

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 91-20 Approval Date 10-23-92 Effective Date 9-1-92

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.

*Description provided on attachment.

TN: 17-005

Supersedes:

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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

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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

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.

TM No. 85-41

Supersedes

TM No. 76-51

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. 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.

TN: 13-013
Supersedes:
TN: 95-16

Approval Date: 12/20/13
Effective Date: 01/01/2014

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.

TN: 17-010
Supersedes:
TN: 95-16

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Effective Date: 07/01/2017 01/01/2017

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: 17-010
Supersedes:
TN: 12-003

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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:

29. Integrated Care Models

- Provided: No limitations With limitations*
- Not provided.

*Description provided on attachment.

TN: 17-015
Supersedes:
TN: 12-004

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

Inpatient hospital services are provided pursuant to 42 CFR 440.10 and are those services provided to a patient during an inpatient stay in a hospital facility which meets Medicare conditions of participation as defined in 42 C.F.R. 482.

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.

Items and services that are not medically necessary or are provided in a medically unnecessary place of service are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; services of an experimental nature; and dental procedures which can be performed in the dentist's office or other nonhospital setting.

A limited number of services are covered under the Ohio Medicaid program upon the provider obtaining prior authorization from the Ohio Medicaid agency or its designee. Limits on number or duration of services are not placed on beneficiaries aged 21 and younger when medically necessary.

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.

2. a. Outpatient hospital services.

Outpatient services are provided pursuant to 42 CFR 440.20 and those professional services provided to a patient at a hospital facility which 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. Services included under this benefit also include urgent care and behavioral health services provided in outpatient provider-based settings.

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.

Items and services that are not medically necessary or are provided in a medically unnecessary place of service are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; services of an experimental nature; and dental procedures which can be performed in the dentist's office or other non-hospital setting.

A limited number of services are covered under the Ohio Medicaid program upon the provider obtaining prior authorization from the Ohio Medicaid agency or its designee. Limits on number or duration of services are not placed on beneficiaries aged 21 and younger when medically necessary.

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

An eligible provider of rural health clinic (RHC) services is an entity that meets the definition of an RHC set forth in 42 CFR 491.2 and has been certified as an RHC under Medicare.

The following RHC services are covered by the Ohio Department of Medicaid in accordance with Section 1861(aa)(1) of the Social Security Act:

1. Services that are rendered by a physician, physician assistant, or advanced practice registered nurse employed by or otherwise compensated by the RHC;
2. Mental or behavioral health services, including therapy and testing;
3. Services provided under supervision that would be covered if they were rendered by a physician or an advanced practice registered nurse; and
4. Visiting nurse services.

Services and supplies furnished as "incident to the professional services" by an RHC are also covered services.

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

An eligible provider of FQHC services is an entity that has been determined by the Federal Health Resources and Services Administration to meet all requirements under Section 330 of the Public Health Service Act (PHSA) and that has entered into an agreement with CMS to meet Medicare program requirements.

FQHC covered services under Medicaid are defined under Section 1905(l)(2) of the Social Security Act. FQHC services are listed in Section 1861(aa)(1)(A), (B) and (C) of the Act, and include drugs and biologicals referenced in 1861(s)(10)(A) and (B) of the Act.

The following FQHC services are covered by the Ohio Department of Medicaid in accordance with Section 1905(a)(2)(C) of the Social Security Act:

1. Medical services, which may comprise any of the following services or items:
 - a. All services referenced at 42 USC 1395x(aa)(3);
 - b. Professional services furnished by a physician, physician assistant, or advanced practice registered nurse, except for mental or behavioral health services provided by an advanced practice registered nurse;
 - c. Services and supplies incident to the professional services of a physician, physician assistant, advanced practice registered nurse, clinical social worker, or psychologist for which no separate payment is made;
 - d. Services of a registered nurse acting under the direct supervision of a physician unless provided incident to a professional service; or
 - e. Visiting nurse services,
2. Dental services,
3. Physical therapy services and occupational therapy services,
4. Mental health services,
5. Speech pathology and audiology services,
6. Podiatry services,
7. Vision services,
8. Chiropractic services, and
9. Transportation services.

Services and supplies furnished as "incident to the professional services" by an FQHC are also covered services.

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Supersedes

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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.

Laboratory services

A laboratory service is covered only if it meets the following 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.

A laboratory service is not covered if it meets either of the following two criteria:

1. It is incidental to, duplicative of, incompatible with, or unnecessary because of another covered health service; or
2. It is 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);

A laboratory service provided to an individual who has received another service that is experimental in nature or that is performed for purposes of research or clinical trial may be covered if it meets all of the following criteria:

1. The laboratory service is medically necessary;
2. The laboratory service is not itself experimental; and
3. The need for the laboratory service did not arise solely because the individual received an experimental service or participated in research or a clinical trial.

3. Other laboratory and x-ray services.

X-ray services

X-ray services determined by the department not to be medically necessary will not be covered.

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:

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.

A portable x-ray supplier participating in Medicaid must also meet Medicare conditions of participation as a supplier of portable x-ray services.

3. X-ray services provided by independent diagnostic testing facilities (IDTFs):

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

4. X-ray services provided by mammography suppliers:

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

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

Included in the nursing facility per diem rate is room and board, including a private room if medically necessary, such as the need for infection control. The services included and not included in the nursing facility per diem rate are specified in Section 001.4 of Attachment 4.19-D, Supplement 1.

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TN: 16-006

Approved JUN 24 2019

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

Pursuant to Section 1905(r) of the Social Security Act, the following services rendered to a Medicaid-eligible individual younger than 21 years of age are covered:

- Screening services;
- Vision services;
- Dental services;
- Hearing services;
- All medically necessary screenings, health care, diagnostic services, treatment, and other measures described in 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions, regardless of whether such measures are covered by the Ohio Medicaid program.

Early and periodic screening, diagnostic, and treatment (EPSDT) services are covered at the following frequencies:

- For all services, at intervals that meet reasonable standards of medical or dental practice in accordance with the American Academy of Pediatrics Bright Futures Guidelines for Preventive Health Care at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
- For immunizations, in accordance with the periodicity schedule applicable to pediatric vaccines established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention at <http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>;
- For dental services provided to individuals older than six and younger than twenty-one, at least once every one hundred eighty days; and
- For all services, at such other intervals indicated as medically necessary to determine the existence of a suspected illness or condition.

Necessary additional medical services rendered during, as part of, or as a result of a screening visit are covered.

Coverage limits that have been established may be exceeded with prior authorization.

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.

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TN: 16-001
Supersedes
TN: 10-013

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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:

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 agency not to be medically necessary will not be covered.

In certain circumstances, the State might use prior authorization to determine medical necessity.

Services furnished by an optometrist within an optometrist's scope of practice are considered to be physicians' services under this plan.

Optometrists' services furnished to a resident of a long-term care facility must be requested in writing by the resident or the resident's authorized representative.

Recipients younger than age twenty-one can access physicians' 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.

Podiatrists' services are covered by Ohio Medicaid in accordance with 42 CFR § 440.60.

Podiatrists' services are provided consistent with the scope of practice as defined under State law.

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

Limitations:

1. Coverage of debridement of nails is limited to a maximum of one treatment within a 60-day period.
2. General anesthesia services provided by a podiatrist are not covered.
3. Coverage of physical medicine services provided by a podiatrist is limited to acute conditions or periods or acute exacerbation of chronic disease.

Additional services in excess of limitations are available through prior authorization upon a demonstration of medical necessity.

Beneficiaries younger than age twenty-one can access other podiatrists' 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.
(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.

