACTED]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services
- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
- X Provided: X With limitations
 Not provided.
- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.
- Provided: With limitations*
 X Not provided.
20. Extended services for pregnant women
- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
- X Additional coverage ++
- b. Services for any other medical conditions that may complicate pregnancy.
- X Additional coverage ++
- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment. X

TN No. 94-16
Supersedes Approval Date 7-7-94 Effective Date 4-1-94
TN No. 91-20

State/Territory: Ohio

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

Provided: No limitations With limitations*
 Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided: No limitations With limitations*
 Not provided

23. Certified pediatric or family nurse practitioners' services.

Provided: No limitations With limitations*
 Not provided

*Description provided on attachment.

TN: 12-003
Supersedes:
TN: 97-14

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State of Ohio
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-a. Transportation

Provided: No limitations With limitations*
 Not Provided

24-b. Services Furnished in a Religious Nonmedical Health Care Institution

Provided: No limitations With limitations*
 Not Provided

24-c. Affiliations

Provided: No limitations With limitations*
 Not Provided

24-d. Skilled Nursing Facility Services for Individuals Under Age 21

Provided: No limitations With limitations*
 Not Provided

24-e. Emergency Hospital Services

Provided: No limitations With limitations*
 Not Provided

24-f. Personal Care Services

Provided: No limitations With limitations*
 Not Provided

24-g. Critical Access Hospital (CAH) Services

Provided: No limitations With limitations*
 Not Provided

*Description provided on attachment

Transmittal Number 09-010
Supersedes
Transmittal Number 91-20

Approval Date: **SEP 23 2011**
Effective Date: 8/1/09

State: OHIO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

 provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

 Provided: State Approved (Not Physician) Service Plan Allowed
 Services Outside the Home Also Allowed
 Limitations Described on Attachment

X Not Provided.

State of Ohio
PACE State Plan Amendment

Attachment 3.1-A
Page 11

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-A.

Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

TN No. 02-011

Approval Date 7-18-02

Effective Date 11-01-02

Supersedes

TN No. NA/New Page

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers.

Provided: No limitations With limitations None licensed or approved

Please describe any limitations: Coverage and limitations are described under Attachment 3.1-A, Item 28

(ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center.

Provided: No limitations With limitations (please describe below)

Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: Coverage and limitations are described under Attachment 3.1-A, Item 28

Please check all that apply:

(a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

- physicians
- Certified nurse midwives
- Certified pediatric or family nurse practitioner services

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

TN: 12-004

Supersedes:

TN: 09-010

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Effective Date: 01/01/2012

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Thirty (30) day limitation per spell-of-illness. A spell-of-illness begins on the day of admission to a hospital and ends sixty (60) days after discharge. Days in excess of thirty (30) or additional hospitalizations before sixty (60) days have past since a prior hospitalization can be covered if certified by a hospital UR committee or PSRO/PRO as medically necessary. Medically necessity for admission and continued stay must be approved by the hospital utilization review committee or its designee, or by a PSRO/PRO. Most elective hospital admissions are subject to preadmission certification. For hospitals paid on a prospective basis, days not approved as medically necessary are not recognized in determining whether a case qualifies for additional outlier payments.

A prospective reimbursement methodology based on DRGs was adopted on October 1, 1984 for inpatient hospital services. All inpatient services are subject to prospective payment except for long-term care and rehabilitative hospitals excluded from Medicare's prospective payment system. Hospitals in non-Ohio states which provide care to Ohio Medicaid recipients are paid under the prospective payment system. Hospitals in contiguous states with Ohio Medicaid payments in excess of \$50,000 annually are peer-grouped with the Ohio peer group with the most similar wage indice and paid that peer group's rates. Hospitals in contiguous states with less than \$50,000 in payments annually and hospitals in non-contiguous states are paid based on the peer group 12 (rural hospital) rate.

Except for hospitals that are approved by Medicare to charge patients a single rate that covers hospital and physicians' services, Medicaid does not cover, as an inpatient service, those physicians' services furnished to individual patients. In determining whether services are covered as a physician service or a hospital service, Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

Certain specific items and services are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; treatment of obesity; cosmetic surgery; acupuncture; services of an experimental nature; dental procedures which can be performed in the dentist's office or other nonhospital setting; and patient convenience items. Also, coverage of inpatient days for treatment of chemical dependency is limited to coverage of services for detoxification. Inpatient care for rehabilitative services related to chemical dependencies is noncovered.

TNS # 90-38
SUPERSEDES
TNS # 85-41

APPROVAL DATE 10/12/90
EFFECTIVE DATE 7/1/90

STATE OF OHIO

ATTACHMENT 3.1-A
PRE-PRINT PAGE 1
ITEM 2, PAGE 1 OF 22-a. Outpatient hospital services.

Outpatient services are those professional services provided to a patient at a hospital facility which is certified by the Ohio Department of Health for Medicare participation and meets Medicare conditions of participation. Outpatient services include services provided to a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission.

Except for hospitals that are approved by Medicare to charge patients a single rate that covers hospital and physicians' services, Medicaid does not cover, as an outpatient service, those physicians' services furnished to individual patients. In determining whether services are covered as a physician service or a hospital service, Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

~~The number of outpatient visit includes, but is not limited to the following maximums:~~

- ~~- The maximum number of outpatient visits covered without prior authorization is four per month per recipient per provider. Additional visits, up to a maximum of ten visits, may be covered for physician services, EPSDT services, family planning, and emergency dental services, subject to prior authorization. A visit includes all services provided for an outpatient on any one date of service.~~
- ~~- The maximum number of outpatient visits, when the professional service is rendered by a practitioner whose scope of treatment is less than a physician's (i.e., chiropractor, speech therapist, audiologist, psychologist, etc.), is generally four per month.~~
- ~~- Physical therapist services are limited by a specific number of treatments.~~

Certain specific items and services are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; treatment of obesity; cosmetic surgery; acupuncture; services of an experimental nature; dental procedures which can be performed in the dentist's office or other non-hospital setting; and patient convenience items.

2-b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

Limited to public, private, nonprofit or proprietary freestanding corporations designed to provide services on an outpatient basis. Services provided by Rural Health Clinics are subject to coverage and limitation policies effective for the various disciplines as described in this attachment. RHCs are certified by the Ohio Department of Health as meeting the conditions of certification for rural health clinics under Title XVIII Medicare and which have filed an agreement with HHS to be a provider of Rural Health Clinic services under Medicare.

RHCs are subject to the same limitations as ambulatory health care clinic program as defined in attachment 3.1-A (9), additionally, RHCs are subject to the same limitations as are other practitioners when rendering similar services in a RHC setting.

TNS # 90-38
SUPERSEDES
TNS # 85-41

APPROVAL DATE 10/12/90
EFFECTIVE DATE 2/1/90

2-c. Federally Qualified Health Center (FOHC) Services

Refer to Attachment 4.19-B, Item 2-c for a description of coverage and reimbursement.

3. Other laboratory and x-ray services.

Laboratory and x-ray services are covered by Ohio Medicaid in accordance with 42 § CFR 440.30.

Beneficiaries younger than age twenty-one can access other laboratory and x-ray services without limitation when such services are medically necessary.

Services determined by the department as not medically necessary will not be covered.

Laboratory services

A laboratory service is covered only if it meets three criteria:

1. It is medically necessary or it is provided in conjunction with a covered medically necessary health service;
2. It is performed by a provider having appropriate certification in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA); and
3. It is performed at the written or electronic request of a practitioner authorized under State law to order it.

Limitations: The following laboratory services are non-covered:

1. Laboratory services that are incidental to, duplicative of, incompatible with, or unnecessary because of another covered health service;
2. Laboratory services performed in conjunction with a non-covered service (e.g., abortion that does not meet federal requirements, sterilization that does not meet federal requirements, infertility service);

X-ray services

Limitations:

1. X-ray services provided by chiropractors:

Coverage is limited to those diagnostic x-rays that are required to determine the existence of a subluxation. Procedure codes and frequencies of service are specified by the State Medicaid Agency.

2. X-ray services provided by portable x-ray suppliers:

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Coverage is limited to the following radiology procedures:

- a. The taking of skeletal images involving the extremities, pelvis, vertebral column, and skull;
- b. The taking of images of the chest or abdomen; and
- c. The performance of diagnostic mammograms if the provider meets the requirements set forth in 21 CFR part 900 subpart B.

The following procedures are not covered for a portable x-ray supplier:

- a. Procedures involving fluoroscopy;
 - b. Procedures involving the use of contrast media;
 - c. Procedures requiring the administration of a substance to the patient, the injection of a substance into the patient, or special manipulation of the patient;
 - d. Procedures that require the specialized skill or knowledge of a physician; and
 - e. Procedures that are not of a diagnostic nature.
3. X-ray services provided by independent diagnostic testing facilities (IDTFs):

Coverage is limited to diagnostic procedures that do not require CLIA certification.

Most IDTFs provide their services at fixed locations; some IDTFs also provide services in large vehicles that serve as mobile diagnostic imaging centers.

4. X-ray services provided by mammography suppliers:

Coverage is limited to mammography procedures, which are a subset of IDTF services.

ITEM 4-A

STATE OF OHIO

ATTACHMENT 3.1-A
PRE-PRINT PAGE 2
~~ITEM 4~~ PAGE 1 OF 2
REFERENCE SUPPLEMENT 2

4-a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

REFERENCE SUPPLEMENT 2, RULE 5101:3-3-05 AND RULE 5101:3-3-15.

SUBSTITUTE PAGE

TN No. 93-39

APPROVAL DATE 2-16-94

SUPERSEDES

TN No. 90-38

EFFECTIVE DATE 10-1-93

ITEM 4-A

STATE OF OHIO

ATTACHMENT 3.1-A
PRE-PRINT PAGE 2
~~ITEM 4,~~ PAGE 2 OF 2
REFERENCE SUPPLEMENT 3

4-a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

REFERENCE SUPPLEMENT 3, RULE 5101:3-3-541 AND RULE 5101: 3-3-545.

TN No. 94-31
SUPERSEDES
TN No. NEW

APPROVAL DATE 2-21-95
EFFECTIVE DATE 12/10/94

STATE OF OHIO

ITEM 4B
19 141

ATTACHMENT 3.1-A
PRE-PRINT PAGE 1
~~ITEM 4, PAGE 2 OF 2~~

4-b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

IN OHIO HEALTHCARE IS THE PROMOTIONAL NAME FOR EPSDT. THIS PROGRAM IS AVAILABLE FOR ALL MEDICAID ELIGIBLE INDIVIDUALS FROM BIRTH TO 21 YEARS.

SCREENING SERVICES, VISION SERVICES, HEARING SERVICES, DENTAL SERVICES AND ALL MEDICALLY NECESSARY FOLLOW-UP SERVICES ARE COVERED UNDER THE OHIO MEDICAID EPSDT PROGRAM IN ACCORDANCE WITH THE FEDERAL REQUIREMENTS.

THE MINIMUM PERIODICITY SCHEDULE FOR EPSDT SCREENING SERVICES, VISION SERVICES AND HEARING SERVICES IS AT THE AGES OF 1, 3, 5, 7, 11, AND 16 YEARS. THE MINIMUM PERIODICITY SCHEDULE FOR DENTAL SERVICES IS 1 EXAMINATION PER YEAR.

BENEFITS FOR RECIPIENTS PARTICIPATING IN THE EPSDT PROGRAM ARE NOT LIMITED TO THE SERVICES COVERED UNDER THE MINIMUM PERIODICITY SCHEDULE.

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SUPERSEDES
TNS # 90-38

APPROVAL DATE 4/3/91
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4. c. (i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Attachment. 2.2-A, if this eligibility option is elected by the State.

Family planning services are services and supplies that prevent or delay pregnancy. Such services are Medicaid-coverable and available to Medicaid-eligible beneficiaries who want to prevent pregnancy.

Services and supplies that prevent or delay pregnancy are services provided for the primary purpose of contraceptive management. These services are identified in Ohio Administrative Code and may include the following:

1. Office and other outpatient visits and consultations;
2. Counseling and education;
3. Medical procedures;
4. Laboratory examinations and tests;
5. Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration, both male and female sterilization procedures provided in accordance with 42 CFR 441, Subpart F, and natural family planning.

The following services and supplies may be covered by Medicaid but are not covered as family planning services under Ohio Medicaid family planning provisions:

1. Hysterectomy;
2. Treatment of medical complications resulting from a family planning service that is provided in a level of care higher than an office or a clinic;
3. Preconception services;
4. Pregnancy services;
5. Pregnancy termination (induced abortions); and
6. Transportation.

Infertility services are not covered by Ohio Medicaid.

4. c. (ii) Family planning-related services provided under the above State Eligibility Option

The following family planning-related services are provided under the State Eligibility Option for Family Planning Services:

Family planning-related services include the following, when conducted as part of a visit for the purpose of delivering family planning services or as a follow-up to a visit for the purpose of delivering family planning services:

- diagnostic procedures and treatment of sexually transmitted infections;
- mammography when indicated by breast exam; and
- HPV and hepatitis B vaccinations provided per ACIP recommendations.

4. d. Tobacco cessation counseling services for pregnant women.

1) Face-to-face tobacco cessation counseling services provided (by):

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services;* or
- (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

Provided: No limitations With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

6/14/13

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5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

Physicians' services are covered by Ohio Medicaid in accordance with 42 CFR § 440.50.

Services determined by the department as not medically necessary will not be covered.

A limited number of physicians' services (e.g., surgical removal of supernumerary teeth) are covered under the Ohio Medicaid program upon the provider obtaining prior authorization from the Medicaid agency or its designee before the provider renders the services.

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5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. (Continued)

Beneficiaries younger than age twenty-one can access physicians' services without limitation when medically necessary.

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. (Continued)

Optometrists' services

Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether they are furnished by a physician or an optometrist.

Optometrists currently licensed under Chapters 4725. and 4731. of the Revised Code are eligible to participate in the medicaid program. Covered optometrists' services include examinations, fittings, diagnosis and treatment services, and dispensing of ophthalmic materials (contact lenses, low vision aids, etc.) within the scope of practice established by Chapters 4725. and 4731. of the Revised Code.

The following provisions apply to optometrists' services:

Optometrists' services provided in an LTCF must have a written request for examination or treatment signed by the consumer or responsible guardian that is retained by the billing provider.

Beneficiaries younger than age twenty-one can access physicians' services, including optometrists' services, without limitation when such services are medically necessary.

6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

The visit and service limitations applied to physicians are applied to podiatrists (see Attachment 3.1-A, Item 5, Pages 1 and 2).

In addition, the following podiatric services are not covered by the program:

The evaluation or treatment of a flat foot condition, regardless of the underlying pathology.

The evaluation of subluxations of the foot and nonsurgical measures to correct the condition or to alleviate symptoms.

Routine foot care for ambulatory or bed-ridden patients. Routine foot care includes the cutting or removal of corns, warts or calluses; the trimming of nails; observation and cleansing of the feet, use of skin creams to maintain skin tone; and nail care not involving surgery. (If the foot care is an integral part of active covered treatment of foot lesions, such as infections and diabetic ulcers -- such treatment is covered under the program.)

Vitamin B-12 injections when administered to strengthen tendons, ligaments, etc., of the foot to treat myositis.

X-rays for soft tissue diagnosis.

In addition, the following limitations apply:

Reimbursable visit levels are limited to minimal, brief, limited and intermediate visits.

Reimbursement consultation visit levels are limited to limited, intermediate, and extended visits.

Reimbursement for visits provided to a Long-Term Care Facility (LTCF) resident is limited to one visit per month.

Reimbursement for debridement of nails is limited to a maximum of one treatment within a 60-day period.

TNS # 90-38
SUPERSEDES
TNS # 90-26

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6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law.
(Continued)

b. Optometrists' services

Optometrists' services (other than those provided under 42 CFR 435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

6. Medical care and any other types of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law.

c. CHIROPRACTOR Services – D.C.

Chiropractic services shall be provided only by chiropractors within their scope of practice as defined by state law and in accordance with CFR 410.21 and 440.60.

For dates of service prior to January 1, 2004:

Treatment by means of manual manipulation of the spine to correct a subluxation is limited to that personally provided by a chiropractor. Chiropractic is limited to treatments on 30 dates of services per individual per 12-month period. Limits can be exceeded based on medical necessity under the EPSDT benefit.

For dates of service from January 1, 2004 through December 31, 2007:

Chiropractic services were not covered for adults 21 years of age and older except if the individual is enrolled in a Medicaid managed care plan (MCP) and the MCP elects to continue to cover adult chiropractor services, or, if the individual is covered under Medicare, Medicaid will continue to pay Medicare cost sharing for chiropractor services covered by Medicare.

For dates of service on and after January 1, 2008:

Chiropractic services are limited to treatments on 30 dates of service per individual per 12-month period for consumers under the age of 21 years old.

Chiropractic services are limited to treatments on 15 dates of service per individual per 12-month period for consumers 21 years of age and older.

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6. Medical care and any other types of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Other practitioners' services

(1) Mechanotherapists' services

Mechanotherapists' services are covered by Ohio Medicaid in accordance with 42 CFR § 440.60. Mechanotherapists are licensed providers who provide services within the scope of their practice under State law.

Mechanotherapists' services must be reasonable in amount, frequency, and duration. Each period of treatment (i.e., no more than sixty days for rehabilitative services or no more than six months for developmental services) must begin with an evaluation.

A mechanotherapist must develop a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific therapeutic procedures to be used and specific functional goals.

The mechanotherapist must conduct and document a therapy progress summary/progress report at the conclusion of each period of treatment. If an additional treatment period is indicated, then the current period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not.

Mechanotherapists' services provided to long-term care facility residents are included as long-term care facility services. Long-term care facilities are responsible for ensuring that their recipient-residents obtain necessary therapy services.

Limitations

Beneficiaries younger than age twenty-one can access mechanotherapists' services without limitation when medically necessary.