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TN: 05-028

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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.

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 42 CFR 410.21 and 440.60.

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.

Medically necessary acupuncture services rendered by chiropractors are covered by Ohio Medicaid in accordance with 42 CFR 440.60. A chiropractor must hold a current, valid certificate issued by the state chiropractic board to practice acupuncture. Acupuncture services rendered by a chiropractor must be provided consistent with a chiropractor's scope of practice as defined under Ohio law.

Services beyond the above-listed limits may be allowed when medically necessary and approved through the prior authorization process.

TN: 18-001

Supersedes

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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.

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 – 42 CFR 440.60

2. Non-Physician Licensed Behavioral Health Practitioners

A non-physician licensed behavioral health practitioner (NP-LBHP) is an individual who is licensed in the State of Ohio and operating within the scope of practice defined in State law and operating in any setting permissible under State practice law.

NP-LBHPs include individuals licensed and able to practice independently as:

- Licensed psychologists;
- Board-licensed school psychologists;
- Licensed professional clinical counselors (LPCCs);
- Licensed independent social workers (LISWs); and
- Licensed independent marriage and family therapists (LIMFTs).
- Licensed independent chemical dependency counselors (LICDCs)

NP-LBHPs also include the following professionals, licensed by a professional Board in the state of Ohio and authorized to practice under full or partial clinical supervision of a physician, licensed psychologist, advanced practice nurse or independent NP-LBHP as outlined in state law:

- Licensed professional counselors;
- Licensed chemical dependency counselors III;
- Licensed chemical dependency counselors II;
- Licensed social workers; and
- Licensed marriage and family therapists.

NP-LBHPs also include the following professionals who are in licensure Board-approved training and under the general or direct supervision of a psychologist authorized to do so under state law:

- Doctoral psychology trainees; and
- Board-registered psychology assistants.

NP-LBHPs also include the following professionals who are in licensure Board-approved training and under the general or direct supervision of a physician, licensed psychologist, advanced practice nurse or independent NP-LBHP authorized to do so under state law:

- Registered counselor trainees;
- Registered social work trainees; and
- Registered marriage and family therapist trainees.

NP-LBHPs also include the following professionals meeting training and education standards set by a professional Board in the state of Ohio and under the direct supervision of a physician, licensed psychologist, advanced practice nurse or independent NP-LBHP authorized to do so under state law:

- Chemical Dependency Counselor Assistant

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Supersedes:

TN: 16-004

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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 – 42 CFR 440.60

2. Non-Physician Licensed Behavioral Health Practitioners

Any NP-LBHP providing behavioral health services who is not licensed to practice independently (i.e., not a licensed psychologist, board-licensed school psychologist, LPCC, LISW, LIMFT, or LICDC) must operate within a provider agency licensed, certified or designated by ODM or its designee in settings permissible by that designation.

Limitations:

1. Psychological testing is limited to a maximum of twelve hours per twelve-month period per recipient in a non-hospital setting.
2. Neuropsychological testing is limited to a maximum of eight hours per twelve-month period per recipient in a non-hospital setting.
3. Diagnostic interview examinations will be limited to one code per recipient per 12-month period and may not be billed on the same date of services as a therapeutic visit.
4. Structured screening and brief intervention limited to one code per recipient per 12-month period.

Additional services beyond the established limits may be allowed when medically necessary and approved through the prior authorization process. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an on-going basis as determined by ODM.

Beneficiaries younger than age twenty-one can access non-physician licensed behavioral health practitioners' services without limitation when such services are medically necessary.

NP-LBHP services by any independent practitioner 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 NP-LBHP services, or, if the individual is covered under Medicare, Medicaid will continue to pay Medicare cost sharing for independent NP-LBHP services covered by Medicare.

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Approval Date: 1/19/18

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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 and the administration of drugs by injection 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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TN: 09-036

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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 licensed under Ohio law and provide services under the supervision, control, and direction of one or more physicians.

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.

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

(6) Licensed advanced practice registered nurses' (APRNs') services provided within their scope of practice under State law.

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 (Continued)

7. Dietitians' services

Dietitians' services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.130.

Registered dietitian nutritionists (RDNs) practicing in non-institutional settings and licensed dietitians (LDs) practicing in non-institutional settings may enroll in Medicaid as independent providers and submit claims for dietitians' services.

Coverage extends to the full scope of practice of RDNs or LDs, which consists of the following dietitians' services:

- Initial assessment and intervention
- Reassessment and intervention
- Group counseling

For services rendered by a dietitian who is employed by a hospital and is practicing in a hospital setting, payment of valid claims is made only to the hospital.

The licensure and scope of practice for dietitians is defined by Ohio law.

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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

(8) Anesthesiologist Assistants' services.

The services of an Anesthesiologist Assistant are covered by Ohio Medicaid in accordance with 42 CFR 440.60.

The services of an Anesthesiologist Assistant are provided consistent with the scope of practice as defined under State law. An Anesthesiologist Assistant requires the direct supervision of a supervising anesthesiologist, and must hold a current, valid certificate issued by the State Medical Board to practice as an Anesthesiologist Assistant.

Services determined by the agency not to be medically necessary will not be covered.

Recipients younger than age twenty-one can access the services of an Anesthesiologist Assistant without limitation when such services are medically necessary.

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Supersedes:

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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

(9) Acupuncturists

Medically necessary acupuncture services are covered by Ohio Medicaid in accordance with 42 CFR 440.60.

An acupuncturist must hold a current, valid acupuncturist license issued by the state medical board.

Acupuncture services rendered by an acupuncturist with an acupuncturist license must be provided consistent with an acupuncturist's scope of practice as defined under Ohio law.

Coverage of acupuncture services is limited to 30 acupuncture visits per benefit year. Additional acupuncture services in excess of this limitation are available through prior authorization upon a demonstration of medical necessity.

Recipients younger than age twenty-one can access the services of an acupuncturist with an acupuncturist license without limitation when such services are medically necessary.

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TN: New

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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.

Intermittent or part-time nursing services are available to any Medicaid beneficiary with a medical need for intermittent or part-time nursing services in the beneficiary's place of residence or in any setting in which normal life activities take place. The place of services does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Intermittent or part-time nursing services can only be provided by a Medicare Certified Home Health Agency. Such certification requires meeting all the requirements of Medicare Conditions of Participation. Such agencies must also be enrolled as an Ohio Medicaid provider.

Intermittent or part-time nursing services must be ordered by the qualifying treating physician, and included in a beneficiary's plan of care that is reviewed by that physician at least every 60 days. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in the state of Ohio.

Intermittent or part-time nursing services are covered only if the qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the beneficiary within the ninety days prior to the home health care start of care date, or within thirty days following the start of care date inclusive of the start of care date. A certified nurse practitioner, clinical nurse specialist, or certified nurse midwife, in collaboration with the qualifying treating physician, or a physician assistant under the supervision of the qualifying treating physician, may perform the face-to-face encounter for the purposes of the supervising physician certifying the need for home health services.

The face-to-face encounter with the beneficiary must occur independent of any provision of home health services to the beneficiary by the individual performing the face-to-face encounter. Only the qualifying treating physician may order these services, document the face-to-face encounter, and certify medical necessity.