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6. Medical care and any other types of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law.

d. **OTHER PRACTITIONER Services**
LICENSED PSYCHOLOGIST Services

Effective January 1, 2008

Covered services are those professional procedures listed in Ohio Administrative Code. Covered psychotherapy and psychological testing services are limited to those personally provided by a psychologist.

Psychological testing is limited to a maximum of eight hours per 12-month period per recipient in a non-hospital setting.

Therapeutic visits and diagnostic interview examinations in excess of a combined 25 dates of service per recipient in a 12-month period in a non-hospital setting are not covered.

Diagnostic interview examinations will be limited to one per recipient per 12-month period and may not be billed on the same date of service as a therapeutic visit.

Limits can be exceeded based on medical necessity under the EPSDT benefit.

Inpatient hospital services by psychologists are bundled with the inpatient facility services.

Psychological services as incident to other provider services (e.g., physician offices, FQHCs) are allowed except as follows: If the individual is enrolled in a Medicaid managed care plan (MCP) and the MCP elects to continue to cover adult independent psychology services, or, if the individual is covered under Medicare, Medicaid will continue to pay Medicare cost sharing for independent psychology services covered by Medicare.

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6. Medical care and any other types of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law.

d. OTHER PRACTITIONER Services
LICENSED PSYCHOLOGIST Services continued

For dates of service from January 1, 2004 through December 31, 2007:

Psychology services provided by an independently practicing psychologist and independent group psychology practice were not covered services for adults 21 years of age and older, except as follows:

If the individual is enrolled in a Medicaid managed care plan (MCP) and the MCP elects to continue to cover adult independent psychology services. If the individual is covered under Medicare, Medicaid will continue to pay Medicare cost sharing for independent psychology services covered by Medicare.

The following services are not covered:

Sensitivity training, encounter groups or workshops;

Sexual competency training;

Marathons and retreats for mental disorders; and

Education testing and diagnosis..

Services of psychologists provided in long-term care facilities are covered by payment to the facility. (See Attachment 4.12-D.)

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6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

d. Other Practitioners' Services. (Continued)

Nursing Services Delivered Through A Medicaid School Program Provider

Nursing services described here are available when provided through a Medicaid school program provider. Reimbursement for nursing services may require that the services be prescribed by a Medicaid authorized prescriber, who is either a physician, podiatrist, or dentist, licensed by the state and working within his or her scope of practice as defined by Ohio law. Services must be delivered by a licensed registered nurse or licensed practical nurse working within their scope of practice as defined in Ohio law. Such services may include, but are not limited to, tube feeds, bowel and bladder care, catheterizations, dressing changes, and medication administration. Nursing services are also available out side of a Medicaid school program provider as a part of physician services, home health services, ambulatory care center/clinic services, outpatient hospital services, nursing facility services and private duty nursing services.

In order to receive reimbursement for nursing services the Medicaid school program provider must document the service in a child's individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA) prior to the provision of the service. Services may also include the initial assessment conducted by a licensed registered nurse or licensed practical nurse as a part of the multi-factored evaluation team, and for subsequent assessments and reviews conducted in accordance with IDEA.

Coverage of nursing services provided by a licensed nurse must meet conditions of medical necessity established by the department.

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6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

d. Other practitioners' services

(4) Pharmacists' services.

The Department covers the administration of seasonal and pandemic influenza vaccines by licensed pharmacists who are practicing within their scope and employed by pharmacies that contract with Ohio Medicaid. Participating pharmacies and pharmacists must meet all requirements set forth by the Ohio Board of Pharmacy.

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- 6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law.

(Continued)

d. Other practitioners' services

5. Physician Assistants' services

Physician assistants must be employed by or under contract with a physician, physician group practice, or clinic. Limitations applicable to physicians' services also apply to physician assistants' services.

The scope of physician assistants' services is defined by Ohio law. Physician assistants' services must be authorized by Ohio law (or otherwise approved by the state medical board) and within the scope of practice of the physician assistant's supervising physician.

The following services are not covered when provided by a physician assistant:

- Assistant-at-surgery services;
- Visits and/or procedures provided on the same date of service by both a physician assistant and his/her supervising physician, employing physician, employing physician group practice, or employing clinic and billed as separate procedure codes;
- Consultations and critical/intensive care services (although physician assistants may provide services that are valuable components of a consultation, ultimately a consultation is the responsibility of a physician); and
- Services prohibited by State law.

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7. Home Health

Home health services are available to any Medicaid consumer with a medical need for part-time and intermittent services in the home setting. This setting does not include a hospital, a skilled or non-skilled nursing facility, or an intermediate care facility for persons with mental retardation.

Home health services include home health nursing, home health aide, physical therapy, occupational therapy and speech therapy.

Fourteen hours of nursing and/or aide services per week can be provided through the home health benefit. Children (up to the age of 21) are not subject to this 14 hour per week limit – they can access whatever they need as long as it is medically necessary.

Home health services must be ordered by the treating physician, and included in a consumer's plan of care that is reviewed by that physician at least every 60 days.

Home health services can only be provided by a Medicare Certified Home Health Agency (MCRHHA) in accordance with CFR 440.70. Such certification requires meeting all the requirements of Medicare Conditions of Participation. MCRHHAs must also be enrolled as an Ohio Medicaid provider.

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8. Private duty nursing services.

Private Duty Nursing (PDN) is a service provided in the home and in the community for beneficiaries needing continuous periods of nursing to stay in the home rather than an institutional setting. The service is provided in the beneficiary's covered place of residence or in the community due to the beneficiary's medical condition or functional limitation. The level of care is determined by the treating physician signed orders and incorporated into the plan of care. The program allows beneficiaries to access PDN through three different avenues.

The first avenue is a post-hospital service of up to 60 days duration and 56 hours per week for all Medicaid beneficiaries who have a medical necessity for such services as determined by the treating physician upon discharge from a three day or more covered inpatient stay when all of the following conditions apply:

- The 60 days begin once the beneficiary is discharged from the hospital to the beneficiary's place of residence, from the last inpatient stay whether or not it was in an inpatient hospital or inpatient rehabilitation unit of a hospital; and
- The 60 days will begin once the beneficiary is discharged from a hospital to a nursing facility although PDN is not available while residing in a nursing facility; and
- The beneficiary has a skilled level of care (SLOC) as evidenced by a medical condition that temporarily reflects SLOC; and
- PDN must not be for the provision of maintenance care.

The second avenue is for beneficiaries up to age 21 who have a PDN authorization by the Medicaid agency or the agency's designee for the PDN services that are medically necessary for the health and welfare of the beneficiary.

The third avenue is for beneficiaries age 21 or older who have a PDN authorization by the Medicaid agency or the agency's designee for the PDN services that are medically necessary for the health and welfare of the adult beneficiary when all of the following conditions apply:

- The beneficiary requires continuous nursing including the provision of on-going maintenance care; and
- The beneficiary has a comparable level of care (LOC) as evidenced by either enrollment in an HCBS waiver, or a comparable institutional level of care evaluated initially and annually by Medicaid agency or its designee; and
- The beneficiary must have a PDN authorization approved by the Medicaid agency or its designee to establish medical necessity and comparable LOC; and

The service is provided to all Medicaid beneficiaries who meet a skilled level of care for post-hospital service and an institutional level of care for adults and children who do not

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have a hospital stay and need to receive continuous nursing care from an independent registered nurse; independent licensed practical nurse; Medicare Certified Home Health Agency; or a home health agency accredited by a national accreditation organization approved by the Centers for Medicare and Medicaid Services (CMS), which may include, but is not limited to, one of the following: the Accreditation Commission for Health Care (ACHC), the Community Health Accreditation Program (CHAP), and the Joint Commission (TJC).

PDN visits are typically continuous nursing visits that are both medically necessary and more than four hours, but less than or equal to 12 hours in length. There must be a lapse of two or more hours between the provision of home health nursing or PDN. The only exceptions to these requirements are as follows:

- An unusual, occasional circumstance requires a medically necessary visit of up to and including 16 hours; or
- Less than a two hour lapse between visits has occurred and the length of the PDN service requires an agency to provide a change in staff; or
- Less than a two hour lapse between visits has occurred and the PDN service is provided by more than one non-agency provider; or
- The Medicaid agency or its designee has authorized PDN visits that are four hours or less in length.

Individuals up to age 21 can access PDN services without limitation when medically necessary.

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9. Clinic services.

Clinic services are covered by Ohio Medicaid in accordance with 42 CFR § 440.90.

Services determined by the department as not medically necessary will not be covered.

Clinic services under this section are limited to fee-for-service ambulatory health care clinics (AHCCs), defined as free-standing ambulatory health care facilities that furnish outpatient (non-institutional) health care by or under the direction of a physician or dentist, without regard to whether the clinic itself is administered by a physician or dentist.

All Medicaid providers must:

- Render services in compliance with all state and federal laws, including but not limited to licensure and credentialing required for the provision of any service provided; and
- Have the ability and legal authority to provide services for which they bill.

Fee-for-service ambulatory health care clinics (AHCCs) must:

- Be a facility as defined in 42 CFR 440.90;
- Meet the physician direction requirements in accordance with Section 4320, paragraph B of the State Medicaid Manual;
- Be free-standing facilities;
- Furnish outpatient health care by or under the direction of a physician or dentist;
- Not be eligible as a Medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as physical therapists, occupational therapists, psychologists, or chiropractors;
- Be enrolled as a Medicare provider; and
- Bill Medicare as the primary insurer for services provided to patients eligible for both Medicare and Medicaid.

Limitations:

- Primary care clinics provide health care, health counseling, patient education, diagnosis and treatment of acute and chronic illnesses, and appropriate medication management in coordination/collaboration with other health care professionals and systems. Primary care clinics must have formal working arrangements with other medical providers for the services needed by the consumers beyond the capability of the clinic. Primary care clinics must be certified or accredited by The Joint Commission, The Accreditation Association For Ambulatory Health Care (AAAHC), The Healthcare Facilities Accreditation Program of the American Osteopathic Association, The Community Health Accreditation Program (CHAP), other recognized accrediting agencies, or receive state or federal grant funds for the provision of health services.
- Public health department clinics are entities that have legal status as a county or city health department, or combined health district and/or that meet the standards for boards of health and local health departments in Ohio.

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- **Behavioral health clinics** are clinics that provide only mental health and/or addiction services and that do not meet the requirements of any other AHCC type.
- Outpatient rehabilitation clinics provide physical therapy, occupational therapy, speech-language pathology services and audiology services and must be certified by Medicare as either an outpatient rehabilitation clinic or a comprehensive outpatient rehabilitation clinic.
- Family planning clinics provide services to individuals to enable them to determine freely the number and spacing of their children. Family planning clinics must meet at least one of the following qualifications: Affiliation with the Planned Parenthood Federation of America (PPFA), receive a grant award for the provision of family planning services under Title X of the Public Health Services Act; or receive a grant award through the Ohio Department of Health for family planning services under the child and family health services program, and/or receive a grant award through the Ohio Department of Health's women's health services, in accordance with rule 3701-68-01 of the Administrative Code.
- Professional optometry school clinics are clinics accredited by the Accreditation Council on Optometry Education (ACOE) of the American Optometric Association.
- Professional dental school clinics are training facilities for a professional dental school, accredited by the Commission On Dental Accreditation (CODA) of the American Dental Association (ADA).
- Speech-language/audiology clinics specialize in speech-language/audiology services in accordance with rule 5101:3-4-17 of the Administrative Code and provide services by professionals holding a certificate of clinical competence in speech-language pathology (CCC-SLP) and/or a Certificate of Clinical Competence in Audiology (CCC-A), issued by the American Speech-Language Hearing Association (ASHA).
- Diagnostic imaging clinics provide diagnostic imaging services at freestanding diagnostic imaging centers performed by appropriately licensed, registered, and credentialed persons.
- End-stage renal disease (ESRD) dialysis clinics are renal dialysis facilities that provide chronic maintenance dialysis for end-stage renal disease, are certified by Medicare as a dialysis facility, and are licensed by the Ohio Department of Health as a dialysis provider.

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9. Clinic services, continued.

b. Outpatient health facilities (OHFs).

OHF services are provided in accordance with 42 CFR 440.90. OHFs are freestanding.

According to Ohio law, an outpatient health facility:

- Is a facility that provides comprehensive primary health services by or under the direction of a physician at least five days per week on a forty-hour per week basis to outpatients;
- Is operated by the board of health of a city, general health district, another public agency, nonprofit private agency, or organization under the direction and control of a governing board that has no health-related responsibilities other than the direction and control of one or more such outpatient health facilities; and
- Receives at least seventy-five per cent of its operating funds from public sources, except that it does not include an outpatient hospital facility or a federally qualified health center as defined in Sec. 1905(l)(2)(B) of the "Social Security Act," 103 Stat. 2264 (1989), 42 U.S.C.A. 1396d(l)(2)(B).

For a facility to qualify as an OHF, the facility must:

- Have health and medical care policies developed with the advice of, and subject to review by, an advisory committee of professional personnel, including one or more physicians, one or more dentists if dental care is provided, and one or more registered nurses;
- Have a medical director, a dental director if dental care is provided, and a nursing director responsible for the execution of such policies;
- Have physicians, dentists, nursing, and ancillary staff appropriate to the scope of services provided;
- Require that the care of every patient be under the supervision of a physician, provides for medical care in case of emergency, has in effect a written agreement with one or more hospitals and one or more other outpatient facilities, and has an established system for the referral of patients to other resources and a utilization review plan and program;
- Maintain clinical records on all patients;
- Provide nursing services and other therapeutic services in compliance with applicable laws and rules, and have a registered nurse on duty at all times when the facility is in operation;
- Follow approved methods and procedures for the dispensing and administration of drugs and biologicals;

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9. Clinic services, continued.

b. Outpatient health facilities (OHFs), continued.

- Maintain the accounting and record-keeping system required under federal laws and regulations for the determination of reasonable and allowable costs.

“Comprehensive primary health services” means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that include all of the following:

- Services of physicians, physician assistants, and certified nurse practitioners (limitations are described in Attachment 3.1-A, Items 5, 17, and 23);
- Diagnostic laboratory and radiological services (limitations are described in Attachment 3.1-A, Item 3);
- Preventive health services, such as children’s eye and ear examinations, perinatal services, well child services, and family planning services (limitations are described in Attachment 3.1-A, Items 4-b, 4-c, 5, 6, 10, 11, 17, 20, 23);
- Arrangements for emergency medical services;
- Transportation services (limitations are described in Attachment 3.1-A, Item 24-a)

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9. Clinic services, continued.

c. Ambulatory surgery centers (ASCs).

An ambulatory surgery center (ASC) is any distinct, freestanding entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. All ASCs that meet the standards provided in 42 C.F.R. 416.20 to 416.49 (effective dates of these regulations are set forth below) and are certified for Medicare participation by the Ohio Department of Health are eligible to become Medicaid providers upon execution of the "Ohio Medicaid Provider Agreement."

Covered "ASC facility services" are items and services furnished by an ASC in connection with a covered ASC surgical services. ASC facility services include but are not limited to:

Nursing, technician, and related services;

Use of the ASC facility;

Drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of the surgical procedure;

Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

Administrative, recordkeeping, and housekeeping items and services;

Materials for anesthesia;

Intraocular lenses; and

Supervision of the services of an anesthetist by the operating surgeon.

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10. Dental services.

Covered services are identified at the following website: jfs.ohio.gov/OHP/provider.stm.

Effective for dates of service on and after July 1, 2008, through December 31, 2009, the dental benefit for beneficiaries 21 years of age and older includes two annual routine exams and cleanings; x-rays; oral surgery services; simple and complex extractions; fillings; denture services; crowns, posts, and related services; general anesthesia; periodontics; orthodontics; and endodontics, including root canal-procedures.

Effective for dates of service on and after January 1, 2010, the dental benefit for beneficiaries 21 years of age and older includes one annual routine exam and cleaning; x-rays; oral surgery services; simple and complex extractions; fillings; denture services; crowns, posts, and related services; general anesthesia; periodontics; orthodontics; and endodontics, including root canal procedures.

Several dental services provided require prior authorization. Dental services may be provided in an amount beyond established limits with prior authorization.

Individuals up to age 21 can access dental benefits without limitation when medically necessary.

11. Physical Therapy and related services.

a. Physical Therapy

Reimbursement for physical therapy services requires that the services be prescribed by a Medicaid authorized prescriber, who is either a physician, podiatrist, or dentist, licensed by the state and working within his or her scope of practice as defined by Ohio law. A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a Medicaid School Program (MSP) provider, as defined in Ohio Administrative Code (OAC), if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA). All other reimbursement principles detailed below apply to MSP providers in the same manner they apply to community providers.

At a minimum, a qualified physical therapist will be a licensed physical therapist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified physical therapist assistant will be a licensed physical therapist assistant, licensed in accordance with Ohio law, who has completed a two-year program of education. The licensed physical therapist assistant can provide physical therapy only under the supervision of a qualified physical therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current level of physical functioning of the patient and to identify appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.

Independent practitioners of physical therapy must also be certified under the Medicare program and must maintain an independent practice as defined and determined under Medicare.

Physical therapy services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

A physician or licensed physical therapist must develop and forward to the Medicaid authorized prescriber a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific therapeutic procedures to be used, specific functional goals, the prescription for services, and updates to the plan of care. For the MSP provider, the plan of care will be included in the IEP and maintained by the MSP provider.

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A physician, licensed physical therapist, or licensed physical therapist assistant working within his or her scope of practice as defined by state law must furnish the physical therapy services in accordance with the patient's plan of care that has been approved by the Medicaid authorized prescriber or included in the IEP.

The physician or licensed physical therapist must conduct, document, and forward to the Medicaid authorized prescriber a therapy progress summary/progress report at the conclusion of each period of treatment.

Physical therapy services provided to long term care facility residents are included as long term care facility services. Long term care facilities are responsible for ensuring that their recipient-residents obtain necessary physical therapy services.

Limitations

In non-institutional settings, other than schools, a combined maximum of thirty dates of service are allowed per twelve month period for physical therapy and occupational therapy services. In accordance with the EPSDT program, children may receive services beyond established limits, when medically necessary and approved through the prior authorization process.

Maintenance services are non-covered services.

11. Physical Therapy and related services.

b. Occupational Therapy

Reimbursement for occupational therapy services requires that the services be prescribed by a Medicaid authorized prescriber, who is either a physician, podiatrist, or dentist, licensed by the state and working within his or her scope of practice as defined by Ohio law. A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a Medicaid School Program (MSP) provider, as defined in Ohio Administrative Code (OAC), if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA). All other reimbursement principles detailed below apply to MSP providers in the same manner they apply to community providers.

At a minimum, a qualified occupational therapist will be a licensed occupational therapist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified occupational therapy assistant will be a licensed occupational therapy assistant, licensed in accordance with Ohio law, who has completed a two-year program of education. *The licensed occupational therapy assistant can provide occupational therapy only under the supervision of a qualified occupational therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current sensory motor functional level of the patient and identifying appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.*

Independent practitioners of occupational therapy must also be certified under the Medicare program and must maintain an independent practice as defined and determined under Medicare.

Occupational therapy services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

A physician or licensed occupational therapist must develop and forward to the Medicaid authorized prescriber a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific therapeutic procedures to be used, specific functional goals, the prescription for services, and updates to the plan of care.

For the MSP provider, the plan of care will be included in the IEP and maintained by the MSP provider.

A physician, licensed occupational therapist, or licensed occupational therapy assistant working within his or her scope of practice as defined by state law must furnish the occupational therapy services in accordance with the patient's plan of care that has been approved by the Medicaid authorized prescriber or included in the IEP.

The physician or licensed occupational therapist must conduct, document, and forward to the Medicaid authorized prescriber a therapy progress summary/progress report at the conclusion of each period of treatment.

Occupational therapy services provided to long term care facility residents are included as long term care facility services. Long term care facilities are responsible for ensuring that their recipient-residents obtain necessary occupational therapy services.

Limitations

In non-institutional settings, other than schools, a combined maximum of thirty dates of service are allowed per twelve month period for physical therapy and occupational therapy services. In accordance with the EPSDT program, children may receive services beyond established limits, when medically necessary and approved through the prior authorization process.

Maintenance services are non-covered services.

- 11. Physical Therapy and related services.
 - c. Services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist).

Reimbursement for speech-language pathology and audiology (SLPA) services requires that the services be prescribed by a Medicaid authorized prescriber, who is either a physician or dentist licensed by the state and working within his or her scope of practice as defined by Ohio law. A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a Medicaid School Program (MSP) provider, as defined in Ohio Administrative Code (OAC), if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA). All other reimbursement principles detailed below apply to MSP providers in the same manner they apply to community providers.

At a minimum, a qualified speech-language pathologist (SLP) will be a licensed SLP, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified audiologist will be a licensed audiologist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, qualified speech-language pathology and audiology (SLPA) aides will be licensed SLPA aides, licensed in accordance with Ohio law, who have completed training requirements as outlined in the approved application and specific to assigned tasks. The licensed speech-language pathologist or audiologist who signs the application for the aide shall supervise that particular aide. The aide may provide services only under the supervision of the speech-language pathology or audiology supervisor of record for that applicant who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current level of speech-language of the patient and to identify the appropriate speech-language treatment to address the findings of the evaluation/re-evaluation.

SLPA services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

A physician, licensed speech-language pathologist or licensed audiologist must develop and forward to the Medicaid authorized prescriber a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific

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therapeutic procedures to be used, specific functional goals, the prescription for services, and updates to the plan of care. For the MSP provider, the plan of care will be included in the IEP and maintained by the MSP provider.

A physician, licensed speech-language pathologist or audiologist, or licensed SLPA aide working within his or her scope of practice as defined by state law must furnish the SLPA services in accordance with the patient's plan of care that has been approved by the Medicaid authorized prescriber or included in the IEP.

The physician, licensed speech-language pathologist, or licensed audiologist must conduct, document, and forward to the Medicaid authorized prescriber a therapy progress summary/progress report at the conclusion of each period of treatment.

SLPA services provided to long term care facility residents are included as long term care facility services. Long term care facilities are responsible for ensuring that their recipient-residents obtain necessary SLPA services.

Limitations

In non-institutional settings, other than schools, a combined maximum of thirty dates of service are allowed per twelve month period for SLPA services. In accordance with the EPSDT program, children may receive services beyond established limits, when medically necessary and approved through the prior authorization process.

Maintenance services are non-covered services.

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TN# 08-012

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs

Coverage of prescription drugs meets all reporting requirements and provisions of section 1927 of the social security act, including the following requirements as found in Section 1927(d)(5) of the Act:

The prior authorization program provides a response by telephone or other telecommunication device within 24 hours of a request.

The prior authorization program provides for the dispensing of at least a 72-hour supply of a covered drug in an emergency situation.

PREFERRED DRUG LIST

Pursuant to 42 U.S.C. Section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization may be established for certain drug classes, particular drugs or medically accepted indication for uses or doses.

SUPPLEMENTAL REBATES

Based on the requirements in Section 1927 of the Social Security Act, the state has the following policies for the supplemental rebate program for Medicaid recipients:

Supplemental rebates will be accepted from manufacturers according to the supplemental drug-rebate agreement. Supplemental rebates received pursuant to these agreements are only for the Medicaid program.

All drugs covered by the program, irrespective of the requirement to be prior authorized, will comply with the provisions of the nation drug rebate agreement.

A REBATE AGREEMENT BETWEEN THE STATE AND PARTICIPATING MANUFACTURERS FOR DRUGS PROVIDED TO THE MEDICAID PROGRAM, SUBMITTED TO CMS ON FEBRUARY 7, 2007, AND ENTITLED "OHIO SUPPLEMENTAL DRUG REBATE AGREEMENT, #OH SUPP 2007" HAS BEEN AUTHORIZED BY CMS. CHANGES TO THIS SUPPLEMENTAL REBATE AGREEMENT WILL BE SUBMITTED TO CMS FOR AUTHORIZATION. ANY OTHER VERSIONS OF THE SUPPLEMENTAL REBATE AGREEMENT PREDATING THIS VERSION OF THE SUPPLEMENTAL REBATE AGREEMENT WILL NO LONGER BE IN PLACE EFFECTIVE OCTOBER 1, 2007.

The unit rebate amount is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(d) of the Social Security Act.

Supplemental drug rebates received under this agreement by the state that are in excess of those required under the National Drug Rebate Agreement will be shared with the federal government on the percentage basis required by law.

TNS# 07-001

APPROVAL DATE JUN 04 2007

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EFFECTIVE DATE 1/1/2007

TNS# 04-014

Provisions related to Medicare Part D Prescription Drug Coverage

Pursuant to Section 1935(d)(1) of the Social Security Act, effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

Pursuant to Sections 1927(d)(2) and 1935(d)(2) of the Social Security Act, the Medicaid agency provides coverage for the following Medicare-excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

The following drugs, which are subject to restriction under Section 1927(d)(2) of the Social Security Act, are covered:

- (a) agents when used for anorexia, weight loss, or weight gain
- (b) agents when used to promote fertility
- (c) agents when used for cosmetic purposes or hair growth
- (d) agents when used for the symptomatic relief of cough and colds (only cough suppressants)
- (e) agents when used to promote smoking cessation
- (f) prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- (g) nonprescription drugs (only cough suppressants, antacids, antidiarrheals, stool softeners, laxatives), except, in the case of pregnant women (and postpartum women through the end of the month in which the 60-day period following termination of pregnancy ends) when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the counter monograph process for purposes of promoting, and when used to promote, tobacco cessation
- (h) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- (i) barbiturates (Not covered for dually eligible individuals)
- (j) benzodiazepines (Not covered for dually eligible individuals)
- (k) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

12. a. Prescribed drugs, continued.

Selected over-the-counter drugs provided by nursing facilities for their recipient-residents are included in the nursing facility services. Nursing facilities receive a per diem amount that includes payment for selected over-the-counter drugs and are responsible for ensuring that their recipient-residents obtain those drugs. For dates of service on or after 8/1/09, selected over-the-counter drugs are paid for by the nursing facilities and are not eligible for reimbursement on a fee-for-service basis. Reimbursement methodology for nursing facilities is described in Attachment 4.19-D.

Excluded Drug Coverage of Smoking/Tobacco Cessation Products for Pregnant Women

The Medicaid agency will provide coverage of prescription and over-the-counter (OTC) tobacco/smoking cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

6/14/13

TN: 11-013
Supersedes:
TN: 09-018

Approval Date: 6/14/13
Effective Date: 01/01/2012

OHIO SUPPLEMENTAL DRUG REBATE AGREEMENT

#OH Supp 2007

1. PARTIES/PERIOD

- 1.1 This Supplemental Drug Rebate Agreement ("Agreement") is made and entered into by and between the State of Ohio ("State"), represented by the Ohio Department of Department of Job & Family Services ("Department"), and _____ ("Manufacturer"), Labeler Code(s) _____. The parties, in consideration of the covenants, conditions, agreements, and stipulations expressed in this Agreement, do hereby agree as follows.

2. PURPOSE

- 2.1 It is the intent of this Agreement that the State will receive Supplemental Rebates, in addition to the rebates received under Manufacturer's CMS Agreement, pursuant to Section 1927 of the Social Security Act (42 U.S.C. §1396r-8), for the Manufacturer's Supplemental Covered Product(s) quarterly utilization in the Ohio Medicaid Program in which there is Medicaid federal financial participation. The parties also intend for this Agreement to meet the requirements of federal law at Section 1927 of the Social Security Act (42 U.S.C. §1396r-8).

3. DEFINITIONS

- 3.1 "Average Manufacturer Price" (AMP) means Manufacturer's price for the Covered Product(s). AMP will be calculated as specified in Manufacturer's CMS Agreement.
- 3.2 "Best Price" shall mean Best Price as set forth in 42 U.S.C. Sec. 1396r-8, as such statute may be amended from time to time, excluding State Supplemental Rebate amounts.
- 3.3 "Covered Product(s)" means the pharmaceutical product(s) of the Manufacturer pursuant to Section 1927 of the Social Security Act (42 U.S.C. §1396r-8).
- 3.4 "CMS Agreement" means the Manufacturer's drug rebate contract with the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, entered into pursuant to Section 1927 of the Social Security Act (42 U.S.C. §1396r-8).
- 3.5 "CMS Basic Rebate" means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act [42 U.S.C. §1396r-8(c)(1) and 42 U.S.C. §1396r-8(c)(3)].
- 3.6 "CMS CPI Rebate" means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act [42 U.S.C. §1396r-8(c)(2)].
- 3.7 "CMS Unit Rebate Amount" means, the unit amount computed by CMS to which the Medicaid utilization information may be applied by states in invoicing the Manufacturer for the rebate payment due.

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- 3.8 "Manufacturer" means, for purposes of this Agreement, the non-state party to this Agreement, which may be a pharmaceutical manufacturer, labeler or other entity not prohibited by law from entering into this Agreement, as identified in Section 1.1 of this Agreement. .
- 3.9 "Net Cost Per Unit" or "Net Cost" means, with respect to the Supplemental Covered Product(s), the amount per NDC# agreed upon by the parties to this Agreement and set forth in the attached Addendum A.
- 3.10 "Pharmacy Provider" means an entity licensed or permitted by state law to dispense legend drugs, and enrolled as a state Medicaid provider.
- 3.11 "CMS Rebate" means, with respect to the Covered Product(s), the quarterly payment by Manufacturer to states as detailed in Sections 3.5, 3.6, and 4.1 of this Agreement.
- 3.12 "State Utilization Data" means the data used by the Department to reimburse pharmacy providers under the Ohio Medicaid Program. State Utilization Data excludes data from covered entities identified in Title 42 U.S.C. §256b(a)(4) in accordance with Title 42 U.S.C. §256b(a)(5)(A) and 1396r-8(a)(5)(C).
- 3.13 "Supplemental Covered Product(s)" means the Manufacturer's Covered Product(s), as listed in the attached Addendum/Addenda, that are the subject of this Agreement and for which Manufacturer has agreed to pay Supplemental Rebates. These are the Manufacturer's Covered Product(s) that received preferred status on the Ohio Medicaid Preferred Drug List as a result of this Agreement.
- 3.14 "Supplemental Rebate Amount Per Unit" means, with respect to the Supplemental Covered Product(s), the amount(s) by NDC#, as specified in the attached Addendum/Addenda, that the Manufacturer has agreed to reimburse the Department per unit of Supplemental Covered Product in accordance with the formula detailed in the attached Addendum/Addenda.
- 3.15 "Rebate Summary" means the report itemizing the State Utilization Data supporting the Department's invoice for Supplemental Rebates. The Rebate Summary will comply in all respects with requirements for Medicaid Utilization Information in the CMS Agreement.
- 3.16 "Supplemental Rebate" means, with respect to the Supplemental Covered Product(s), the quarterly payment by Manufacturer pursuant to Section 4.2 of this Agreement.
- 3.17 "Wholesale Acquisition Cost" or "WAC" means the Manufacturer's U.S. Dollar wholesale acquisition price in effect on the last day of the applicable quarter on a unit basis, as published by a third party source, such as First Databank, for each product and is understood to represent the Manufacturer's published price for a drug product to wholesalers. Any dispute as to the applicable WAC shall be conducted in accordance with the dispute provisions contained herein.

4. MANUFACTURER'S RESPONSIBILITIES

- 4.1 Manufacturer will continue to calculate and provide the Department a CMS Rebate for the Covered Product(s), which includes the CMS Basic Rebate and CMS CPI Rebate, as appropriate. The CMS Rebate represents the discount obtained by multiplying the units of the Covered Product(s) reimbursed by the Department in the preceding quarter by the per unit rebate amount provided to the Department by CMS. CMS will calculate the CMS Rebate amount in accordance with Manufacturer's CMS Agreement.

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Manufacturer's obligation for CMS Rebates will continue for the duration of the Manufacturer's CMS Agreement and is not affected by this Agreement.

- 4.2 In addition to the CMS Rebates described in Sections 3.5, 3.6, and 4.1 of this Agreement, Manufacturer will remit to the Department Supplemental Rebates for the Supplemental Covered Product(s) utilization in the Ohio Medicaid Program. The Supplemental Rebates will be calculated on a calendar quarter basis and provided via an invoice to the Manufacturer's CMS financial contact. The Supplemental Rebate for the quarter will be determined by multiplying the number of units of each of the Supplemental Covered Product(s) (by NDC#) reimbursed by the Department, for Ohio Medicaid utilization, in the preceding quarter by its corresponding Supplemental Rebate Amount Per Unit, which is determined pursuant to the terms of the *Ohio Supplemental-Rebate Agreement Addendum A attached hereto*, and summing the products of said multiplication(s). The Manufacturer's obligation for Supplemental Rebates will continue for the duration of this Agreement.
- 4.3 The Manufacturer will pay the Supplemental Rebate(s) set forth in this Agreement for utilization of the Supplemental Covered Product(s) during the twelve (12) month period beginning Start Date and ending End Date, as well as for any additional periods during which this Agreement remains in effect.
- 4.4 The quarters to be used for calculating the Supplemental Rebates in Section 4.2 of this Agreement will be those ending on March 31, June 30, September 30, and December 31 of each calendar year during the term of this Agreement.
- 4.5 Manufacturer shall submit the Supplemental Rebate payment within thirty-eight (38) days of the Manufacturer's receipt of the Rebate Summary from the Department.
- 4.6 Manufacturer will pay the Supplemental Rebate(s), including any applicable interest in accordance with Section 1903 (d)(5) of the Act. Interest on the Supplemental Rebates payable under Section 4.2 of this Agreement begins accruing thirty-eight (38) calendar days from the postmark date of the Department's invoice and supporting Rebate Summary sent to the Manufacturer and interest will continue to accrue until the postmark date of the Manufacturer's payment. The interest rate will be calculated as required under federal guidelines for the rebates described in Sections 3.5, 3.6 and 4.1. If the Department has not received the Supplemental Rebates payable under Section 4.2 of this Agreement, including any applicable interest, within 180 days of the postmark date of the Department's invoice and supporting Rebate Summary sent to Manufacturer, this Agreement will be deemed to be in default and State may terminate this Agreement by providing Manufacturer with written notice of termination. Said notice of termination shall cite this section of the Agreement and the termination shall not affect Manufacturer's obligation to remit Supplemental Rebates for utilization of Manufacturer's Supplemental Covered Products that occurred prior to the termination of this Agreement.
- 4.7 Manufacturer agrees to continue to pay Supplemental Rebates on the Supplemental Covered Product(s) for as long as this Agreement is in force and State Utilization Data shows that payment was made for the Supplemental Covered Product(s), regardless of whether the Manufacturer continues to market the Supplemental Covered Product(s). *If Manufacturer discontinues the manufacture, sale or distribution of any Manufacturer Product or decides to transfer or license any Manufacturer Product to a third party,*

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Manufacturer shall continue to have liability under this Agreement for the same period of time that Manufacturer has liability for CMS Rebates under Manufacturer's CMS Agreement for said assigned Supplemental Covered Product(s). Manufacturer shall provide the Department with notice of the sale of said Supplemental Covered Product(s) concurrent with Manufacturer's notice to CMS. If a Supplemental Covered Product is assigned pursuant to this Section, Manufacturer shall provide the Department with an update of the information contained in Section 9.3 herein with respect to the Supplemental Covered Product(s)'s new owner.