Applicable limits are:

- No more than a combined total of eight hours per day of intermittent or part-time nursing services, home health aide services, and physical therapy, occupational therapy, or speech pathology and audiology services;
- No more than a combined total of 14 hours per week of intermittent or part-time nursing services and home health aide services, or as prior authorized by ODM or its designee;
- Visits shall not be more than four hours in length;

7. Home health services, continued.

- 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.
- An RN assessment cannot be concurrently performed with any other service during a visit in which the RN is furnishing home health services;
 - An RN assessment must be performed on an individual prior to the start of home health services for the first time, prior to any change of order to an individual's home health services, and/or any time the RN is informed that the individual receiving the home health services has experienced a significant change in his or her condition that warrants a new RN assessment;
 - An RN assessment may be performed no more than once every sixty days, unless a significant change warrants a subsequent RN assessment;
 - When an individual is enrolled on an ODM-administered waiver, RN assessment services must be prior-approved by ODM and be specified on the individual's service plan;
 - RN consultation services are not covered for consultations between RNs; and
 - RN consultations are not covered when performed with nursing delegation services under the Ohio Department of Developmental Disabilities (DODD) waiver.

An individual can also access intermittent or part-time nursing services and/or home health aide services upon discharge from a covered inpatient hospital stay when medically necessary.

Additional intermittent or part-time nursing services provided by a home health agency beyond the established limits may be allowed when medically necessary, and as prior authorized by ODM or its designee.

Beneficiaries younger than age twenty-one can access intermittent or part-time nursing services without limitation when medically necessary.

7. Home health services, continued.

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

Home health aide services are available to any Medicaid beneficiary with a medical need for home health aide services in the beneficiary's place of residence, licensed child day-care center, or, for a child three years and under, in a setting where the child receives early

intervention services as indicated in the individualized family service plan. The place of services does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities.

7. Home health services, continued.

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

Home health aide services can only be provided by a Medicare Certified Home Health Agency. Such certification requires meeting all the requirements of Medicare Conditions of Participation. Such agencies must also be enrolled as an Ohio Medicaid provider.

Home health aide services must be ordered by the qualifying treating physician, and included in a beneficiary's plan of care that is reviewed by that physician at least every 60 days. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in the state of Ohio.

Home health aide services are covered only if the qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the beneficiary within the ninety days prior to the home health care start of care date, or within thirty days following the start of care date inclusive of the start of care date. A certified nurse practitioner, clinical nurse specialist, or certified nurse midwife, in collaboration with the qualifying treating physician, or a physician assistant under the supervision of the qualifying treating physician, may perform the face-to-face encounter for the purposes of the supervising physician certifying the need for home health services.

The face-to-face encounter with the beneficiary must occur independent of any provision of home health services to the beneficiary by the individual performing the face-to-face encounter. Only the qualifying treating physician may order these services, document the face-to-face encounter, and certify medical necessity.

Applicable limits are:

- No more than a combined total of eight hours per day of intermittent or part-time nursing services, home health aide services, and physical therapy, occupational therapy, or speech pathology and audiology services;
- No more than a combined total of 14 hours per week of intermittent or part-time nursing services and home health aide services, or as prior authorized by ODM or its designee; and
- Visits shall not be more than four hours in length.

An individual can also access intermittent or part-time nursing services and/or home health aide services upon discharge from a covered inpatient hospital stay when medically necessary.

Additional home health aide services provided by a home health agency beyond the established limits may be allowed when medically necessary, and as prior authorized by ODM or its designee.

Beneficiaries younger than age twenty-one can access home health aide services without limitation when medically necessary.

Additional home health aide services provided by a home health agency beyond the established limits may be allowed when medically necessary.

Beneficiaries younger than age twenty-one can access home health aide services without limitation when medically necessary.

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7. Home health services, continued.

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

Medical supplies, equipment, and appliances must be medically necessary and provided in accordance with 42 CFR 440.70.

Before medical supplies, equipment, or appliances may be prescribed, a practitioner must document a face-to-face encounter with the Medicaid-eligible individual. With proper documentation, a single face-to-face encounter can serve as the basis for more than one prescription.

Prior authorization (PA) must be obtained before payment can be made for certain covered items or for quantities of certain items beyond established limits. Limitations can be found on the Ohio Department of Medicaid website at <https://medicaid.ohio.gov/>.

Beneficiaries younger than age twenty-one can access medical supplies, equipment, and appliances without limitation when such items are medically necessary.

7. Home health services, continued.

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

Physical therapy, occupational therapy, or speech-language pathology and audiology services are available to any Medicaid beneficiary with a medical need for physical therapy, occupational therapy, or speech-language pathology and audiology services in the beneficiary's place of residence, or in any setting in which normal life activities take place. The place of services does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Physical therapy, occupational therapy, or speech-language pathology and audiology services must be ordered by the qualifying treating physician, and included in a beneficiary's plan of care that is reviewed by that physician at least every 60 days.

Providers of these services under the home health benefit must meet the same requirements of providers of such services under the physical therapy and related benefit, described under Attachment 3.1-A, Item 11.

Physical therapy, occupational therapy, or speech-language pathology and audiology services can only be provided by a Medicare Certified Home Health Agency. Such certification requires meeting all the requirements of Medicare Conditions of Participation. Such agencies must also be enrolled as an Ohio Medicaid provider.

Applicable limits are:

- No more than a combined total of eight hours per day of intermittent or part-time nursing services, home health aide services, and physical therapy, occupational therapy, or speech-language pathology and audiology services; and
- Visits shall not be more than four hours in length.

There are no weekly limits for physical therapy, occupational therapy, or speech pathology and audiology services.

Additional physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility beyond the established limits may be allowed when medically necessary, and as prior authorized by ODM or its designee.

Beneficiaries younger than age twenty-one can access physical therapy, occupational therapy, or speech-language pathology and audiology services without limitation when medically necessary.

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 and is limited 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.

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 non-agency registered nurse; non-agency 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 required to be continuous nursing visits that are medically necessary and:

- More than 4 hours but less than or equal to 12 hours in length a visit, and
- Require a lapse of two or more hours between the provision of home health nursing and PDN.

The exceptions to the visit requirements, above, are as follows:

- An unforeseen event which causes a medically necessary visit to end in less than four hours or extend beyond twelve hours, up to and including but no more than 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.

Applicable limits to PDN are:

- The PDN post-hospital service is limited to 60 days, as described, above, in the first avenue.
- PDN services provided through the second and third avenues have no limits on the number of PDN visits.
- An RN assessment must be performed on an individual prior to the start of PDN services for the first time, prior to any change of order to an individual's PDN services, and/or any time the RN is informed that the individual receiving the PDN services has experienced a significant change in his or her condition that warrants a new RN assessment.
- An RN assessment cannot be concurrently performed with any other service during a visit in which the RN is furnishing PDN services.
- An RN assessment cannot be performed more than once every sixty days, unless a significant change warrants a subsequent RN assessment.

- When an individual is enrolled on an ODM-administered waiver, RN assessment services must be prior-approved by ODM and be specified on the individual's service plan.
- RN consultations are not covered for consultations between RNs.

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- RN consultations are not covered when performed with nursing delegation services under the Ohio Department of Developmental Disabilities (DODD) waiver.

Additional private duty nursing services provided beyond the established limits may be allowed when medically necessary.

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

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9. Clinic services.

a. Service-Based Ambulatory Health Care Clinic (AHCC) Services.

Clinic services provided at an AHCC are covered by Ohio Medicaid in accordance with 42 CFR 440.90.

A service-based AHCC is an entity that meets all of the following criteria: (1) it renders clinic services on an outpatient basis under the direction of a physician or dentist; (2) it operates from a fixed location, a specifically designed mobile unit, or both; (3) it is freestanding—administratively, organizationally, and financially independent of an institution such as a hospital or long-term care facility (it may be physically located in a hospital or long-term care facility so long as it remains independent); and (4) it does not provide overnight accommodations.