- 4.8 Unless notified otherwise, Manufacturer will send Supplemental Rebate payments to Department's Lock box at the following address. Since this is a lock box, it is not possible to provide a confirmation signature. Manufacturer must send all payments only to this address by regular mail, **NO** return receipt requested:

Ohio Department of Job and Family Services
P.O. Box 712110
Cincinnati, OH 45271-2110

5. DEPARTMENT RESPONSIBILITIES

- 5.1 Subject to the concurrence of the State Pharmacy and Therapeutics Committee, the Department will classify Manufacturer's Supplemental Covered Product(s) as "preferred" in the Ohio Medicaid Preferred Drug List. The Department may determine, as a result of a therapeutic class review, that prior authorization is required for all preferred drugs in a therapeutic class. If prior authorization is required for any Supplemental Covered Product, the Department will comply with all provisions of section 1927(d) of the Social Security Act applicable to Prior Authorization programs.
- 5.2 The Department will provide aggregate State Utilization Data to Manufacturer on a quarterly basis. This data will be based on paid claims data (data used to reimburse pharmacy providers) under the Ohio Medicaid Program, will be consistent with any applicable Federal or State guidelines, regulations and standards for such data, and will be the basis for the Department's calculation of the Supplemental Rebate(s).
- 5.3 The Department will maintain those data systems necessary to calculate the Supplemental Rebate(s). In the event material discrepancies are discovered, the Department will promptly justify its data or make an appropriate adjustment, which may include a credit as to the amount of the Supplemental Rebates, or a refund to Manufacturer as the parties may agree.
- 5.4 The Department shall maintain electronic or other claims records, for such time periods as are required by CMS to permit verification of the calculation of CMS Rebates, to permit Manufacturer to verify through an audit process the Rebate Summaries provided by the Department. Any audit conducted pursuant to this Section 5.4 shall be conducted by independent auditors, at Manufacturer's expense, during regular business hours and not more often than one (1) time per calendar year. The independent auditors shall provide at least thirty (30) days prior written notification of their intent to audit. The Department shall make available to the independent auditors such records as are required to demonstrate the accuracy of the claims submitted to the Manufacturer under this Agreement. The independent auditors may be required to enter into confidentiality agreements with the State and Manufacturer as necessary to comply with state and federal

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laws and regulations governing the privacy of individual or other health information or information that is proprietary and/or confidential. The independent auditors will not be provided access to information related to other manufacturers.

- 5.5 Upon implementation of this Agreement, and from time to time thereafter, the Department and Manufacturer may meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Department to Manufacturer are adequate for the purposes of this Agreement.
- 5.6 The State shall obtain CMS approval of its state Medicaid plan, including the State's establishment of its Medicaid preferred drug list/supplemental-drug rebate program under which the Supplemental Rebates contracted for herein will be paid. Manufacturer shall not be required to remit any Supplemental Rebates that have accrued and are due until State has obtained the CMS approval provided for in this Section.

6. DISPUTE RESOLUTION

- 6.1 In the event that in any quarter a discrepancy in State Utilization Data is questioned by the Manufacturer, which the Manufacturer and the Department in good faith are unable to resolve, the Manufacturer will provide written notice of the discrepancy to the Department.
- 6.2 If the Manufacturer in good faith believes the State Utilization Data is erroneous, the Manufacturer shall pay the Department that portion of the Supplemental Rebate claimed, that is not in dispute by the required date in Section 4.6. The balance in dispute, if any, will be paid by the Manufacturer to the Department by the due date of the next quarterly payment after resolution of the dispute.
- 6.3 The Department and the Manufacturer will use their best efforts to resolve any discrepancy within sixty (60) days of receipt of written notification. Should additional information be required to resolve disputes, the Department will cooperate with the Manufacturer in obtaining the additional information.
- 6.4 In the event that the Department and the Manufacturer are not able to resolve a discrepancy regarding State Utilization Data as provided for in Sections 6.1 through 6.3, the Manufacturer may request a reconsideration of the Department's determination within thirty (30) days after the end of the sixty (60) day period identified in Section 6.3. The Manufacturer shall submit to the Department, along with its written request, its argument in writing, along with any other materials, supporting its position.
- 6.5 In the event that the Department and the Manufacturer are unable to resolve a discrepancy regarding State Utilization Data as provided for in Sections 6.1 through 6.4, the parties will utilize the same State procedure that is used to resolve disputes under the Medicaid Rebate Program, consistent with CMS' *Best Practices Guide for Dispute Resolution Under the Medicaid Drug Rebate Program*.

7. CONFIDENTIALITY PROVISIONS

- 7.1 Subject to 42 U.S.C. 1396r-8(b)(3)(D), Ohio Revised Code § 5101.31, other relevant federal and state laws, and the parties agreement herein, the parties agree that this Agreement and all information provided pursuant to this Agreement will not be disclosed and that the parties will not duplicate or use the information, except in connection with this Agreement or as may be required by judicial order. The parties

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further agree that any information provided by Manufacturer to the State, the Department or any agent of either party pursuant to this Agreement and this Agreement itself constitute confidential commercial and financial information not subject to public disclosure. Furthermore, all pricing and other confidential information will not be released to any person or entity not a party or agent of a party to this Agreement. Confidential information, including but not limited to trade secrets, Best Price information, Net Cost information, AMP, other confidential pricing information, utilization data and this Agreement itself will not be disclosed, or used except in connection with this Agreement or as may be required by statute, regulation, or judicial order. In the event an attempt is made to compel either party to divulge confidential and/or proprietary information related to this Agreement, said party shall notify the other party to this Agreement in a prompt manner to allow the other party to seek injunctive or other relief prohibiting the disclosure of such information.

- 7.2 The Manufacturer will hold the State Utilization Data confidential. If the Manufacturer audits this information or receives further information on such data, that information shall also be held confidential. The Manufacturer shall have the right to disclose State Utilization Data to auditors who must agree to keep such information confidential.
- 7.3 Notwithstanding the non-renewal or termination of this Agreement for any reason, these confidentiality provisions will remain in full force and effect.

8. NON-RENEWAL or TERMINATION

- 8.1 This Agreement shall be effective the 1st day of Month, Year, and shall have the twelve (12) month term indicated in Section 4.3, *supra*. This Agreement shall automatically renew for additional one (1) year terms unless one party hereto provides the other, on or before sixty (60) days prior to the then current expiration date of this Agreement, written notice of said party's intent not to renew this Agreement or unless said parties have executed a new agreement. Nothing contained herein shall prevent Manufacturer and State from mutually agreeing to the amending of this Agreement to increase the Supplemental Rebates and/or add additional Supplemental Covered Products to this Agreement.
- 8.2 Notwithstanding the above, either party may terminate this Agreement by providing the other party with sixty (60) days prior written notice of termination.
- 8.3 Notwithstanding any non-renewal or termination of this Agreement, Supplemental Rebates shall continue to be due and payable from the Manufacturer under Section 4.2 for any Supplemental Covered Product(s) utilization for which the Department's obligation to reimburse arose prior to the effective date of termination of this Agreement.

9. GENERAL PROVISIONS

- 9.1 This Agreement will be construed and interpreted in accordance with the laws of the State of Ohio and 42 U.S.C. §1396r-8.

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9.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested or via overnight courier. Notice to the Department will be sent to:

Deputy Director for Contracts
Ohio Department of Job and Family Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-3414

With a copy to:

Manager of Industry Relations
ACS Government HealthCare Solutions
365 Northridge Road, Suite 400
Atlanta, Georgia 30350

9.3 Notice to Manufacturer will be sent to:

_____ (Name)
_____ (Title)
_____ (Company Name)
_____ (Address)

9.4 Nothing herein shall be construed or interpreted as limiting or otherwise affecting the State's or Manufacturer's ability to pursue its rights arising out of the terms and conditions of the Agreement in the event that a dispute between the parties is not otherwise resolved. Proper venue and jurisdiction for any legal action relating to this Agreement shall be in the courts of Franklin County, Ohio.

9.5 Manufacturer and the agents and employees of Manufacturer in the performance of this Agreement, will act in an independent capacity and not as officers, employees or agents of the State.

9.6 Manufacturer may not assign this Agreement, either in whole or in part, without the prior written consent of the Department, except as provided for in Section 4.7. However, in the event of a transfer in ownership of the Manufacturer, the Agreement is automatically assigned to the new owner, subject to the terms and conditions of this Agreement. If the Agreement is assigned pursuant to this Section, Manufacturer shall provide the Department with an update of the information contained in Section 9.3, *supra*.

9.7 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal or state requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision. The parties agree to negotiate replacement provisions, to afford the parties as much of the benefit of their original bargain as is possible.

9.8 The Department and Manufacturer declare that this Agreement, including attachments and Addenda/Addendum, contains a total integration of all rights and obligations of both parties. There are no extrinsic conditions, collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of both parties that any and all prior or

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contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind.

9.9 This Agreement will not be altered except by an amendment in writing signed by both parties and approved or authorized by CMS. No individual is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Department and Manufacturer.

9.10 Inasmuch as the Supplemental Rebate(s) required by this Agreement are for Ohio Medicaid Program beneficiaries, it is agreed, in accordance with Medicaid Drug Rebate Program Release #102 For State Medicaid Directors and other applicable law, that the Supplemental Rebate(s) do not establish a new "Best Price" for purposes of Manufacturer's CMS Agreement. Both parties are entering into this Agreement with the express understanding and intention that CMS's approval of the Ohio Supplemental Rebate Program and this Agreement will prevent Manufacturer's Best Price and AMP from being affected by the payment of Supplemental Rebates under this Agreement and that such is a condition precedent to the performance of this Agreement. Upon request of Manufacturer, Department shall provide a copy of the written confirmation of: CMS's approval of the Ohio Supplemental Rebate Program and this Agreement. After such request, Manufacturer shall not be required to remit any Supplemental Rebates that have accrued and are due under this Agreement until after the State provides such written confirmation.

9.11 In the event that the Department requires prior authorization of Manufacturer's Supplemental Covered Product(s) consistent with Section 5.1, this Agreement remains in force. If, however, a Supplemental Covered Product(s) of the Manufacturer should require prior authorization and not the whole class, the Department shall notify Manufacturer and the parties agree that the affected Supplemental Covered Product (by NDC) shall be removed from this Agreement upon Manufacturer's written request, provided Manufacturer submits its request for removal to State no later than thirty (30) days following Manufacturer's receipt of the State's notice of prior authorization. Said removal shall be retroactive to the date the affected Supplemental Covered Product (by NDC) was subjected to prior authorization.

As evidence of their Agreement to the foregoing terms and conditions, the parties have signed below.

STATE OF OHIO, OHIO DEPARTMENT OF JOB & FAMILY SERVICES

By: _____ Date: _____

Name: _____

Title: Director _____

MANUFACTURER

Company: _____

By: _____ Date: _____

Name: _____

Title: _____

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ADDENDUM A

This Addendum A to the Ohio Supplemental Drug Rebate Agreement #OH Supp 2007 ("Agreement") between the State of Ohio, represented by the Ohio Department of Job & Family Services ("Department"), and _____ ("Manufacturer"), Labeler Code(s) _____, is in effect as of _____, 200__, and provides as follows:

The Supplemental Rebate Amount per Unit for each NDC of a Supplemental Covered Product is calculated according to the following formula:

$$\text{Supplemental Rebate Amount per Unit} = \text{WAC per Unit} \text{ minus } \text{CMS Unit Rebate Amount} \text{ minus } \text{Net Cost per Unit}$$

Where the CMS Unit Rebate Amount is as determined by CMS for the applicable quarter; and

Where the Net Cost per Unit ("Net Cost") equals the per unit cost negotiated and agreed upon by Department and Manufacturer as set forth in the table below; and

Where the Supplemental Rebate Amount per Unit will be greater than or equal to zero.

Department and Manufacturer agree that the Manufacturer's Covered Products set forth herein are the Supplemental Covered Products that are the subject of this Agreement and that the Net Cost of each Supplemental Covered Product included in this Addendum will be as set forth in the table below:

Supplemental Covered Product (i.e., drug name)	Dosage/Package Size	Unit Type	NDC-11	Net Cost per Unit ("Net Cost")

Manufacturer warrants and agrees that this Agreement and Addendum includes and encompasses all NDC's currently available for each Supplemental Covered Product. In the event that an additional NDC, not included in this Addendum, becomes available for a Supplemental Covered Product, Manufacturer agrees that it will extend an offer to amend this Addendum to include the new NDC(s) at Net Cost(s) that is/are equivalent to the Net Cost(s) of the other NDC(s) of the Supplemental Covered Product.

As evidence of their Agreement to the foregoing terms and conditions the parties have signed below.

STATE OF OHIO, OHIO DEPARTMENT OF JOB & FAMILY SERVICES

By: _____ Date: _____

Name: _____

Title: Director

MANUFACTURER

Company: _____

By: _____ Date: _____

Name: _____

Title: _____

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b. Dentures

Requires prior authorization.

c. Prosthetic devices

Requires prior authorization.

Hearing aid procurement depends on a physician's prescription and a report of hearing loss, if a hearing aid is recommended.

d. Eyeglasses

No spare eyeglasses or replacements due to personal preference. No trimmed frames. Certain other items require prior authorization.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

1. Rehabilitative services provided by community mental health facilities

The following community mental health services provided in accordance with 42 CFR 440.130(d), Ohio Administrative Code rules governing the coverage and reimbursement of the Medicaid program, and the certification requirements of the Ohio Department of Mental Health (ODMH) are covered as optional rehabilitative services.

Covered mental health services do not include services provided to individuals aged 21 - 65 who reside in facilities that meet the Federal definition of an institution for mental disease.

Covered mental health services only include services that are rendered by or are rendered under the lawful direction of providers who meet the applicable Federal and/or State definition of a qualified Medicaid provider.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Behavioral health counseling and therapy

Service Description:

Behavioral health counseling and therapy service means interaction with a person served in which the focus is on treatment of the person's mental illness or emotional disturbance. When the person served is a child or adolescent, the interaction may also be with the family members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such services are part of the individual service plan (ISP).

Behavioral health counseling and therapy service shall consist of a series of time-limited, structured sessions that work toward the attainment of mutually defined goals as identified in the ISP. Behavioral health counseling and therapy service may be provided in the agency or in the natural environment of the person served, and regardless of the location shall be provided in such a way as to ensure privacy. The natural environment is a client-centered approach to providing services in the environment in which the client feels the most comfortable. This allows the clinician to go to the client to provide care rather than the client going to the clinician. The State does not reimburse for the clinician's time in traveling to the client.

For behavioral health counseling and therapy services for children and adolescents, the agency shall ensure timely collateral contacts with family members, parents or guardian and/or with other agencies or providers providing services to the child/adolescent.

Limitations:

Behavioral health counseling and therapy services are limited to 52 hours per twelve month period. Beneficiaries younger than age twenty-one can access community mental health services beyond established limits when medically necessary.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Eligible Providers:

The following individuals are eligible to provide all components of the behavioral health counseling and therapy service: medical doctor or doctor of osteopathic medicine; registered nurse; master of science in nursing; clinical nurse specialist; nurse practitioner; social worker trainee; social worker; independent social worker; independent marriage and family therapist; marriage and family therapist; counselor trainee; professional counselor; professional clinical counselor; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; psychology assistant; assistant; psychology aide; aide; school psychology assistant; school psychology intern; school psychology trainee; licensed school psychologist; or psychologist. All providers require supervision, except those listed below as eligible to supervise behavioral health counseling and therapy service unless otherwise noted.

The following individuals must be supervised in the provision of this service: registered nurse; social worker trainee; social worker; counselor trainee; professional counselor; marriage and family therapist. Supervision may be provided by any professional licensed in the following paragraph.

The following individuals are eligible to supervise behavioral health counseling and therapy service: medical doctor or doctor of osteopathic medicine; master of science in nursing; clinical nurse specialist; nurse practitioner; independent social worker; independent marriage and family therapist; professional clinical counselor; licensed school psychologist; or psychologist.

The following individuals must be supervised in the provision of this services by a psychologist, or by another psychology supervisee registered to practice under the supervision of the same psychologist's license: psychology assistant; assistant; psychology aide; aide; school psychology assistant; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee. Under Ohio law, psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee must be supervised, but is also eligible to provided supervision under the registration and supervision of a psychologist.

Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying, or registering bodies.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Mental health assessment services

Service Description:

Mental health assessment is a clinical evaluation provided by a provider of services either at specified times or in response to treatment, or when significant changes occur. It is a process of gathering information to assess client needs and functioning in order to determine appropriate service/treatment based on identification of the presenting problem, evaluation of mental status, and formulation of a diagnostic impression. The outcome of mental health assessment is to determine the need for care, and recommend appropriate services/treatment and/or the need for further assessment. Results of the mental health assessment shall be shared with the client.

An initial mental health assessment must be completed prior to the initiation of any mental health services. The only exceptions to this is the delivery of crisis intervention mental health services or pharmacologic management services as the least restrictive alternative in an emergency situation.

The initial mental health assessment must, and subsequent mental health assessments may, include at minimum:

- (a) An age appropriate psychosocial history and assessment, to include consideration of multi-cultural/ethnic influences;
- (b) The presenting problem;
- (c) A diagnostic impression and treatment recommendations;
- (d) For any service provided in a type 1 residential facility licensed by ODMH pursuant to rules 5122-30-01 to 5122-30-30 of the Administrative Code, a physical health screening to determine the need for a physical health assessment. Such screening shall be completed within one week of admission to the facility. Room and board provided in residential facilities is not eligible for Medicaid reimbursement; and
- (e) As determined by the provider, any other clinically indicated areas. Other clinically indicated areas include areas of assessment the provider may determine to be indicated, such as, age appropriate areas of assessment for children, growth and development, family effect on

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

child and child effect on family, daily activities, use of alcohol/drugs, behavioral/cognitive/emotional functioning, and mental status exam.