The following types of Ohio Medicaid providers may enroll as service-based AHCCs and render clinic services:

An End-Stage Renal Disease (ESRD) Dialysis Clinic, defined in 42 CFR 494.10, that meets the following criteria: (a) it is certified by Medicare as a dialysis facility; and (b) it is licensed by the Ohio Department of Health, or if it is located outside of Ohio, is licensed by its respective state's authority.

A Family Planning Clinic that meets the following criteria: (a) it is a public or nonprofit organization; (b) it complies with federal guidelines set forth in 42 U.S.C. 300; and (c) it receives funding for pregnancy prevention services through Title X of the Public Health Services Act.

An Outpatient Rehabilitation Clinic that delivers rehabilitation services at a Medicare-certified rehabilitation agency, defined in 42 CFR 485.703, or at a Medicare-certified comprehensive outpatient rehabilitation facility (CORF), defined in 42 CFR 485.51.

A Primary Care Clinic that meets either of the following criteria: (a) it receives state or federal grant funds for the provision of health services; or it provides primary care services by virtue of certification or accreditation by one of the following entities: Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Osteopathic Association (AOA), or Community Health Accreditation Program (CHAP).

A Professional Dental School Clinic associated with an accredited dental school.

A Professional Optometry School Clinic associated with an accredited optometry school.

A Public Health Department Clinic that meets the standards set forth in Ohio Revised Code (section 3701.342) and has legal status as a local health department created by a city health district, general health district, or combined health district and/or meets standards for boards of health and local health departments in Ohio.

A Speech-Language-Audiology Clinic that specializes in and provides speech, language, or audiology services delivered by professionals who have been certified by the American speech-language-hearing association (ASHA).

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 surgical centers (ASCs).

An ambulatory surgical center (ASC) is an entity that has a valid agreement with the Centers for Medicare and Medicaid Services (CMS) to provide ASC services in the Medicare program. ASCs 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 service. 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.

10. Dental services.

The dental benefit for beneficiaries 21 years of age and older includes services in the following categories: clinical oral examination; diagnostic imaging and interpretation; tests and laboratory examinations; preventive services; restorative services; endodontic services; periodontic services; prosthodontic services; oral surgery; orthodontic services; other services, and anesthesia.

Limitations:

- Comprehensive oral evaluation 1 per 5 years per provider per patient;
- Periodic oral evaluation - Patient younger than 21: 1 per 180 days. Patient 21 or older: 1 per 365 days;
- Comprehensive periodontal evaluation, new or established patient - 1 per 365 days;
- Intraoral images, complete series (including bitewings) - 1 per 5 years per provider;
- Bitewing image, one - 1 per 6 months;
- Bitewing images, two - 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Bitewing images, three - 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Bitewing images, complete series (at least four images) - 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Panoramic image - Patient 6 or older: 1 per 5 years;
- Dental prophylaxis, adult - Patient younger than 21: 1 per 180 days. Patient 21 or older: 1 per 365 days;
- Dental prophylaxis, child - 1 per 180 days;
- Topical fluoride treatment - 1 per 180 days;
- Tobacco counseling for control and prevention of oral disease – 2 per 365 days
- Sealant – 1 per tooth;
- Interim caries arresting medicament application - 4 teeth per date of service;
- Periodontal maintenance - 1 per 365 days;
- Relining, all dentures - 1 per 3 years;
- Alveoplasty, in conjunction with extraction, per quadrant - 1 per quadrant;
- Alveoplasty, not in conjunction with extraction, per quadrant - 1 per quadrant.

Prior authorization is required for the following dental services: ceramic crowns, post and core, gingivectomy, gingivoplasty, scaling and root planing, dentures, surgical extractions, comprehensive orthodonture, temporomandibular joint therapy, maxillofacial prosthetics and unspecified procedures not adequately described by a procedure code.

Dental services may be provided in an amount beyond established limits with prior authorization, upon a demonstration of medical necessity.

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

11. Physical Therapy and related services.

a. Physical therapy services

Physical therapy services are covered by Ohio Medicaid in accordance with 42 CFR § 440.110.

Beneficiaries younger than age 21 can access physical therapy services without limitation when such services are medically necessary.

Physical therapy services determined by the department as not medically necessary will not be covered.

Limitations:

Physical therapy services must be provided by a physical therapist, a physical therapist assistant, or a physical therapy student who is completing an internship, providing physical therapy services in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

Licensed physical therapist assistants must provide physical therapy only under the direct supervision of a physical therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter.

Physical therapy services must be for a reasonable amount, frequency, and duration. Physical therapy services must be provided in accordance with a documented treatment plan that is based on a documented clinical evaluation and assessment.

For rehabilitative services, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is 60 days; for developmental services for children and habilitative services for adults, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is six months.

Ohio Medicaid covers 30 physical therapy service visits in the non-institutional setting per benefit year without prior authorization. Additional visits may be provided in an amount beyond established limits with prior authorization, upon a demonstration of medical necessity.

11. Physical Therapy and related services, continued.

b. Occupational therapy services

Occupational therapy services are covered by Ohio Medicaid in accordance with 42 CFR § 440.110.

Beneficiaries younger than age 21 can access occupational therapy services without limitation when such services are medically necessary.

Occupational therapy services determined by the department as not medically necessary will not be covered.

Limitations:

Occupational therapy services must be provided by an occupational therapist, an occupational therapist assistant, or an occupational therapy student who is completing an internship, providing occupational therapy services in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

Licensed occupational therapy assistants must provide occupational therapy only under the direct supervision of an occupational therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter.

Occupational therapy services must be for a reasonable amount, frequency, and duration.

Occupational therapy services must be provided in accordance with a documented treatment plan that is based on a documented clinical evaluation and assessment.

For rehabilitative services, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is 60 days; for developmental services for children and habilitative services for adults, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is six months.

Ohio Medicaid covers 30 occupational therapy service visits in the non-institutional setting per benefit year without prior authorization. Additional visits may be provided in an amount beyond established limits with prior authorization, upon a demonstration of medical necessity.

11. Physical Therapy and related services, continued.

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

Services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist) are covered by Ohio Medicaid in accordance with 42 CFR § 440.110.

Beneficiaries younger than age 21 can access services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist) without limitation when such services are medically necessary.

Services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist) determined by the department as not medically necessary will not be covered.

Services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist) are speech-language pathology services and audiology services.

Limitations:

Speech-language pathology services:

Speech-language pathology services must be provided by a speech-language pathologist (SLP), a speech-language pathology aide (SLPA), a speech-language pathology (SLP) student who is completing an internship, or a person holding a conditional license to practice speech-language pathology, providing speech-language pathology services in accordance with Ohio law and 42 CFR 440.110.

An SLPA must provide SLP services under the direct supervision of a speech-language pathologist who conducts face-to-face client evaluations initially and periodically (not less than annually) thereafter.

SLP services must be for a reasonable amount, frequency, and duration. SLP services must be provided in accordance with a documented treatment plan that is based on a documented clinical evaluation and assessment.

For rehabilitative services, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is 60 days; for developmental services for children and habilitative services for adults, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is six months.

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

Ohio Medicaid covers 30 service visits provided by or under supervision of a speech pathologist or audiologist per Medicaid beneficiary in non-institutional settings per benefit year without prior authorization. Additional visits may be provided in an amount beyond established limits with prior authorization, upon a demonstration of medical necessity.

Audiology services:

Audiology services must be provided by an audiologist, an audiology aide, an audiology student who is completing an internship, or a person holding a conditional license to practice audiology, providing audiology services in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

Audiology aides must provide audiology services under the direct supervision of an audiologist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter.