Limitations:

Mental health assessment services provided by non-physicians are limited to 4 hours per twelve month period. Mental health assessment services provided by physicians are limited to 2 hours per twelve month period. Beneficiaries younger than age twenty-one can access community mental health services beyond established limits when medically necessary.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Eligible Providers:

The following individuals are eligible to provide all components of the mental health assessment service: medical doctor or doctor of osteopathic medicine; physician assistant; registered nurse; master of science in nursing; clinical nurse specialist; nurse practitioner; social worker trainee; social worker; independent social worker; independent marriage and family therapist; marriage and family therapist; counselor trainee; professional counselor; professional clinical counselor; licensed school psychologist; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; psychology assistant; assistant; psychology aide; aide; school psychology assistant; school psychology intern; school psychology trainee; or psychologist. All providers require supervision, except those listed below as eligible to supervise mental health assessment service unless otherwise noted.

The following individuals must be supervised in the provision of this service: physician assistant; registered nurse; social worker trainee; social worker; marriage and family therapist; counselor trainee; professional counselor. Supervision may be provided by any professional listed in the following paragraph.

The following individuals are eligible to supervise the mental health assessment service: medical doctor or doctor of osteopathic medicine; master of science in nursing; clinical nurse specialist; nurse practitioner; independent social worker; independent marriage and family therapist; professional clinical counselor; licensed school psychologist; or psychologist.

The following individuals must be supervised in the provision of this service by a psychologist, or by another psychology supervisee registered to practice under the supervision of the same psychologist's license: psychology assistant; assistant; psychology aide; aide; school psychology assistant; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee. Under Ohio law, a psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee must be supervised, but is also eligible to provide supervision under the registration and supervision of a psychologist.

Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Duplication of services and billing is prohibited if school psychologists and licensed school psychologist assistants are furnishing mental health assessment services to children under other parts of the Medicaid program (such as the Medicaid in Schools program).

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Pharmacologic management services

Service Description:

Pharmacologic management service is a psychiatric/mental health/medical service used to reduce/stabilize and/or eliminate psychiatric symptoms with the goal of improved functioning, including management and reduction of symptoms. Pharmacologic management services result in well-informed/educated individuals and family members and in decreased/minimized symptoms and improved/maintained functioning for individuals receiving the service. The purpose/intent is to:

- (1) Address psychiatric/mental health needs as identified in the mental health assessment and documented in the client's ISP;
- (2) Evaluate medication prescription, administration, monitoring, and supervision;
- (3) Inform individuals and family regarding medication and its actions, effects and side effects so that they can effectively participate in decisions concerning medication that is administered/dispensed to them;
- (4) Assist individuals in obtaining prescribed medications, when needed; and
- (5) Provide follow-up, as needed

Pharmacologic management service shall consist of one or more of the following elements as they relate to the individual's psychiatric needs, and as clinically indicated:

- (1) Performance of a psychiatric/mental health examination;
- (2) Prescription of medications and related processes which include:
 - (a) Consideration of allergies, substance use, current medications, medical history, and physical status;
 - (b) Behavioral health education to individuals and/or families (e.g., purpose, risks, side effects, and benefits of the medication prescribed); and

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

(c) Collaboration with the individual and/or family, including their response to the education, as clinically indicated. The method of delivery of education can be to an individual or group of individuals.

(3) Administration and supervision of medication and follow-up, as clinically indicated. Prescription, administration and supervision of medication are governed by professional licensure standards, Ohio Revised Code, Ohio Administrative Code, and scope of practice.

(4) Medication monitoring consisting of monitoring the effects of medication, symptoms, behavioral health education and collaboration with the individual and/or family as clinically indicated. The method of delivery of medication monitoring can be to an individual or group of individuals.

Limitations:

Pharmacologic management services are limited to 24 hours per twelve month period. Beneficiaries younger than age twenty-one can access community mental health services beyond established limits when medically necessary.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Eligible Providers:

The following individuals are eligible to provide all components of the pharmacologic management service: medical doctor or doctor of osteopathic medicine; physician assistant; pharmacist; licensed practical nurse; registered nurse; master of science in nursing; clinical nurse specialist; or nurse practitioner. All providers require supervision, except those listed below as eligible to supervise pharmacological management service.

The following individuals must be supervised in the provision of this service: physician assistant; licensed practical nurse. Supervision for these individuals may be provided by any professional listed in the following paragraph.

The following individuals are eligible to supervise the pharmacologic management service: medical doctor or doctor of osteopathic medicine; pharmacist; registered nurse; master of science in nursing; clinical nurse specialist; or nurse practitioner.

Licensed, certified, or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Partial Hospitalization service

Service Description:

Partial hospitalization is an intensive, structured, goal-oriented, distinct and identifiable treatment service that utilizes multiple mental health services that address the individualized mental health needs of the client. Partial hospitalization services are clinically indicated by assessment with clear admission and discharge criteria. The environment at this level of treatment is highly structured, and has an appropriate staff-to-client ratio to guarantee sufficient therapeutic services and professional monitoring, control, and protection. The purpose and intent of partial hospitalization 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 toward and improved quality of life with the support of an appropriate level of care.

Partial hospitalization must be an intense treatment service that consists of high levels of face-to-face mental health services that address the individualized mental health needs of the individual as identified in his/her ISP. Partial hospitalization program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive services that may include the following:

- (1) Determination of needed mental health services;
- (2) Skills development
 - (a) Interpersonal and social competency as age, developmentally, and clinically appropriate, such as:
 - (i) Functional relationships with adults;
 - (ii) Functional relationship with peers;
 - (iii) Functional relationship with the community/schools;
 - (iv) Functional relations with employer/family; and
 - (v) Functional relations with authority figures.
 - (b) Problem solving, conflict resolution, and emotions/behavior management.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

(c) Developing positive coping mechanisms;

- (3) Managing mental health and behavioral symptoms to enhance independent living; and
- (4) Psychoeducational services 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 ISP and be provided with the knowledge and support of the interdisciplinary/intersystem team providing treatment in coordination with the ISP.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Eligible Providers:

The following individuals are eligible to provide all components of the partial hospitalization service, except for determination of needed mental health services: medical doctor or doctor of osteopathic medicine; physician assistant; licensed practical nurse; registered nurse; master of science in nursing; clinical nurse specialist; nurse practitioner; social work assistant; social worker trainee; social worker; independent social worker; independent marriage and family therapist; marriage and family therapist; counselor trainee; professional counselor; professional clinical counselor; school psychology assistant/intern/trainee; licensed school psychologist; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; psychology assistant; assistant; psychology aide; aide; psychologist; or qualified mental health specialist. Under the partial hospitalization service, only those individuals eligible to provide the mental health assessment service are eligible to determine the needed mental health services. All providers require supervision, except those listed below as eligible to provide the mental health assessment services are eligible to determine the needed mental health services. All providers require supervision, except those listed below as eligible to supervise partial hospitalization services unless otherwise noted.

The following individuals must be supervised in the provision of this service: physician assistant, licensed practical nurse; registered nurse; social work assistant; social worker trainee; counselor trainee; qualified mental health specialist. Supervision may be provided by any professional listed in the following paragraph.

The following individuals are eligible to supervise the partial hospitalization service: medical doctor or doctor of osteopathic medicine; master of science in nursing; clinical nurse specialist; nurse practitioner; independent social worker; independent marriage and family therapist; marriage and family therapist; professional counselor; professional clinical counselor; licensed school psychologist; or psychologist.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

The following individuals must be supervised in the provision of this service by a psychologist, or by another psychology supervisee registered to practice under the supervision of the same psychologist's license: psychology assistant; assistant; psychology aide; aide; school psychology assistant; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee. Under Ohio law, a psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee must be supervised, but is also eligible to provide supervision under the registration and supervision of a psychologist.

Under Ohio law, a social worker may supervise mental health activities provided by a qualified mental health specialist, but must also be supervised.

Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies.

Duplication of services and billing is prohibited if school psychologists and licensed school psychologist assistants are furnishing partial hospitalization services to children under other parts of the Medicaid program (such as the Medicaid in Schools program).

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Crisis intervention mental health services

Service Description:

Crisis intervention is that process of responding to emergency situations and includes: assessment, immediate stabilization, and the determination of level of care in the least restrictive environment in a manner that is timely, responsive, and therapeutic. Crisis intervention mental health services need to be accessible, responsive and timely in order to be able to safely de-escalate an individual or situation, provide hospital pre-screening and mental status evaluation, determine appropriate treatment services, and coordinate the follow through of those services and referral linkages. Outcomes may include: de-escalating and/or stabilizing the individual and/or environment, linking the individual to the appropriate level of care and services including peer support, assuring safety, developing a crisis plan, providing information as appropriate to family/significant others, and resolving the emergent situation.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Eligible Providers:

The following individuals are eligible to provide all components of the crisis intervention mental health service: medical doctor or doctor of osteopathic medicine; physician assistant; licensed practical nurse; registered nurse; master of science in nursing; clinical nurse specialist; nurse practitioner; social worker assistant; social worker trainee; social worker; independent social worker; independent marriage and family therapist; marriage and family therapist; counselor trainee; professional counselor; professional clinical counselor; school psychology assistant; school psychology intern; school psychology trainee; licensed school psychologist; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; psychology assistant; assistant; psychology aide; aide; psychologist; or qualified mental health specialist. All providers require supervision, except those listed below as eligible to supervise crisis intervention service unless otherwise noted.

The following individuals must be supervised in the provision of this service: physician assistant; licensed practical nurse; registered nurse; social worker assistant; social worker trainee; social worker; counselor trainee; professional counselor; qualified mental health specialist; marriage and family therapist. Supervision may be provided by any professional listed in the following paragraph.

The following individuals are eligible to supervise the crisis intervention mental health service: medical doctor or doctor of osteopathic medicine; master of science in nursing; clinical nurse specialist; nurse practitioner; independent social worker; independent marriage and family therapist; professional clinical counselor; licensed school psychologist; or psychologist.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

The following individuals must be supervised in the provision of this service by a psychologist, or by another psychology supervisee registered to practice under the supervision of the same psychologist's license: psychology assistant; assistant; psychology aide; aide; school psychology assistant; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee. Under Ohio law, psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee must be supervised, but is also eligible to provide supervision under the registration and supervision of a psychologist.

Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies.

Duplication of services and billing is prohibited if school psychologists and licensed school psychologist assistants are furnishing crisis intervention services to children under other parts of the Medicaid program (such as the Medicaid in Schools program).

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Community Psychiatric Supportive Treatment

Service Description:

Community psychiatric supportive treatment (CPST) service is a rehabilitative service intended to maximize the reduction of symptoms of mental illness in order to restore the individual's functioning to the highest level possible. CPST supports the individual's ability to take responsibility for managing his/her mental illness and achieving and maintaining his/her rehabilitative and/or recovery goals. CPST is a service comprised of individualized mental health services that are delivered in a variety of locations based upon the natural environment(s) of the individual, i.e., home and community locations. The natural environment is a client-centered approach to providing services in the environment in which the client feels the most comfortable. This allows the clinician to go to the client to provide care rather than the client going to the clinician. The CPST service is provided to adults, children, and adolescents. It may also be provided to the service recipient's parents, guardians, families, and/or significant others, when appropriate, and when provided for the exclusive benefit of the service recipient.

The CPST service is comprised of the following services as they relate to the individual's symptoms of mental illness and corresponding deficits in current functioning:

- (1) Coordination and implementation of the service recipient's ISP, including ensuring that the ISP reflects the most current services necessary to address the individual's mental health needs and symptoms of his/her mental illness.
- (2) Support in crisis situations, including de-escalation, advocacy for additional services, coordination, and linkage. This component of the CPST service is not a crisis intervention itself, but refers to activities intended to provide support in crisis situations.
- (3) Assessing the individual's needs, including psychiatric, physical health, entitlement benefits, wellness, support system, and community resources, e.g., the need for housing, vocational assistance, income support, transportation, etc.
- (4) Individualized, restorative services and training to improve interpersonal, community integration, and independent living skills when the individual's mental illness impacts his/her ability to function in and adapt to home, school, work and community environments.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

- (5) Assisting the individual to acquire psychiatric symptom self-monitoring and management skills so that the individual learns to identify and minimize the negative effects of the mental illness that interfere with his/her daily functioning.
- (6) Advocacy and outreach when the individual's mental illness prevents him/her from doing this for him/herself. This component of the CPST service includes advocating for a client, when due to symptoms of mental illness, the client is unable to advocate for himself for other necessary services such as housing, entitlements, etc. Outreach allows for services to be provided in the client's natural environment.
- (7) Mental illness, recovery wellness management education and training. The education and training may also be provided to the individual's parent or guardian and family and/or significant others, when appropriate, and when: this education and training is based on the individual's mental illness and symptoms; and this education and training is performed exclusively on behalf of and for the well-being of the individual, and is documented in the ISP.

Limitations:

Community psychiatric supportive treatment services are limited to 104 hours per twelve month period. Additional community psychiatric supportive treatment services beyond the established limits may be allowed when medically necessary and approved through the prior authorization process. Beneficiaries younger than age twenty-one can access community mental health services beyond established limits when medically necessary.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Eligible Providers:

The following individuals are eligible to provide all components of the CPST service: medical doctor or doctor of osteopathic medicine; physician assistant; licensed practical nurse; registered nurse; master science in nursing; clinical nurse specialist; nurse practitioner; social worker assistant; social worker trainee; social worker; independent social worker; counselor trainee; professional counselor; professional clinical counselor; school psychology assistant; licensed school psychologist; psychology intern; psychology fellow; psychology assistant; assistant; psychologist; or qualified mental health specialist. All providers require supervision, except those listed below as eligible to supervise CPST service unless otherwise noted.

The following individuals must be supervised in the provision of this service: physician assistant; licensed practical nurse; social worker assistant; social worker trainee; counselor trainee; qualified mental health specialist. Supervision may be provided by any professional listed in the following paragraph.

The following individuals are eligible to supervise the CPST service: medical doctor or doctor of osteopathic medicine; registered nurse; master of science in nursing; clinical nurse specialist; nurse practitioner; independent social worker; professional counselor; professional clinical counselor; licensed school psychologist; or psychologist.

The following individuals must be supervised in the provision of this service by a psychologist, or by another psychology supervisee registered to practice under the supervision of the same psychologist's license: psychology assistant; assistant; psychology aide; aide; school psychology assistant; psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee. Under Ohio law, a psychology intern; psychology fellow; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee must be supervised, but is also eligible to provide supervision under the registration and supervision of a psychologist.

Under Ohio law, a social worker may supervise mental health activities provided by a qualified mental health specialist, but must also be supervised.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies.

Duplication of services and billing is prohibited if school psychologist and licensed school psychologist assistants are furnishing CPST services to children under other parts of the Medicaid programs (such as the Medicaid in Schools program).

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Summary of Provider Qualifications applicable to Community Mental Health Services

Please Note: In the following paragraphs, the term "registered with the state of Ohio" means an individual known to the state professional and/or licensing boards as a practitioner who has met the applicable professional requirements.

Clinical nurse specialist (CNS) means a registered nurse who holds a current, valid certificate of authority issued by the Ohio board of nursing that authorizes the practice of nursing as a clinical nurse specialist in accordance with Chapter 4723. of the Ohio Revised Code. Requires a Master's degree.

Counselor trainee (CT) means an individual registered with the state of Ohio, counselor, social worker and marriage and family therapist board, as a counselor trainee according to OAC 4757. Requires a Bachelor degree (unspecified) and must be currently enrolled in a university Master's or Doctorate counseling program and enrolled in a practicum or internship course as part of the degree program. Must be supervised by a licensed professional clinical counselor.

Independent marriage and family therapist (IMFT) means an individual who holds a current, valid license as an independent marriage and family therapist, issued by the state of Ohio, counselor, social worker and marriage and family therapist board, according to Chapter 4757. of the Ohio Revised Code. Requires a Master's degree.

Independent social worker (ISW) means an individual who holds a current, valid license as an independent social worker, issued by the state of Ohio, counselor, social worker and marriage and family therapist board, according to Chapter 4757. of the Ohio Revised Code. Requires a Master's degree.

Licensed practical nurse (LPN) means an individual who holds a current, valid license as a licensed practical nurse from the Ohio board of nursing according to Chapter 4723. of the Ohio Revised Code. Requires either an Associate or Bachelor degree.

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d. Rehabilitative services

Licensed school psychologist (L.S.PSY) means an individual who holds a current, valid license from the state board of psychology to practice school psychology according to Chapter 4732. of the Ohio Revised Code, regardless of whether the services are provided in the school, home, or other community setting. Requires either a Master's or Doctorate degree.

School psychology assistant (S. PSY A) means an individual who is registered with the state board of psychology according to Chapter 4732 of the Ohio Administrative Code. Requires either a Master's or Doctorate degree.

School psychology intern (S. PSY I) means an individual who is registered with the state board of psychology according to Chapter 4732 of the Ohio Administrative Code. Requires either a Master's or Doctorate degree. Must be supervised by a psychologist.

School psychology trainee (S. PSY T.) means an individual who is registered with the state board of psychology according to Chapter 4732 of the Ohio Administrative Code. Requires either a Master's or Doctorate degree. Must be supervised by a psychologist.

Marriage and family therapist (MFT) means an individual who holds a current valid license as a marriage and family therapist, issued by the state of Ohio, counselor, social worker and marriage and family therapist board, according to Chapter 4757. of the Ohio Revised Code. Requires a Master's degree.

Master of science in nursing (MSN) means an individual who holds a current, valid license as a registered nurse from the Ohio board of nursing according to Chapter 4723 of the Ohio Revised Code, a certificate of authority (COA) issued by the board, and holds a masters degree or doctorate in nursing with a specialization in psychiatric nursing or graduate equivalent, as accepted by the Ohio board of nursing, i.e., R.N.C., MS., N.D., or M.A.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Medical doctor (MD) means an individual who is a physician licensed by the state medical board according to Chapter 4731. of the Ohio Revised Code to practice medicine, or a medical officer of the government of the United States while in this state in the performance of his or her official duties.

Doctor of osteopathic medicine (DO) means a doctor of osteopathic medicine who is a physician as defined in Chapter 4731. of the Ohio Revised Code.

Certified Nurse practitioner (NP) means a registered nurse who holds a current, valid certificate of authority issued by the Ohio board of nursing that authorizes the practice of nursing as a nurse practitioner in accordance with Chapter 4723. of the Ohio Revised Code.

Pharmacist (PHAR) means an individual who holds a current, valid license from the Ohio board of pharmacy according to Chapter 4729, of the Ohio Revised Code. Requires a graduate degree in pharmacy.

Physician assistant (PA) means an individual who is registered with the state of Ohio medical board as a physician assistant under Chapter 4730. of the Ohio Revised Code to provide services under the supervision and direction of a licensed physician or a group of physicians who are responsible for his or her performance.

Professional clinical counselor (PCC) means an individual who holds a current, valid license issued by the state of Ohio, counselor, social worker and marriage and family therapist board, as a professional clinical counselor according to Chapter 4757. of the Ohio Revised Code. Requires a Master's degree.

Professional counselor (PC) means an individual who holds a current, valid license issued by the state of Ohio, counselor, social worker and marriage and family therapist board, as a professional counselor according to Chapter 4757. of the Ohio Revised Code. Requires a Bachelor or Master's degree.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Psychologist (PSY) means an individual who holds a current valid license from the state board of psychology, issued under Chapter 4732. of the Ohio Revised Code and who, in addition, meets either of the criteria as set forth in divisions (I)(1) and (I)(2) of section 5122.01 of the Ohio Revised Code. Division (I)(2) of section 5122.01 of the Ohio Revised Code requires a doctoral degree and a minimum of two years of full time professional experience which meets those required for licensure by the state board of psychology. Division (I)(1) of section 5122.01 of the Ohio Revised Code requires a Master's degree in psychology and at least four years of psychological work as deemed satisfactory by the state board of psychology.

Psychology assistant (Psy Asst) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Requires a Master's degree in psychology. Must be supervised by a psychologist.

Assistant (Assistant) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Requires a Master's degree in a related field such as sociology, criminal justice, or human development and family science. Must be supervised by a psychologist.

Psychology aide (Psy Aide) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Requires a Bachelor degree in psychology. Must be supervised by a psychologist.

Aide (Aide) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Requires a Bachelor degree in a related field such as sociology, criminal justice or early childhood development and education. Must be supervised by a psychologist.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Psychology intern (PI) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Enrolled in a graduate degree program, or has completed a Master's or Doctorate degree. Must be supervised by a psychologist. A psychology intern is an individual in a formal internship as part of the education and training required to earn a doctoral degree that will serve as the degree required for independent licensure as a psychologist in the state of Ohio. This internship is an off-site, year-long, intensive training experience that is required for the doctoral degree to be granted. There is a minimum of 4 years doctoral program education, training and experience.

Psychology fellow (PF) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Enrolled in a graduate degree program, or has complete a Master's or Doctorate degree. Must be supervised by a psychologist. A psychology fellow is a post-doctoral trainee or individual in an internship as part of the education and training required to earn a doctoral degree that will serve as the degree required for independent licensure as a psychologist in the state of Ohio. There is a minimum of 4 years of doctoral program education, training and experience.

Psychology postdoctoral trainee (PPT) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Requires a Doctorate degree. Must be supervised by a psychologist. A psychology postdoctoral trainee is an individual who has completed the qualifying doctoral degree and is registered with the board to accrue the 1,800 post-doctoral hours under the close supervision of one or more psychologists.

Psychology resident (PR) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Enrolled in a graduate degree program, or has completed a Master's or Doctorate degree. Must be supervised by a psychologist. A psychology resident is an individual providing services at an internship or post-doctoral level. The title is used interchangeably with either psychology intern or psychology fellow and offered as an alternative job title/registration if needed to align with other internal agency job titles or needs. There is a minimum of 4 years of doctoral program education, training and experience.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Psychology trainee (PT) means an individual who is registered with the state board of psychology according to Chapter 4732. of the Ohio Administrative Code. Enrolled in a graduate degree program, or has completed a Master's degree. Must be supervised by a psychologist. A psychology trainee is a doctoral student at the pre-internship level, receiving supervision of provision of clinical services only, e.g., behavioral health therapy and counseling, mental health assessment, etc.

Qualified Mental Health Specialist (QMWS) means an individual who has received training for or education in mental health competencies and who has demonstrated, prior to or within ninety days of hire, competencies in basic mental health skills along with competencies established by the agency, and who is not otherwise designated as a provider or supervisor, and who is not required to perform duties covered under the scope of practice according to Ohio professional licensure. Basic mental health competencies for each QMHS shall include, at a minimum, an understanding of mental illness, psychiatric symptoms, and impact on functioning and behavior; how to therapeutically engage a mentally ill person; concepts of recovery/resiliency; crisis response procedures; an understanding of the community mental health system; de-escalation techniques and understanding how his/her behavior can impact the behavior of individuals with mental illness. The agency shall establish additional competency requirements, as appropriate, for each QMHS based upon the mental health services and activities to be performed, characteristics and needs of the persons to be served, and skills appropriate to the position.

The QMHS is eligible to provide partial hospitalization, crisis intervention, or CPST services, and must meet specific competencies required to provide these specific services. A QMHS must be supervised by a practitioner eligible to supervise the specific service being rendered. Alternative job titles assigned by agencies that employ QMHSs may include CPST worker, community support program worker, recovery specialist, or recovery support specialist.

Registered nurse (RN) means an individual who holds a current, valid license as a registered nurse from the Ohio board of nursing according to Chapter 4723. of the Ohio Revised Code. Associate degree or Bachelor degree.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Social worker (SW) means an individual who holds a current valid license as a social worker, issued by the state of Ohio, counselor, social worker and marriage and family therapist board, according to Chapter 4755. of the Ohio Revised Code. Bachelor or Master's degree.

Social worker assistant (SWA) means an individual who holds a current, valid license as a social worker assistant, issued by the state of Ohio, counselor, social worker and marriage and family therapist board, according to Chapter 4757. of the Ohio Revised Code. Associate or Bachelor degree.

Social worker trainee (SWT) means an individual who is a graduate student seeking licensure as a social worker or an independent social worker who is currently enrolled in a practicum, internship, or field work course in a social work education program accredited by the "counsel on social work education (CSWE)" and is registered as a social worker trainee with the state of Ohio, counselor, social worker and marriage and family therapist board according to Chapter 4757. of the Ohio Administrative Code. Must be supervised by a licensed independent social worker.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

1.(a) MENTAL HEALTH SERVICES DELIVERED THROUGH A
MEDICAID SCHOOL PROGRAM PROVIDER

Counseling, social work and psychology/school psychology services described here are available when provided through a Medicaid school program provider when the service is recommended by a licensed counselor, social worker, or psychologist/school psychologist acting within the scope of his or her practice as defined in Ohio law. These services will be provided in compliance with 42 CFR 440.130. Counseling, social work and psychology/school psychology (mental health) services are also available through the community mental health system.

In order to be reimbursed for the provision of counseling, social work and psychology/school psychology services provided through a Medicaid school program provider the service must be documented in a child's individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA) prior to the provision of the service. Services may include, but are not limited to behavioral health counseling and therapy, mental health assessment, interactive psychotherapy, individual psychotherapy and family therapy when services are provided to or for the Medicaid eligible child to maximize the reduction of a mental disability and to restore the child to his best possible functional level. Services may also include the initial assessment conducted by a licensed counselor, psychologist/school psychologist or social worker as a part of the multi-factored evaluation team and for subsequent assessments and reviews conducted in accordance with IDEA.

Qualified practitioner who can deliver the services:

Licensed clinical counselor who holds a current, valid license to practice issued under Ohio Revised Code, and who holds a graduate degree in counseling from an accredited educational institution, completes a minimum of ninety quarter hours of graduate credit in counselor training, and has had 2 years post-graduate or 1 year post-doctorate supervised experience in counseling.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

1.(a) MENTAL HEALTH SERVICES DELIVERED THROUGH A
MEDICAID SCHOOL PROGRAM PROVIDER

Licensed counselor who holds a current, valid license to practice issued under Ohio Revised Code, and who holds a graduate degree in counseling from an accredited educational institution and complete a minimum of ninety quarter hours of in-graduate or post-graduate credit in counselor training.

Licensed independent social worker who holds a current, valid license to practice issued under Ohio Revised Code, and who holds a master or doctorate degree in social work from an accredited educational institution and complete at least two years of post-master's degree social work experience supervised by an independent social worker.

Licensed social worker who holds a current, valid license to practice issued under Ohio Revised Code, and who holds from an accredited educational institution either a baccalaureate degree in social work, a baccalaureate degree in a program closely related to social work (prior to October 10, 1992 and approved by the committee), a master of social work degree, or a doctorate in social work.

Licensed psychologist who holds a current, valid license to practice psychology issued under Ohio Revised Code, who has received from an educational institution accredited or recognized by national or regional accrediting agencies as maintaining satisfactory standards an earned doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology (the board), and has had at least two years of supervised professional experience in psychological work of a type satisfactory to the board, at least one year of which must be postdoctoral.

Licensed school psychologist who holds a current, valid license to practice school psychology issued under Ohio Revised Code, who has received from an educational institution accredited or recognized by

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

**1.(a) MENTAL HEALTH SERVICES DELIVERED THROUGH A
MEDICAID SCHOOL PROGRAM PROVIDER**

national or regional accrediting agencies as maintaining satisfactory standards, including those approved by the state board of education for the training of school psychologists, at least a master's degree in school psychology, or a degree considered equivalent by the board; has completed at least sixty quarter hours, or the semester hours equivalent, at the graduate level, of accredited study in course work relevant to the study of school psychology.

Coverage of counseling and psychology/school psychology services provided by a licensed counselor, psychologist/school psychologist or social worker must meet conditions of medical necessity established by the department.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

2. Rehabilitative services provided by alcohol and other drug treatment programs

The following alcohol and other drug treatment services provided in accordance with 42 CFR 440.130(d), Ohio Administrative Code rules governing coverage and reimbursement under the Medicaid program and the certification requirements of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) under the Ohio Administrative Code are covered as optional rehabilitative services.

Covered alcohol and other drug treatment services do not include services provided to individuals aged 21 – 65 who reside in facilities that meet the Federal definition of an institution for mental disease.

Covered alcohol and other drug treatment services only include services that are rendered by or are rendered under the lawful direction of providers who meet the applicable Federal and/or State definition of a qualified Medicaid provider.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Ambulatory Detoxification

Service Description:

Ambulatory Detoxification as defined in paragraph (X) of rule 3793:2-1-08 of the Administrative Code. Ambulatory Detoxification services means face-to-face interactions with an individual who is suffering mild to moderate symptoms of withdrawal, for the purpose of alcohol and/or drug detoxification. This service shall be directed by a physician, under a defined set of policies and procedures, who is licensed by the state of Ohio medical board.

Eligible Providers:

The following individuals are eligible to provide ambulatory detoxification: a physician, a clinical nurse specialist, a certified nurse practitioner or a registered nurse. A licensed practical nurse is eligible to provide ambulatory detoxification only while under supervision and at the direction of a physician or a registered nurse.

Ambulatory detoxification is measured and reported on a one day unit basis and, therefore, there are no fractions of this unit.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Assessment

Service Description:

Assessment as defined in paragraph (K) of rule 3793:2-1-08 of the Ohio Administrative Code. Assessment service means the evaluation of an individual to determine the nature and extent of his/her abuse, misuse and/or addiction to alcohol and/or other drugs. Assessment services shall consist of time limited, structured, face-to-face sessions.

- (1) Face-to-face assessment sessions can include family members, legal guardians and/or significant others when the intended outcome of sessions is to ascertain the nature and extent of a client's alcohol and/or drug problem.
- (2) Assessment services may be provided at an alcohol and drug addiction program site certified by the Ohio Department of Alcohol and Drug Addiction Services or in the natural environment of the client being served.
- (3) Assessment includes at a minimum, the following information:
 - (a) Presenting problem(s) and/or precipitating factors leading to the need for an assessment;
 - (b) History of alcohol and other drug use by client and family members and/or significant others;
 - (c) Current over-the-counter and prescription medications being used;
 - (d) History of treatment for alcohol and other drug abuse;
 - (e) Medical history;
 - (f) Allergies to include food and drug reactions;
 - (g) Employment history;
 - (h) Educational history;
 - (i) Legal history to include pending charges and parole/probation status;
 - (j) Mental status screen including but not limited to, appearance, attitude, motor activity, affect, mood, speech and thought content;

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

- (k) Psychiatric history;
- (l) Family history;
- (m) Sexual history;
- (n) Religion/spiritual orientation;
- (o) Strengths/assets;
- (p) Weaknesses/limitations;
- (q) Degree of severity for the following dimensions: intoxication and withdrawal potential, biomedical conditions and complications, emotional/behavioral/cognitive conditions and complications, treatment acceptance/resistance, relapse potential, recovery environment and family or care giver functioning (youth only);
- (r) Recommendations for treatment.

Eligible Providers:

The following individuals are eligible to provide, including diagnosing, all components of assessment and may supervise other providers of assessment: physician, clinical nurse specialist, certified nurse practitioner, psychologist, professional clinical counselor, licensed independent social worker, licensed independent marriage and family therapist or a licensed independent chemical dependency counselor.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

The following individuals are eligible to provide all components of assessment, including diagnosing, while under supervision: licensed marriage and family therapist, professional counselor, licensed social worker, counselor trainee, or a licensed chemical dependency counselor III.

Eligible Providers:

The following individuals are eligible to provide all components of assessment, excluding diagnosing, while under supervision: licensed practical nurse, chemical dependency counselor assistant, licensed chemical dependency counselor II, psychology assistant, social work assistant, licensed school psychologist, certified school psychologist and students enrolled in an accredited educational institution in Ohio and performing an internship or field placement.

Assessment is measured and reported on a one hour unit basis. Fractions of this unit are allowed in six minute increments represented by tenths.

Crisis Intervention

Service Description:

Crisis intervention as defined in paragraph (L) of rule 3793:2-1-08 of the Ohio Administrative Code. A crisis intervention service is a face-to-face interaction with a client that is in response to a crisis or emergency situation experienced by the client, a family member and/or significant other. Crisis intervention begins with an evaluation of what happened during the crisis and the individual's response or responses to it. An individual's reaction to a crisis can include emotional reactions (such as fear, anger, guilt, anxiety, grief), mental reactions (such as difficulty concentrating, confusion, nightmares), physical reactions (such as headaches, dizziness, fatigue, stomach problems), and behavioral reactions (sleep and appetite problems, isolation, restlessness). Information about the individual's strengths, coping skills, and social support networks is also obtained.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

- (1) Crisis intervention services can be provided at a program site certified by the Ohio Department of Alcohol and Drug Addiction Services or in the client's natural environment.
- (a) Individuals who have unstable medical problems shall be referred to a medical facility.
- (b) Individuals who have unstable psychiatric problems shall be referred to a psychiatric facility.
- (c) Individuals who are experiencing withdrawal symptoms from use of alcohol and/or other drugs shall be referred to a person and/or entity that can provide the appropriate level of detoxification services.
- (2) Individual service providers of crisis intervention services shall have current training and/or certification, with documentation of same in their personnel files, in the following:
- (a) Cardio-pulmonary resuscitation techniques
- (b) First aid
- (c) De-escalation techniques

Eligible Providers:

The following individuals who also have current training and/or certification, with documentation of same in their personnel files, in Cardio-pulmonary resuscitation techniques, First aid, and De-escalation techniques are eligible to provide all components of crisis intervention and may supervise other providers of crisis intervention: physician, clinical nurse specialist, registered nurse, certified nurse practitioner, psychologist, professional clinical counselor, licensed independent social worker, licensed independent marriage and family therapist, licensed independent chemical dependency counselor and licensed chemical dependency counselor III.

The following individuals who also have current training and/or certification, with documentation of same in their personnel files, in Cardio-pulmonary resuscitation techniques, First aid, and De-escalation techniques are eligible to provide all components of crisis intervention while under supervision: licensed practical nurse, chemical dependency counselor assistant, licensed chemical dependency counselor II, psychology assistant, professional counselor, licensed social worker, social work

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

assistant, counselor trainee, licensed marriage and family therapist, licensed school psychologist, certified school psychologist and students enrolled in an accredited educational institution in Ohio and performing an internship or field placement.

Crisis intervention is measured and reported on a one hour unit basis. Fractions of this unit are allowed in six minute increments represented by tenths.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Group Counseling

Service Description:

Group counseling as defined in paragraph (O) of rule 3793:2-1-08 of the Ohio Administrative Code. Group counseling means the utilization of special skills to assist two or more individuals in achieving treatment objectives. This occurs through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making and/or discussing information related to alcohol and other drug related problems. Group counseling services shall be provided at a program site certified by the Ohio Department of Alcohol and Drug Addiction Services or in the client's natural environment. The client to counselor ratio for group counseling shall not be greater than 12:1. Group counseling shall be documented per paragraphs (M) and (N) of rule 3793:2-1-06 of the Administrative Code. Group sessions, which focus on helping individuals increase awareness and knowledge of the nature, extent and harm of their alcohol and drug addiction do not have a client to counselor ratio requirement. Such group sessions can consist of lecture, viewing a video or a structured discussion session and shall be documented per paragraph (O)(1) of rule 3793:2-1-06 of the Administrative Code.

Eligible Providers:

The following individuals are eligible to provide group counseling and may supervise other providers of group counseling: physician, clinical nurse specialist, registered nurse, certified nurse practitioner, psychologist, professional clinical counselor, licensed independent social worker, licensed independent marriage and family therapist, licensed independent chemical dependency counselor and licensed chemical dependency counselor III.