Audiology services must be for a reasonable amount, frequency, and duration. Audiology services must be provided in accordance with a documented treatment plan that is based on a documented clinical evaluation and assessment.

For rehabilitative services, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is 60 days; for developmental services for children and habilitative services for adults, reevaluation may not be made more frequently than 30 days and the maximum period without reevaluation is six months.

Ohio Medicaid covers 30 service visits provided by or under supervision of a speech pathologist or audiologist per Medicaid beneficiary in non-institutional settings per benefit year without prior authorization. Additional visits may be provided in an amount beyond established limits with prior authorization, upon a demonstration of medical necessity.

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 prescribed 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. Effective January 1, 2020, the Managed Care Plans contracted with the Ohio Department of Medicaid (ODM) will follow the preferred drug list established by ODM.

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 and will be collected from manufacturers based on drug utilization for both fee-for-service and managed care plan participants.

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

CMS has authorized Ohio to enter into “the Sovereign States Drug Consortium (SSDC)” Medicaid multi-state purchasing pool. The updated “Ohio Medicaid Supplemental Rebate Agreement” between the State and participating manufacturers for drugs provided to the Medicaid program, submitted to CMS on November 1, 2019 supersedes the “Ohio Supplemental Drug Rebate Agreement” approved in OH SPA TN16-027. CMS has authorized the updated agreement. The updated agreement applies to drugs dispensed effective January 1, 2020.

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.

TN: 19-023

Supersedes

TN: 18-011

Approval Date: 12/13/19

Effective Date: 01/01/2020

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 the symptomatic relief of cough and colds
- (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- (e) nonprescription drugs (only cough and cold products, antihistamines, antacids, antidiarrheals, stool softeners, laxatives, analgesics, and topical products including acne, antifungals, and corticosteroids)
- (f) 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
- (g) 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.

TN: 17-023

Supersedes

TN: 13-034Approval Date: ~~09/26/17~~Effective Date: 04/01/2017

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

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.

Select active pharmaceutical ingredients (APIs) and excipients used in extemporaneously compounded prescriptions are covered when dispensed by a participating pharmacy provider pursuant to a prescription issued by a licensed prescriber following all state and federal laws. A list of the covered APIs and excipients can be found at the following:

<http://pharmacy.medicaid.ohio.gov/drug-coverage>.

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.

TN: 17-023

Supersedes:

TN: 11-013

Approval Date: 09/26/17

Effective Date: 04/01/2017

Pages 3 through 11 obsoleted by SPA TN 16-027

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

b. Dentures.

Payment for the provision of dentures, either full or partial, requires prior authorization (PA).

No payment is authorized for a preformed denture with teeth already mounted (i.e., a denture module for which no impression is made of the patient). Payment for a denture will not be authorized if dentures made for the patient in the recent past were unsatisfactory because of irremediable psychological or physiological reasons.

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

c. Prosthetic devices.

Payment for the following items requires prior authorization (PA):

Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control

Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature

Lower extremity prosthesis, not otherwise specified

Upper extremity prosthesis, not otherwise specified

Unlisted procedure for miscellaneous prosthetic services

A hearing aid may be provided every four years without PA. This limit may be exceeded with PA.

Payment for a hearing aid requires a prescription and a test for hearing loss.

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

d. Eyeglasses.

Payment for the following items and services requires prior authorization (PA) and, when appropriate, documentation of medical necessity:

Glass lenses

Tinted lenses

Ultraviolet-protective lenses

Photochromatic lenses

Frames or lenses provided by a source other than an optical laboratory holding a current volume purchase contract

A complete set of eyeglasses (i.e., frame and lenses) may be provided every 24 months without PA. Eyeglasses may be provided more frequently if medical necessity criteria are met or if PA is obtained.

No separate payment is made for lenses prescribed as supplementary sunglasses in addition to regular eyeglasses, unless medical necessity is demonstrated and prior authorization is obtained.

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

a. Diagnostic services

Diagnostic services are covered by Ohio Medicaid in accordance with 42 CFR 440.130(a) and State law.

Beneficiaries younger than twenty-one can access diagnostic services without limitation when such services are medically necessary.

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

Diagnostic services are limited to lead investigation to determine the source of lead poisoning for a child who is diagnosed with an elevated blood lead level as defined by the Centers for Disease Control and Prevention (CDC). The investigation will be conducted in the child's home or primary residence. A maximum of two sites may be investigated. Lead investigations beyond the child's home or primary residence, such as in community settings, schools, or other residences, are not reimbursable.

Provider limitations:

Investigations shall be performed by Public Health Lead Investigators, who are authorized and defined by State law.

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

c. Preventive services.

Preventive services are covered by Ohio Medicaid in accordance with Section 4106 of the Affordable Care Act and 42 CFR § 440.130(c).

All USPSTF grade A and B preventive services and approved vaccines recommended by ACIP, and their administration, are covered and reimbursed, without cost-sharing.

The State assures that it has documentation available to support the claiming of FMAP for all USPSTF grade A and B preventive services and approved vaccines recommended by ACIP, and their administration.

The State assures that it has a method to update coverage and billing codes to comply with any changes that are made to USPSTF or ACIP recommendations.

In addition to the services specified under section 4106 of the Affordable Care Act, Ohio covers, without cost-sharing, services specified under Public Health Service Act section 2713 which is in alignment with the Alternative Benefit Plan.

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

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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

1. Mental Health Rehabilitative services

The following explanations apply to the mental health rehabilitative services covered under Item 13-d-1, which are:

- Therapeutic Behavioral Services (TBS)
- Psychosocial Rehabilitation (PSR)

These rehabilitative services are provided to all Medicaid eligible adults and children with an identified mental health and/or substance abuse diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed behavioral health practitioner or physician who is acting within the scope of his/her professional license and applicable state law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. Licensed practitioners of the healing arts operating within their scope of practice under State license include: a medical doctor or doctor of osteopathic medicine; psychologist; clinical nurse specialist; nurse practitioner; licensed independent social worker; licensed social worker; licensed professional clinical counselor; licensed professional counselor; licensed independent marriage and family therapist; licensed marriage and family therapist; or Board-licensed school psychologist. Nursing activities performed as part of Rehabilitative Services by Registered Nurses (RN) and Licensed Practical Nurses (LPN) must be ordered by a physician, physician assistant (PA), clinical nurse specialist (CNS) or certified nurse practitioner (CNP) unless, for RNs, an order is not required in accordance with nursing scope of practice. Direct services provided by the licensed practitioner not listed under TBS or PSR are billable under other sections of the State Plan (e.g., Physician and Other Licensed Practitioner).

Service Utilization:

The components included in the service must be intended to achieve identified treatment plan goals or objectives. All rehabilitative services are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible individual in accordance with section 1902(a)(10)(A) of the Act.

These rehabilitative services are provided according to an individualized treatment plan, which is subject to prior approval. The components included in the service must be intended to achieve identified treatment plan goals or objectives. The frequency and duration of rehabilitation services will be identified in the individual treatment plan and must be supported by an identified need and recovery goal.

The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. At a minimum, annual reevaluations of the treatment plan must occur. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level.

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TN: 17-008

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Effective Date: 08/01/2019

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

The following Evidence-Based Practices (EBPs) provided as part of Rehabilitative Services require prior approval and fidelity reviews on an ongoing basis as determined necessary by ODM or its designee: Assertive Community Treatment (ACT). ACT includes individualized treatment at the needed intensity using components A – H listed under TBS and all aspects of PSR provided by other qualified providers of TBS and PSR. ACT also includes coordination of behavioral health services and coordination with collaterals including sharing information with healthcare and other providers. Additional EBP techniques included in Rehabilitative Services and not requiring ongoing fidelity reviews, such as trauma-focused CBT, may be integrated into rehabilitation services by providers without prior approval. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the Medicaid behavioral health treatment goals. All coordination regarding Medicaid behavioral health services must be documented in the individual's medical record.