The following individuals are eligible to provide group counseling while under supervision: licensed practical nurse, chemical dependency counselor assistant, licensed chemical dependency counselor II, psychology assistant, professional counselor, licensed social worker, counselor trainee, licensed marriage and family therapist, licensed school psychologist, certified school psychologist and students enrolled in an accredited educational institution in Ohio and performing an internship or field placement.

Group counseling is measured and reported on a fifteen minute unit basis and, therefore, fractions of this unit are not allowed.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Individual Counseling

Service Description:

Individual counseling is provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.

Individual counseling as defined in paragraph (N) of rule 3793:2-1-08 of the Ohio Administrative Code. Individual counseling involves a face-to-face encounter between a client or client and family member and a counselor. Individual counseling means the utilization of special skills to assist an individual in achieving treatment objectives through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making and/or discussing didactic materials with regard to alcohol and other drug related problems. Individual counseling services can be provided at a program site certified by the Ohio Department of Alcohol and Drug Addiction Services or in the client's natural environment.

Eligible Providers:

The following individuals are eligible to provide individual counseling and may supervise other providers of individual counseling: physician, clinical nurse specialist, registered nurse, certified nurse practitioner, psychologist, professional clinical counselor, licensed independent social worker, licensed independent marriage and family therapist, licensed independent chemical dependency counselor and licensed chemical dependency counselor III.

The following individuals are eligible to provide individual counseling while under supervision: licensed practical nurse, chemical dependency counselor assistant, licensed chemical dependency counselor II, psychology assistant, professional counselor, licensed social worker, counselor trainee, licensed marriage and family therapist, licensed school psychologist, certified school psychologist and students enrolled in an accredited educational institution in Ohio and performing an internship or field placement.

Individual counseling is measured and reported on a fifteen minute unit basis and, therefore, fractions of this unit are not allowed.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Intensive Outpatient

Service Description:

Intensive outpatient as defined in paragraph (Q) of rule 3793:2-1-08 of the Ohio Administrative Code. Intensive outpatient service means structured individual and group alcohol and drug addiction activities and services that are provided at a certified treatment program site for a minimum of eight hours per week with services provided at least three days per week.

- (1) Intensive outpatient services shall be provided at a treatment program site certified by the department of alcohol and drug addiction services.
- (2) Intensive outpatient services shall include the following services:
- (a) Assessment.
 - (b) Individual counseling.
 - (c) Group counseling.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

(d) Crisis intervention as needed.

- (3) Group counseling shall be provided each day intensive outpatient services are offered.

Eligible Providers:

The following individuals are eligible to provide all components of intensive outpatient and may supervise other providers of components of intensive outpatient: physician, clinical nurse specialist, registered nurse, certified nurse practitioner, psychologist, professional clinical counselor, licensed independent social worker, licensed independent marriage and family therapist, licensed independent chemical dependency counselor and licensed chemical dependency counselor III.

The following individuals are eligible to provide all components of intensive outpatient while under supervision: licensed practical nurse, chemical dependency counselor assistant, licensed chemical dependency counselor II, psychology assistant, professional counselor, licensed social worker, counselor trainee, licensed marriage and family therapist, licensed school psychologist, certified school psychologist and students enrolled in an accredited educational institution in Ohio and performing an internship or field placement.

The following individual may provide all components of intensive outpatient, excluding individual and group counseling, while under supervision: social work assistant.

Intensive outpatient is measured and reported on a one day unit and, therefore, fractions of this unit are not allowed.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Laboratory Urinalysis

Service Description:

Laboratory urinalysis as defined in paragraph (R)(1) of rule 3793:2-1-08 of the Ohio Administrative Code. Laboratory urinalysis means the testing of an individual's urine specimen to detect the presence of alcohol and other drugs.

Laboratory testing procedures include:

- (a) Urine specimens for urinalysis/lab analysis can be collected at a program site certified by the Ohio department of alcohol and drug addiction services, in the client's natural environment or at a laboratory.
- (b) Programs that perform urinalysis/lab analysis shall have a standing physician's, clinical nurse specialist's or certified nurse practitioner's order for each client needing this service.
- (c) Programs that perform urinalysis/lab analysis shall have a written procedure for a chain of custody of urine specimens.
- (d) Urine specimens shall be collected in a manner to minimize falsification.
- (e) Containers for urine specimens shall be labeled to reflect:
 - (i) The identification of the person from whom the specimen was obtained.
 - (ii) Date that the specimen was obtained.
- (f) Urinalysis/lab analysis shall be performed by a laboratory that is in compliance with all applicable federal proficiency testing and licensing standards.
- (g) Results of urinalysis/lab analysis testing shall be reviewed by the program staff and a copy of the results placed in the client's file. Positive results shall be shared with the client.

Eligible Providers:

The following individuals are eligible to order and request laboratory urinalysis: physician, clinical nurse specialist or certified nurse practitioner.

The following individuals are eligible to request laboratory urinalysis once an order has been issued: registered nurse, licensed practical nurse, psychologist, psychology

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

assistant, professional clinical counselor, professional counselor, licensed independent social worker, licensed social worker, social work assistant, counselor trainee, licensed independent marriage and family therapist, licensed marriage and family therapist, licensed independent chemical dependency counselor, chemical dependency counselor assistant, licensed chemical dependency counselor II, licensed chemical dependency counselor III, licensed school psychologist, certified school psychologist or students enrolled in an accredited educational institution in Ohio and performing an internship or field placement.

Laboratory urinalysis is measured and reported on a per screen unit, regardless of the number of panels, and, therefore, there are no fractions of this unit.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services, continued.

Medical/Somatic

Service Description:

Medical/Somatic as defined in paragraph (S) of rule 3793:2-1-08 of the Ohio Administrative Code. Medical/somatic services mean medical services, medication administration services, medication assisted treatment, and the dispensing of medications in an alcohol and other drug treatment program.

- (1) Medical/somatic services shall be delivered at a program site certified by the Ohio department of alcohol and drug addiction services.
- (2) Medical services means those activities performed by a physician, registered nurse or licensed practical nurse to address the physical needs of clients. Medical services include, but are not limited to: health care examinations, health assessments, taking vital signs and reviewing laboratory findings.
 - (a) Medical services shall be delivered by staff who are credentialed by the Ohio board of nursing or by the Ohio state medical board.
 - (b) Providers of medical services shall be supervised by a registered nurse who is registered with the Ohio nursing board or by a physician who is licensed by the Ohio state medical board.
- (3) Medication administration services means the administration or dispensing of medications to clients. This service does not include detoxification, rehabilitation, opioid agonist administration or urinalysis. Only physicians and pharmacists are authorized to dispense medications.
- (4) Medication assisted treatment means the services of a medical professional directly related to the use of medications to provide a whole patient approach to the treatment of substance abuse disorders. This includes, but is not limited to, services associated with prescribing medications, the direct administration of medications and follow-up monitoring of patient health related to the use of medications. Medications utilized must be approved by the U.S. food and drug administration specifically for the treatment of alcohol and/or drug abuse or dependence. Medication assisted treatment does not include the services opioid agonist administration or ambulatory detoxification as defined in Ohio Administrative Code rule 3793: 2-1-08. Medication assisted treatment

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services, continued.

shall be administered in the following manner:

- (a) At an outpatient or residential program certified by the department of alcohol and drug addiction services or in the natural environment of the client.
- (b) By a physician who is licensed by the state of Ohio medical board and is in compliance with any applicable waiver requirement related to the Drug Addiction Treatment Act (DATA) of 2000. The physician is the only medical professional who may provide medication assisted treatment in the natural environment of the client.
- (c) Services of a non physician medical professional must be directed by the treating physician and shall be considered a component of the medication assisted treatment service.
- (d) The treating physician must be immediately available to assist the non-physician.
- (e) Comply with all state and federal laws and regulations related to the administration, dispensing and prescribing of medication assisted treatment.

Eligible Providers:

The following individual is eligible to provide all components of medical/somatic and may supervise other providers of medical/somatic: a physician.

The following individuals are eligible to provide all components of medical/somatic and may supervise other providers of medical/somatic, except for providers of medication assisted treatment: a clinical nurse specialist, a certified nurse practitioner or a registered nurse.

A licensed practical nurse may provide all components of medical/somatic at the direction of and while under supervision by a physician, a clinical nurse specialist, a certified nurse practitioner or a registered nurse.

Medical/somatic is measured and reported on a one hour unit basis. Fractions of this unit are allowed in six minute increments represented by tenths.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Opioid Agonist Administration

Service Description:

Opioid Agonist Administration as defined in paragraph (T) of rule 3793:2-1-08 of the Ohio Administrative Code. Opioid agonist administration means the administration or dispensing of opioid agonist to an individual only for the treatment of narcotic addiction by an alcohol and other drug treatment program licensed by the Ohio Department of Alcohol and Drug Addiction Services as an opioid agonist program in accordance with section 3793.11 of the Revised Code. Opioid agonist shall be administered and/or dispensed at a program site which is certified as a treatment program by the Ohio Department of Alcohol and Drug Addiction Services and is approved by the U.S. Food and Drug Administration for the use of opioid agonist in the treatment of narcotic addiction.

Eligible Providers:

The following individuals are eligible to provide opioid agonist administration: a physician, a certified nurse practitioner, a clinical nurse specialist, a registered nurse or a licensed practical nurse who has proof of completion of a course in medication administration approved by the Ohio Board of Nursing. Opioid agonist administration is measured and reported on a per dose unit and, therefore, there are no fractions of this unit.

Limitations

The following services are limited to 30 cumulative hours when provided to the same person per week, Sunday through Saturday:

- (1) Group Counseling,
- (2) Individual Counseling, and
- (3) Medical/Somatic.

Beneficiaries younger than age twenty-one can access community alcohol and drug treatment services beyond established limits when medically necessary.

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Supersedes:
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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Summary of Provider Qualifications applicable to Community Alcohol and Other Treatment

Please Note: In the following paragraphs, the term "registered with the state of Ohio" means an individual known to the state professional and/or licensing boards as a practitioner who has met the applicable professional requirements.

A physician as defined in Chapter 4731. of the Ohio Revised Code and who is licensed by the state of Ohio Medical board and has demonstrated experience and/or training in substance use disorder treatment.

A clinical nurse specialist or certified nurse practitioner as defined in Chapter 4723. of the Ohio Revised Code and who is licensed and certified by the state of Ohio nursing board and has demonstrated experience and/or training in substance use disorder treatment. A clinical nurse specialist is required to have a Master's degree.

A psychologist as defined in Chapter 4732. of the Ohio Revised Code and who is licensed by the state of Ohio board of psychology and has demonstrated competence in substance use disorder treatment. A psychologist is required to have a doctoral degree or its equivalent.

A psychology assistant who is practicing under the supervision of a psychologist licensed by the state of Ohio board of psychology and has demonstrated competence in substance use disorder treatment.

A professional clinical counselor licensed by the state of Ohio counselor, social worker, and marriage & family therapist board in accordance with Chapter 4757. of the Ohio Revised Code and whose professional disclosure statement includes substance abuse assessment and counseling. A professional clinical counselor is required to have a Master's degree.

A professional counselor licensed by the state of Ohio counselor, social worker, and marriage & family therapist board in accordance with Chapter 4757. of the Ohio Revised Code and whose professional disclosure statement includes substance abuse assessment and counseling. A professional counselor is required to have a Bachelor's or Master's degree.

A licensed independent social worker licensed by the state of Ohio counselor, social worker, and marriage & family therapist board in accordance with Chapter 4757. of the Ohio Revised Code and whose professional disclosure statement includes substance

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

abuse assessment and counseling. A licensed independent social worker is required to have a Master's degree.

A licensed social worker licensed by the state of Ohio counselor, social worker, and marriage & family therapist board in accordance with Chapter 4757. of the Ohio Revised Code and whose professional disclosure statement includes substance abuse assessment and counseling. A licensed social worker is required to have a Bachelor's or Master's degree.

A licensed marriage and family therapist by the state of Ohio counselor, social worker and marriage & family therapist board in accordance with Chapter 4757. of the Ohio Revised Code and whose professional disclosure statement includes substance abuse assessment and counseling. A licensed marriage and family therapist is required to have a Master's degree.

A licensed independent marriage and family therapist licensed by the state of Ohio counselor, social worker, and marriage & family therapist board in accordance with Chapter 4757. of the Ohio Revised Code and whose professional disclosure statement includes substance abuse assessment and counseling. A licensed independent marriage and family therapist is required to have a Master's degree.

A chemical dependency counselor assistant certified by the Ohio chemical dependency professionals board in accordance with Chapter 4758. of the Ohio Revised Code and is under clinical supervision by either a Physician, a Psychologist, a Professional clinical counselor, a Licensed independent social worker, a Registered nurse, a Licensed independent chemical dependency counselor or a Licensed independent marriage and family therapist. A chemical dependency counselor assistant must have Forty (40) hours of approved education in chemical dependency counseling/clinical methods.

A licensed chemical dependency counselor II licensed by the Ohio chemical dependency professionals board in accordance with Chapter 4758. of the Ohio Revised Code and is under clinical supervision by either a Physician, a Psychologist, a Professional clinical counselor, a Licensed independent social worker, a Registered nurse, a Licensed independent chemical dependency counselor or a Licensed independent marriage and family therapist. A licensed chemical dependency counselor II must have Associate's degree in a behavioral science OR a Bachelor's degree in any field.

A licensed chemical dependency counselor III licensed by the Ohio chemical dependency professionals board in accordance with Chapter 4758, of the Ohio Revised

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

Code and is under clinical supervision by either a Physician, a Psychologist, a Professional clinical counselor, a Licensed independent social worker, a Registered nurse, a Licensed independent chemical dependency counselor or a Licensed independent marriage and family therapist. A licensed chemical dependency counselor III must have a minimum of a Bachelor's degree in a behavioral science.

A licensed independent chemical dependency counselor licensed by the Ohio chemical dependency professionals board in accordance with Chapter 4758. of the Ohio Revised Code. A licensed independent chemical dependency counselor must have a minimum of a Master's degree in a behavioral science.

A nurse registered with the Ohio board of nursing in accordance with Chapter 4723. of the Ohio Revised Code and has demonstrated experience and/or education in substance use disorder treatment. A registered nurse must have an Associate's or Bachelor's degree.

A licensed practical nurse licensed by the Ohio board of nursing in accordance with Chapter 4723. of the Revised Code to practice as a licensed practical nurse in Ohio and has demonstrated experience and/or education in substance use disorder treatment. A licensed practical nurse must have an Associate's or Bachelor's degree.

A school psychologist licensed to practice school psychology in accordance with Chapter 4732. of the Ohio Revised Code who has demonstrated competence in substance use disorder treatment. A licensed school psychologist must have either a Master's or Doctorate degree.

A school psychologist who is certified in accordance with division (M) of section 3319.22 of the Ohio Revised Code and has demonstrated competence in substance use disorder treatment.

A social work assistant who is registered with the state of Ohio counselor, social worker, and marriage and family therapist board in accordance with Chapter 4757. of the Ohio Revised Code, has demonstrated experience and/or education in substance use disorder treatment and is supervised by an individual who is qualified to supervise pursuant to rule 4757-21-01 of the Ohio Administrative Code and to be an alcohol and drug treatment services supervisor.

A counselor trainee who is registered with the state of Ohio counselor, social worker, and marriage and family therapist board in accordance with Chapter 4757. of the Ohio Revised Code and has demonstrated experience and/or education in substance use

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

disorder treatment and is supervised by an individual who is qualified to supervise pursuant to rule 4757-17-01 of the Ohio Administrative Code and to be an alcohol and drug treatment services supervisor.

Students enrolled in an accredited educational institution in Ohio performing an internship or field placement and are under appropriate clinical supervision either by a Physician, a Psychologist, a Professional clinical counselor, a Licensed independent social worker, a Registered nurse, a Licensed independent chemical dependency counselor or a Licensed independent marriage and family therapist. A student shall hold himself out to the public only by clearly indicating his student status and the profession in which he is being trained.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS

~~Rehabilitative services provided hereunder pursuant to the provisions of 42 CFR 440.130(d) are those services provided to Medicaid eligible individuals by nonprofit, public, or proprietary, free standing Habilitation Centers certified by the Department of Mental Retardation and Developmental Disabilities. The services must be primarily medical in nature and will include preventative, diagnostic, therapeutic, rehabilitative, palliative, or remedial services recommended by a physician, or other practitioner of the healing arts within the scope of his practice under state law.~~

~~Covered services are to be provided to individuals who require a coordinated plan of treatment, or who have been certified by the local education agency (LEA) as being in need of professional health services, including medical, remedial, and rehabilitative services to meet their needs and attain their highest possible functional level. Services are to be provided by Habilitation Centers, either directly or through arrangements, to eligible Medicaid recipients residing in their own homes or in supervised residential settings. The covered services are as follows:~~

~~Diagnosis/Assessment and Evaluation Services~~

~~Treatment Review and Interdisciplinary Treatment Planning~~

~~Physician and Nursing Services~~

~~Psychological Testing/Evaluation and Therapy Services~~

TN No. 05-008
SUPERSEDES
TN No. 03-024

APPROVAL DATE: AUG 2
EFFECTIVE DATE: 7/1/05

14. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS (Continued)

~~Counseling and Social Work Services~~

~~Occupational Therapy Services~~

~~Physical Therapy Services~~

~~Speech Therapy and Audiology Services~~

~~Nutrition Services~~

~~Transportation Services~~

~~Coverage for Targeted Case Management (TCM) and Service Coordination is not part of this state plan amendment.~~

~~Rehabilitation services provided by Habilitation Centers will no longer be available under the state plan effective July 1, 2005. The Community Alternative Funding System (CAFS), the program title and funding mechanism for this state plan option, will also be terminated effective July 1, 2005.~~

~~Recipients will be able to access medically necessary rehabilitative services from other provider types as defined in other sections of the state plan and as described in Ohio Administrative Code (OAC) rules. A table delineating how recipients can access such services (as of July 1, 2005) is provided below:~~

Service	Provider Types
Physical Therapy	Fee-for-Service Clinics, Physicians, Independent Physical Therapists, Home Health, Outpatient Hospital services.

Table continued on the following page

TN No. 05-008
SUPERSEDES
TN No. 03-024

APPROVAL DATE: AUG 2 2005
EFFECTIVE DATE: 7/1/05

15. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)**d. Rehabilitative services. (Continued)****4. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

Table continued from page 2 of 3:

<u>Service</u>	<u>Provider Types</u>
Occupational Therapy	Home Health, Outpatient Hospital services
Speech Therapy and Audiology	Fee-for-Service Clinic, Home Health, Outpatient Hospital services
Counseling/Social Work	Physician, Outpatient Hospital services
Psychology	Fee-for-Service Clinic, Community Mental Health Center/Clinic, Independent Practicing Psychologist (for individuals under 21 years of age), Outpatient Hospital services
Nursing	Physician, Clinics, Home Health
Transportation	Enhanced Medicaid transportation (EMT), Ambulette, Ambulance
Aggregated Services	Recipients residing in ICFs/MR will continue to be able to access active treatment services through the ICF/MR. Individuals enrolled in Home and Community Based Services (HCBS) waivers administered by the Ohio Department of MR/DD will continue to receive skills development and support services through the waiver program.

TN No. 05-008
SUPERSEDES
TN No. NewAPPROVAL DATE: AUG 2 2005
EFFECTIVE DATE: 7/1/05

14. Services for individuals 65 or older in institutions for mental diseases.

- a. COVERAGE FOR INDIVIDUALS 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES IS LIMITED TO INPATIENT PSYCHIATRIC SERVICES PROVIDED IN PSYCHIATRIC HOSPITALS AND CERTAIN ALCOHOL AND/OR DRUG ABUSE REHABILITATION HOSPITALS THAT ARE LICENSED BY THE STATE DEPARTMENT OF MENTAL HEALTH OR OPERATED UNDER THE STATE MENTAL HEALTH AUTHORITY.

THIRTY (30) DAY LIMITATION PER SPELL-OF-ILLNESS. A SPELL-OF-ILLNESS BEGINS ON THE DAY OF ADMISSION TO A HOSPITAL AND ENDS 60 DAYS AFTER DISCHARGE. DAYS IN EXCESS OF 30 OR ADDITIONAL HOSPITALIZATIONS BEFORE 60 DAYS HAVE PASSED SINCE A PRIOR HOSPITALIZATION CAN BE COVERED IF CERTIFIED BY A HOSPITAL UR COMMITTEE OR PSRO/PRO AS MEDICALLY NECESSARY. MEDICAL NECESSITY FOR ADMISSION AND CONTINUED STAY MUST BE APPROVED BY THE HOSPITAL UTILIZATION REVIEW COMMITTEE OR ITS DESIGNEE, OR BY A PSRO/PRO. ELECTIVE HOSPITAL ADMISSIONS ARE SUBJECT TO PREADMISSION CERTIFICATION UNLESS ELIGIBILITY IS NOT ESTABLISHED AT THE TIME OF ADMISSION. FOR HOSPITALS PAID ON A PROSPECTIVE BASIS, DAYS NOT APPROVED AS MEDICALLY NECESSARY ARE NOT RECOGNIZED IN DETERMINING WHETHER A CASE QUALIFIES FOR ADDITIONAL OUTLIER PAYMENTS.

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES IS DESCRIBED IN SECTION 4.19-A OF THE STATE PLAN.

EXCEPT FOR HOSPITALS THAT ARE APPROVED BY MEDICARE TO CHARGE PATIENTS A SINGLE RATE THAT COVERS HOSPITAL AND PHYSICIANS' SERVICES, MEDICAID DOES NOT COVER, AS AN INPATIENT SERVICE, THOSE PHYSICIANS' SERVICES FURNISHED TO INDIVIDUAL PATIENTS. IN DETERMINING WHETHER SERVICES ARE COVERED AS A PHYSICIAN SERVICE OR A HOSPITAL SERVICE, MEDICAID USES THE CRITERIA ADOPTED BY THE MEDICARE PROGRAM AS SET FORTH IN 42 CFR 405, SUBPARTS D AND E.

SUBSTITUTE PAGE

TN NO. 95-16
SUPERSEDES
TN NO. 90-38

APPROVAL DATE 5/7/96
EFFECTIVE DATE 6-1-95

14. Services for individuals 65 or older in institutions for mental diseases.

- b. Nursing facility services are provided in institutions meeting standards and licensed as a mental nursing home. Placement and continued placement are subject to UR and UR control measures.
- c. Intermediate care facility services are provided in certified intermediate care sections. Placement and continued placement are subject to UR and UR control measures.

SUBSTITUTE PAGE

TN NO. 95-16
SUPERSEDES
TN NO. 90-38

APPROVAL DATE

5/7/96

EFFECTIVE DATE 6-1-95

15. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

- a. REFERENCE SUPPLEMENT 2, RULE 5101:3-3-06.
- b. REFERENCE IN 4.19-D, RULE 5101:3-3-07.

SUBSTITUTE PAGE

TN No. 93-39
SUPERSEDES
TN No. 90-38

APPROVAL DATE 2-16-94
EFFECTIVE DATE 10-1-93

16. Inpatient psychiatric facility services for individuals under 22 years of age.

- a. COVERAGE FOR INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE IS LIMITED TO INPATIENT PSYCHIATRIC SERVICES PROVIDED IN PSYCHIATRIC HOSPITALS AND CERTAIN ALCOHOL AND/OR DRUG ABUSE REHABILITATION HOSPITALS THAT ARE LICENSED BY THE STATE DEPARTMENT OF MENTAL HEALTH OR OPERATED UNDER THE STATE MENTAL HEALTH AUTHORITY.

THIRTY (30) DAY LIMITATION PER SPELL-OF-ILLNESS. A SPELL-OF-ILLNESS BEGINS ON THE DAY OF ADMISSION TO A HOSPITAL AND ENDS 60 DAYS AFTER DISCHARGE. DAYS IN EXCESS OF 30 OR ADDITIONAL HOSPITALIZATIONS BEFORE 60 DAYS HAVE PASSED SINCE A PRIOR HOSPITALIZATION CAN BE COVERED IF CERTIFIED BY A HOSPITAL UR COMMITTEE OR PSRO/PRO AS MEDICALLY NECESSARY. MEDICAL NECESSITY FOR ADMISSION AND CONTINUED STAY MUST BE APPROVED BY THE HOSPITAL UTILIZATION REVIEW COMMITTEE OR ITS DESIGNEE, OR BY A PSRO/PRO. ELECTIVE HOSPITAL ADMISSIONS ARE SUBJECT TO PREADMISSION CERTIFICATION UNLESS ELIGIBILITY IS NOT ESTABLISHED AT THE TIME OF ADMISSION. FOR HOSPITALS PAID ON A PROSPECTIVE BASIS, DAYS NOT APPROVED AS MEDICALLY NECESSARY ARE NOT RECOGNIZED IN DETERMINING WHETHER A CASE QUALIFIES FOR ADDITIONAL OUTLIER PAYMENTS.

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES IS DESCRIBED IN SECTION 4.19-A OF THE STATE PLAN.

EXCEPT FOR HOSPITALS THAT ARE APPROVED BY MEDICARE TO CHARGE PATIENTS A SINGLE RATE THAT COVERS HOSPITAL AND PHYSICIANS' SERVICES, MEDICAID DOES NOT COVER, AS AN INPATIENT SERVICE, THOSE PHYSICIANS' SERVICES FURNISHED TO INDIVIDUAL PATIENTS. IN DETERMINING WHETHER SERVICES ARE COVERED AS A PHYSICIAN SERVICE OR A HOSPITAL SERVICE, MEDICAID USES THE CRITERIA ADOPTED BY THE MEDICARE PROGRAM AS SET FORTH IN 42 CFR 405, SUBPARTS D AND E.

SUBSTITUTE PAGE

TN NO. 95-16
SUPERSEDES
TN NO. NEW

APPROVAL DATE 5/7/96
EFFECTIVE DATE 6-1-95

17. Nurse-midwife services

In order to participate in the Ohio Medicaid program, a nurse-midwife must be certified by and registered with the Ohio State Medical Board. If the certified nurse-midwife chooses to bill independently for Medicaid services, he/she must also apply for, and be granted, provider status under Ohio Medicaid.

Ohio Medicaid will make payment for all covered services performed by a certified nurse-midwife which are concerned with the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally and gynecologically.

In addition to the general limitations applicable to all providers and the program limitations for obstetrical services, the following services are noncovered nurse midwifery services under the Ohio Medicaid program except when performed by the certified nurse-midwife in an emergency situation. The nature of the emergency must be documented in the remarks section of the invoice.

1. Delivery, breech version, face presentation
2. Use of forceps
3. Management of acute obstetric emergency

The department will reimburse certified nurse-midwives only for the services personally rendered by the nurse-midwife. For all occasions of service billed, documentation must exist of the billing nurse-midwife's involvement with the service rendered. A counter-signature, alone on the records, is not sufficient. A certified nurse-midwife shall not be reimbursed as an independent provider when the department is required to reimburse another provider for the same service.

TN No. 97-13 APPROVAL DATE 8/15/97
SUPERSEDES
TN No. 90-38 EFFECTIVE DATE 7/1/97

18. Hospice care (in accordance with section 1905(o) of the Act).

Hospice care is a benefit for Medicaid beneficiaries who have a terminal illness. Hospice care emphasizes the provision of palliative/supportive services in the beneficiary's home. It is also available to Medicaid beneficiaries who reside in nursing facilities or intermediate care facilities for the mentally retarded. Beneficiaries age twenty-one and over choose Hospice care in lieu of curative care for the terminal illness. Beneficiaries younger than age twenty-one can access Hospice care and concurrent curative treatment without limitation when medically necessary.

A "Hospice" is a public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals. A certified Medicare Hospice provider that meets the Medicare Conditions of Participation for Hospice care can become a provider of Medicaid Hospice care upon execution of the Medicaid provider agreement and approval by the Ohio Department of Job and Family Services (ODJFS).

A Medicaid beneficiary may elect the Hospice benefit if the attending physician and Hospice physician certify that the beneficiary has six months or less in which to live if the illness runs its normal course. The beneficiary age twenty-one and over or authorized representative must sign an election statement, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician. The beneficiary under age twenty-one or authorized representative must sign an election statement, and does not waive any rights to be provided with, or to have payment made for, services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made, in addition to the Hospice care. Election of the Hospice benefit shall be for the same enrollment periods as used for the Medicare Hospice benefit pursuant to Section 1812 (d)(1) of the Act. Beneficiaries dually eligible for Medicare/Medicaid must elect the Medicare and Medicaid Hospice benefits concurrently. Beneficiaries who have third-party coverage of the Hospice benefit must elect the third-party coverage Hospice benefit at the same time that the Medicaid Hospice benefit is elected.

A beneficiary may revoke the election of Hospice care at any time once an election period. Upon revocation, the beneficiary forfeits Hospice coverage for any remaining days in that election period. The beneficiary may elect to receive Hospice benefit for any additional period of eligibility.

Every beneficiary must have a written plan of care developed by the Hospice interdisciplinary team. All covered Hospice care must be consistent with the plan of care. All Hospices providing Hospice care to Medicaid beneficiaries must provide "core" services performed by Hospice employees. These "core" services include: nursing care, medical social services, counseling services including bereavement counseling for the family, and physician services.

18. Hospice care (in accordance with section 1905(o) of the Act), continued.

Other covered Hospice care ("non-core" services) includes:

- Short-term inpatient hospital and respite.
- Medical appliances, including drugs and biologicals.
- Home health aide and homemaker services.
- Physical therapy, occupational therapy, and speech-language pathology.

18. Hospice care (in accordance with section 1905(o) of the Act), continued.

- Transportation services, if needed in order for the beneficiary to receive medical care for the terminal condition.

Hospices may arrange for another individual or entity to furnish services to Medicaid beneficiaries receiving Hospice care. If services are provided under such an arrangement, the Hospice must assume fiscal and professional management responsibility for those services.

State of Ohio

Attachment 3.1-A
Item 19-a
Page 1 of 1

19. Case management services and tuberculosis related services.
 - a. Case management services as defined in, and to the group(s) specified in, Supplement 1 to Attachment 3.1-A (in accordance with Section 1905(a)(19) or Section 1915(g) of the Act).

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TN No. 90-38

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20. Extended services to pregnant women

Pregnant women are covered for all Ohio Medicaid services, without limitations, including the 60 days after pregnancy ends.

20-a. Additional Pregnancy-related and postpartum services for 60 days after the pregnancy ends, are provided if indicated by the pregnant woman's physician. These services include case management (see Supplement 1 to Attachment 3.1-A, page 1), extensive counseling and education, and nutritional counseling.

20-b. Additional services for any other medical conditions that may complicate pregnancy include nutritional intervention which may be provided if indicated by the pregnant woman's physician.

TNS # 90-38
SUPERSEDES
TNS # 88-04

APPROVAL DATE 10/12/90
EFFECTIVE DATE 2/1/90

23. Certified Pediatric and Family Nurse Practitioners' Services

Limitations to certified pediatric and family nurse practitioner services are the same as those listed for physician services and are found in Attachment 3.1-A, Item 5.

TN No. 97-15 APPROVAL DATE 8/15/97
SUPERSEDES
TN No. NEW EFFECTIVE DATE 7/1/97

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-a. Transportation

Transportation provided by nursing facilities for their recipient-residents, including NEMT, is included as a part of nursing facility services. Nursing facilities receive a per diem amount that includes payment for all transportation services and are responsible for ensuring that their recipient-residents obtain those transportation services. Such services are paid for by the nursing facilities and are not eligible for reimbursement on a fee-for-service basis. For dates of service beginning 08/18/2009 and ending 09/30/2009, however, transportation providers may submit claims directly on a fee-for-service basis for providing transportation services to nursing facility residents.

Recipients who are not residents of a nursing facility and who do not require ambulance services may request assistance through the local County Department of Job and Family Services (CDJFS) in securing transportation to or from Medicaid-coverable services. Assistance may be given if no other resources are readily available to a recipient. For each recipient who requests transportation assistance, the CDJFS must select the most cost-effective type of assistance that is appropriate to the recipient's medical condition and enables the recipient to access Medicaid-coverable services in a timely manner.

Appropriate ambulance services, including air ambulance services, are covered on a fee-for-service basis for any recipient who meets at least one of three criteria:

- (i) The individual requires continuous medical supervision or treatment during transport;
- (ii) The individual requires supervised protective restraint during transport; or
- (iii) The individual must remain supine or prone, can be moved only by stretcher, or cannot be safely transported in a seated position.

Appropriate wheelchair van services are covered on a fee-for-service basis for recipients who do not require ambulance services but who do require transport by wheelchair-accessible vehicle to or from Medicaid-coverable services.

Transportation provided on a fee-for-service basis and transportation assistance furnished through the CDJFS are subject to certain limitations:

- (i) The recipient must be Medicaid-eligible at the time of service.
- (ii) The medical service received by the consumer must be either reimbursable under Medicaid or ancillary to a Medicaid-reimbursable service. Hence, the entity furnishing the medical service must be a Medicaid provider.
- (iii) Fee-for-service trips to or from unusual locations require prior approval. For each type of transport, combinations of trip origin and destination that do not require prior approval are spelled out in the administrative rules or in published provider billing information.
- (iv) For each transport by wheelchair van and of each non-emergency transport by ground ambulance, the transportation provider must obtain certification by a licensed practitioner that the transport is necessary. Without such certification, the provider is not entitled to reimbursement.

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-b. Services Furnished in a Religious Nonmedical Health Care Institution

A religious nonmedical health care institution may participate as a long-term care facility in the Ohio Medicaid program if it is licensed as a nursing facility (NF) or intermediate care facility (ICF) and offers only NF or ICF services.

State of Ohio

Attachment 3.1-A

Item 24-c

Page 1 of 1

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-c. Affiliations

This item is not applicable.

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Supersedes

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SEP 23 2011

Effective Date: 8/1/09

State of Ohio

Attachment 3.1-A

Item 24-d

Page 1 of 1

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-d. Skilled Nursing Facility Services for Individuals Under Age 21

Covered services are the same as for individuals 21 years of age or older.
(See Attachment 3.1-A, Pre-Print Page 1, Item 4-a.)

Transmittal Number 09-010

Supersedes

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SEP 23 2011

Effective Date: 8/1/09

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-e. Emergency Hospital Services

These services are covered when they are necessary to prevent the death of the individual or serious impairment to the individual's health, even if the facility neither currently satisfies Title XVIII requirements for Medicare nor provides services that meet the definitions of inpatient or outpatient hospital services. Coverage applies to the period of emergency only.

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-f. Personal Care Services

This item is not applicable.

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-g. Critical Access Hospital (CAH) Services

This item is not applicable.

28. Licensed or otherwise state-approved freestanding birth centers (FBC) and licensed or otherwise state-recognized covered professionals providing services in the freestanding birth center.

Each FBC must be licensed as a FBC by the Ohio Department of Health or by the state licensing agency where the FBC is located if the FBC is located outside the state of Ohio. The State covers out of state FBC services in the instance that an Ohio Medicaid beneficiary is out of State and delivers at such a facility. Each FBC must have a valid, current Ohio Medicaid provider agreement and meet the standards provided in 42 U.S.C. 1396d(1)(3)(B) (effective March 23, 2010).

The following facility services are not covered:

- Maternity care and delivery services provided to women who are not “low-risk expectant mothers”
- Maternity care and delivery services not provided in accordance with the Ohio Department of Health.

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