Provider Agency Qualifications:

Any unlicensed or licensed practitioner providing mental health services must operate within an agency licensed, certified or designated by ODM or its designee that is qualified to provide the supervision required of an unlicensed or licensed practitioner for that service. Any entity providing Mental Health treatment services must be certified by Ohio Department of Medicaid or its designee, in addition to any required scope-of-practice license required for the facility or agency to practice in the State of Ohio.

Limitations:

The components included in the service must be intended to achieve identified treatment plan goals or objectives. Rehabilitative services will not substitute or supplant natural supports. Rehabilitative services do not include, and FFP is not available for any of the following, in accordance with section 1905(a)(13) of the Act:

- a. educational, vocational and job training services;
- b. room and board;
- c. habilitation services (*including financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature*);
- d. services to inmates in public institutions as defined in 42 CFR 435.1010;
- e. services to individuals residing in institutions for mental diseases as described in 42 CFR 435.1010;
- f. recreational and social activities; and
- g. services that must be covered elsewhere in the state Medicaid plan.

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's treatment plan. Solution-focused interventions, emotional and behavioral management, and problem behavior analysis includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation. The combination and intensity of services will be based on an individualized assessment of medical necessity for each beneficiary. TBS is an individual or group face-to-face intervention with the individual, family/caregiver and/or other collateral supports. TBS can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g., provider office sites) and/or socializes; in an office; and/or by telemedicine methods meeting the State Medicaid agency's telemedicine equipment specifications and requirements. The intent of TBS is to restore an individual's functional level as possible and as necessary for integration of the individual as an active and productive member of their community and family with minimal ongoing professional intervention. Activities included must be intended to achieve the identified goals or objectives as set forth in the Medicaid-eligible individual's treatment plan. This includes consultation with a licensed practitioner to assist with the individual's needs and service planning for Medicaid behavioral health services, and referral and linkage to other Medicaid behavioral health services to avoid more restrictive levels of treatment.

Components include:

- A. Treatment Planning - Participating in and utilizing strengths-based treatments/planning which may include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness. This only includes developing the treatment plan for the Medicaid behavioral health services provided to the individual;
- B. Identification of strategies or treatment options - Assisting the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated behavioral health stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration;

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

- C. Counseling - Developing and providing individual supportive counseling including solution-focused interventions, emotional and behavioral management, and problem behavior analysis drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation. The goal is to assist the individual to re-acquire skills to minimize mental health and behavioral symptoms that interfere with the individual's ability to develop and maintain social, interpersonal, self-care, and independent living skills needed to improve and to restore stability and daily functioning within the individual's natural community settings.
- D. Restoration of social skills - Rehabilitation and support with the restoration of social and interpersonal skills, problem solving, conflict resolution, and emotions/behavior management to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop positive coping mechanisms and strategies, and promote effective functioning in the individual's social environment including home, work and school;
- E. Restoration of daily functioning - Assisting the individual to restore daily functioning specific to managing their own home, including managing money and medications, using community resources, and other self-care requirements; and
- F. Crisis prevention and amelioration - Assisting the individual with effectively responding to or avoiding identified precursors or triggers that would put the individual at risk of not remaining in a natural community location, or that result in functional impairments, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or, as appropriate, seeking other supports to restore stability and functioning.
- G. Psychoeducational services including 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, increase their cooperation and collaboration with treatment and rehabilitation and favorably affect their outcomes.
- H. Nursing Services-Performing Nursing Assessments and assisting the individual with individual and group medication education and developing and providing support for symptom management.

Practitioner qualifications:

Any of the components above may be performed by an unlicensed or licensed TBS provider who is an individual who has at least a Bachelor's Degree in social work, psychology, nursing, or in related human services OR at least a Master's Degree in social work, psychology, nursing or in related human services. Providers with a high school diploma may substitute three years of relevant work experience for a Bachelor's degree.

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

Registered nurses may perform any component to the extent they are operating under the scope of their license and performing nursing services. Nursing assessments and group medication education performed under component G must be performed by a registered nurse. Individuals providing services must have training in the general training requirements required by the State Medicaid agency, including cultural competence and trauma-informed care.

Supervisor qualifications:

Unlicensed TBS providers must receive regularly-scheduled clinical supervision when rendering TBS. Licensed TBS providers whose scope of practice requires supervision must also receive regularly-scheduled clinical supervision when rendering TBS. The following licensed practitioners may provide supervision to both unlicensed and licensed TBS providers as appropriate and when operating within their scope of practice: a medical doctor or doctor of osteopathic medicine, registered nurse, Master of Science in nursing, clinical nurse specialist, certified nurse practitioner, licensed independent social worker, licensed social worker, licensed professional counselor, licensed professional clinical counselor, licensed independent marriage and family therapist, licensed marriage and family therapist, Board-licensed school psychologist, or psychologist. Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Psychosocial Rehabilitation (PSR)

PSR assists individuals with implementing interventions outlined in a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with an individual's behavioral health diagnosis. The combination and intensity of services will be based on an individualized assessment of medical necessity for each beneficiary. PSR is an individual face-to-face intervention with the individual. PSR includes restoration, rehabilitation and support of daily functioning to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily functioning. PSR supports the individual with restoration and implementation of daily functioning and daily routines critical to remaining successfully in home, school, work, and community. PSR includes rehabilitation and support to restore skills to function in a natural community environment.

Practitioner qualifications for PSR specialist:

Any of the activities above may be performed by a PSR specialist must be at least 18 years old and have a high school diploma with applicable experience in mental health. These practitioners also include Licensed Practical Nurses (LPNs) to the extent they are operating within the scope of their license. LPNs certified in the prior-approved Evidence-Based Practice of Assertive Community Treatment may also perform the PSR activities above. Individuals providing services must be trained in the general training requirements

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

required by the State Medicaid agency, including cultural competence and trauma-informed care.

PSR specialists in the prior-approved Evidence-Based Practices of Assertive Community Treatment may perform the PSR activities above as a peer and must additionally:

- Be certified in the Evidence-Based Practice of Assertive Community Treatment.
- Be at least 18 years old, and have a high school diploma or equivalent.
- Self-identify as having a lived experience of mental illness as a present or former primary individual of mental health and/or SUD services.
- Be certified in the State of Ohio to provide the service, which includes criminal, abuse/neglect registry, and professional background checks; completion of a state-approved standardized 16-hour on-line basic training; completion of a 40-hour peer service delivery training or three years of formal peer service delivery; and pass the OhioMHAS Peer Recovery Supporter exam. Training includes: academic information, practical knowledge and creative activities focused on the principles and concepts of peer support and how it differs from clinical support, tools for promoting wellness and recovery, knowledge about individual rights advocacy, confidentiality, and boundaries, as well as approaches to care that incorporate creativity. Individuals with histories of criminal justice involvement are not necessarily disqualified from being a peer, but must be reviewed on a case-by-case basis.

Supervisor Qualifications:

PSR providers must receive regularly-scheduled clinical supervision from one of the following practitioners operating within their scope of practice: a medical doctor or doctor of osteopathic medicine, registered nurse, Master of Science in nursing, clinical nurse specialist, certified nurse practitioner, licensed independent social worker, licensed independent marriage and family therapist, licensed social worker, licensed marriage and family therapist, licensed professional counselor, licensed professional clinical counselor, Board-licensed school psychologist, or psychologist. Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues. Direct services provided by the licensed practitioner not listed under PSR are billable under other sections of the State Plan (e.g., Physician and Other Licensed Practitioner).

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Supersedes:

TN: 11-025

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Effective Date: 01/01/2018

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

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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. Mental Health Rehabilitative services

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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. Mental Health Rehabilitative services

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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. Mental Health Rehabilitative services

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

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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; aide; independent marriage and family therapist; marriage and family therapist; psychology aide; psychology postdoctoral trainee; psychology resident; psychology trainee; school psychology intern; school psychology trainee; 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; independent marriage and family therapist; marriage and family therapist; 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.

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Supersedes:
TN: 11-025

Approval Date: 8/5/15
Effective Date: 8/1/2013

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.

TN: 11-025
Supersedes
TN: 08-011

Approval Date: **DEC 22 2011**
Effective Date: 11/1/2011

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

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)(2) 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.

AUG 12 2008

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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. (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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TN No. new EFFECTIVE DATE: 7/1/05

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. Substance use disorder (SUD) services

Substance use disorder (SUD) services include the American Society of Addiction Medicine (ASAM) levels of care for Outpatient and Residential SUD services. All SUD services are provided to all Medicaid beneficiaries with one or more diagnosed SUD(s). Services are subject to prior authorization, must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his or her professional license and applicable state law. Licensed practitioners are licensed by an Ohio professional board and include a medical doctor or doctor of osteopathic medicine; physician assistant; clinical nurse specialist or nurse practitioner who has demonstrated experience and training in treating SUDs; independent social worker; social worker; professional clinical counselor; professional counselor; independent marriage and family therapist; licensed marriage and family therapist; independent chemical dependency counselor; chemical dependency counselor; psychologist or Board-licensed school psychologist. Nursing activities performed as part of Rehabilitative Services by Registered Nurses (RN) and Licensed Practical Nurses (LPN) must be ordered by a physician, physician assistant (PA), clinical nurse specialist (CNS) or certified nurse practitioner (CNP).

All rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual. Rehabilitative services do not include, and FFP is not available for any of the following, in accordance with section 1905(a)(13) of the Act:

- a. educational, vocational and job training services;
- b. room and board;
- c. habilitation services;
- d. services to inmates in public institutions as defined in 42 CFR 435.1010;
- e. services to individuals residing in institutions for mental diseases as described in 42 CFR 435.1010;
- f. recreational and social activities; and
- g. services that must be covered elsewhere in the state Medicaid plan.

These rehabilitative services are provided according to an individualized treatment plan, which is subject to prior approval. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The frequency and duration of rehabilitation services must be identified in the individual treatment plan and must be supported by an identified need and recovery goal. The treatment plan shall be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual’s condition and the standards of practice for the provision of these specific rehabilitative services. At a

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

minimum, annual re-evaluations of the treatment plan must occur. A new treatment plan must be developed if there is no measureable reduction of disability or restoration of functional level.

Ohio Medicaid will not reimburse for 12-step programs.

SUD components for both outpatient and residential ASAM services are designed to help beneficiaries achieve and maintain recovery from SUDs. Services for both ASAM outpatient and residential are described below:

1. Outpatient SUD services

Outpatient SUD services include ASAM levels of care consisting of the delivery of the individual-centered components consistent with the beneficiary’s assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with SUDs. Outpatient SUD services include medically necessary care according to assessed needs as described in the beneficiary’s individualized treatment plan.

- **Outpatient.** Outpatient services are provided in a non-residential, non-hospital treatment setting. Outpatient services may be indicated as an initial modality of care for a beneficiary whose severity of illness warrants this level of treatment, or when a beneficiary’s progress warrants a less intensive modality of service than they are currently receiving. The intensity of the services will be driven by medical necessity.
- **Intensive Outpatient and Partial Hospitalization.** IOP and PH are provided in a non-residential, non-hospital treatment setting. All initial intensive outpatient and partial hospitalization services require prior authorization to establish medical necessity. The intensity of the services will be driven by medical necessity.
- **Opioid Treatment Services: Opioid Treatment Programs (OTPs) and Ambulatory Withdrawal Management with Extended On-site Management.** Both levels are in a non-hospital, non-residential treatment setting. These services are designed to achieve safe withdrawal from mood-altering chemicals and to effectively facilitate the individual’s entry into ongoing treatment and recovery.

The ASAM outpatient levels of care described above include the outpatient components, as found below in paragraphs A-D, that are delivered on an individual or group basis in a

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

wide variety of settings including provider offices or in the community, including a beneficiary’s place of residence.

- (A) A comprehensive assessment using a SUD-specific multidimensional assessment specified by the State reflecting evidence-based clinical treatment guidelines. This includes gathering biopsychosocial information medically necessary as outlined by the SUD-specific multi-dimensional assessment tool.

An SUD assessment also includes the development of a treatment plan based on the comprehensive assessment and the referral to any necessary SUD or mental health services including discharge planning. The treatment plan and referral does not include coordination of non-Medicaid services.

- (B) Skill restoration is a medical or remedial intervention for the maximum reduction of the substance use disorder and the restoration of the beneficiary to his best possible functional level, based on the treatment plan goals and objectives including teaching the beneficiary specific skills for coping with and managing symptoms and behaviors associated with SUDs including nurse psychoeducation/medication education (Individuals receive information and support to understand their condition, medication, and potential side effects. The goal is to increase medication adherence and compliance with medication regimes and the detection of adverse effects.) and withdrawal management (medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence) by any practitioner type.

- (C) Counseling to address a beneficiary’s major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the achievement of treatment goals. This includes counseling by any practitioner type.

- (D) Administration of medications for medication assisted treatment (MAT) when medically necessary. (Note: Medications used for MAT and under the Master Rebate agreement are covered under the pharmacy benefit of the State Plan and will be reimbursed as a separate single line item.) MAT should only be utilized when a beneficiary has an established SUD (e.g., opiate or alcohol dependence condition) that is clinically appropriate for MAT. Counseling and skill restoration are covered in paragraphs (B) and (C) above or elsewhere in the State Plan.

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

2. Residential services

Residential services include ASAM levels of care consisting of individual-centered residential services consistent with the beneficiary’s assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing SUD symptoms and behaviors associated with an SUD diagnosis. These services are designed to help beneficiaries achieve changes in their SUD behaviors. Services should address the beneficiary’s major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential SUD services include medically necessary care according to assessed needs.

Residential SUD services are delivered on an individual or group basis in a wide variety of non-hospital settings. Residential SUD services are provided to help beneficiaries achieve changes in their SUD behaviors. The service setting will be determined by the goal which is identified to be achieved in the beneficiary’s treatment plan. Residential SUD services provided to individuals residing in institutions for mental diseases as described in 42 CFR 435.1010 are not covered.

SUD residential services are provided consistent with the ASAM criteria and requires prior approval and reviews on an ongoing basis as determined necessary by the State or its designee to document compliance with the placement standards. ASAM criteria are used to determine level of care appropriateness and intensity of treatment components.

- **Clinically Managed Low-Intensity Residential Treatment.** Skill restoration is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education, and family life. Residential SUD programs are not recovery residences, sober houses, boarding houses, or group homes where skill restoration and counseling services are not provided on site to the residents as a condition of residence.
- **Clinically Managed Residential Withdrawal Management.** It is provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from the effects of alcohol and/or other drugs. Withdrawal management is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less intensive, non-medical alternative to inpatient withdrawal management.

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

- **Clinically Managed Population-Specific High Intensity Residential Treatment.** The level of impairment is so great that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Similarly, the patient’s cognitive limitations make it unlikely that he or she could benefit from other levels of residential care.
- **Clinically Managed Medium Intensity (adolescents) and High Intensity (adults) Residential Treatment.** Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. It is also to promote abstinence from substance use and antisocial behavior and to effect a global change in participants’ lifestyles, attitudes, and values. Individuals typically have multiple deficits, which include SUDs and may include criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values.
- **Medically Monitored Intensive Inpatient Treatment/Services.** Participants in this level of care possess a high risk of withdrawal symptoms, moderate co-occurring psychiatric and/or medical problems that are of sufficient severity to require a 24-hour treatment LOC. Whereas individuals whose most severe problems are in readiness to change, relapse potential, and living environment are best served in clinically managed residential programs or PHP with supportive housing. This level of service also provides a planned regimen of 24-hour professionally directed evaluation, observation, and medical monitoring of SUD treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures, and clinical protocols. Appropriate for patients whose sub-acute biomedical and emotional, behavior, or cognitive problems are so severe that they require enhanced residential treatment, but who do not need the full resources of an acute care general hospital.
- **Medically Monitored Inpatient Withdrawal Management.** Medically monitored inpatient withdrawal management within an SUD residential program is an organized service delivered by medical and nursing professionals under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care in a non-hospital residential setting.

The ASAM residential levels of care described above include the residential components as found below in paragraphs A-D:

TN: 17-013
Supersedes
TN: 12-007

Approval Date: 2/22/18
Effective Date: 01/01/2018

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

(A) A comprehensive assessment using a SUD-specific multidimensional assessment specified by the State reflecting evidence-based clinical treatment guidelines. This includes gathering results of drug screens and biopsychosocial information medically necessary as outlined by the SUD-specific multi-dimensional assessment tool.

An SUD assessment also includes the development of a treatment plan based on the comprehensive assessment and the referral to any necessary SUD or mental health services including discharge planning. The treatment plan and referral does not include coordination of non-Medicaid services.

(B) Skill restoration is a medical or remedial intervention for the maximum reduction of the substance use disorder and the restoration of the beneficiary to his best possible functional level, based on the treatment plan goals and objectives including teaching the beneficiary specific skills for coping with and managing symptoms and behaviors associated with SUDs including nurse psychoeducation/medication education (Individuals receive information and support to understand their condition, medication, and potential side effects. The goal is to increase medication adherence and compliance with medication regimes and the detection of adverse effects.) and withdrawal management (medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence) by any practitioner type.

(C) Counseling to address a beneficiary's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the achievement of treatment goals. This includes counseling by any practitioner type.

(D) Administration of medications for medication assisted treatment (MAT) when medically necessary. (Note: Medications used for MAT and under the Master Rebate agreement are covered under the pharmacy benefit of the State Plan and will be reimbursed as a separate single line item). MAT should only be utilized when a beneficiary has an established SUD (e.g., opiate or alcohol dependence condition) that is clinically appropriate for MAT. Counseling and skill restoration are covered in paragraphs (B) and (C) above.

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

Summary of Clinical Provider Qualifications applicable to SUD outpatient and residential services

Provider Agency Qualifications:

Any unlicensed practitioner providing behavioral health services must operate within an agency licensed, certified or designated by ODM or its designee qualified to provide the supervision required of an unlicensed practitioner for that service. Any entity providing SUD treatment services must be certified by Ohio Department of Medicaid or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Ohio.

Provider qualifications:

Services are provided by licensed and other professional staff, who are at least eighteen (18) years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and departmentally approved guidelines and certifications. All providers of SUD services are trained in ASAM criteria and service components. All outpatient and residential SUD agencies are certified under state law.

All providers may provide any component (assessment, skill restoration, counseling and administration of medications for Medication Assisted Treatment (MAT)) of the outpatient or residential SUD services consistent with State law and professional practice statutes and rules with the following exceptions:

- Peer recovery supporters may only provide skill restoration and counseling services in outpatient and residential settings, and
- Agencies that provide MAT must comply with federal and state laws regarding controlled substance prescriber availability. All facilities utilizing buprenorphine based medications must have a physician, physician’s assistant; clinical nurse specialist or certified nurse practitioner who is an Ohio authorized prescriber, and who has a Drug Addiction Treatment Act (DATA) waiver to prescribe and dispense or is certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an opioid treatment program (OTP).
- Activities requiring a nurse may only be performed by a registered nurse or a licensed practical nurse within their current scope of practice. Activities performed by a licensed practical nurse must be performed under a physician, physician assistant, clinical nurse specialist, or certified nurse practitioner order.

Unlicensed practitioners who are SUD Peer Recovery Supporters shall:

- Be at least 18 years old;
- Have a high school diploma or equivalent;

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

- Be registered in the State of Ohio to provide peer services;
- Self-identify as having lived experience of an SUD;
- Have taken the state-approved standardized peer recovery supporter training that includes academic information as well as practical knowledge and creative activities focused on the principles and concepts of peer support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge about individual rights advocacy, confidentiality and boundaries as well as approaches to care that incorporate creativity.
- Have achieved a score of at least 70 on the OhioMHAS peer recovery supporter exam;
- Be supervised by a competent behavioral health professional, who is knowledgeable about SUD peer service delivery including: a senior SUD peer recovery supporter or a qualified supervisor.

Unlicensed practitioners must be supervised by a qualified supervisor who is knowledgeable about SUD peer service delivery:

- Medical doctor or doctor of osteopathic medicine;
- Physician’s assistant;
- Clinical nurse specialist;
- Certified nurse practitioner;
- Psychologist;
- Board-licensed school psychologist;
- Licensed independent social worker;
- Licensed professional clinical counselor;
- Licensed independent marriage and family therapist;
- Registered Nurse;
- Licensed Practical Nurse;
- Licensed independent chemical dependency counselor,
- Licensed chemical dependency counselor;
- Licensed professional counselor;
- Licensed social worker,
- Marriage and family therapist , or
- One of the following trainees or assistants registered with and meeting the qualifications of the Ohio board of chemical dependency professionals, Ohio board of psychology or Ohio board of counselors, social workers and marriage and family therapists:
 - o Chemical dependency counselor assistant,
 - o Psychology assistant/intern/trainee,

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

- Counselor trainee;
- Marriage and family therapist trainee;
- Social work trainee; or
- Social work assistant.

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

a. Inpatient hospital services.

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 Ohio Department of Mental Health and Addiction Services or operated under the State Mental Health Authority and meet federal requirements at 42 CFR 441 Subpart C and 42 CFR §440.140.

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.

TN: 15-004
Supersedes
TN: 95-016

Approval date: 9/1/15
Effective date: 3/31/2015

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. Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) or related conditions (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.

a. Including such services in a public institution (or distinct part thereof).

ICF-IID services are covered by Ohio Medicaid in accordance with 42 CFR 440.150.

b. An ICF-IID operator may provide private room accommodations for a Medicaid resident, upon request from the resident.

TN: 19-011
Supersedes:
TN: 13-007

Approval Date: JUN 24 2019
Effective Date: 02/14/2019

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

Coverage for inpatient psychiatric facility services for individuals under 22 years of age is limited to inpatient psychiatric services under the direction of a physician provided in psychiatric hospitals and certain alcohol and/or drug abuse rehabilitation hospitals that are licensed by the Ohio Department of Mental Health and Addiction Services or operated under the State Mental Health Authority and meet federal requirements at 42 CFR 441 Subpart d and 42 CFR §440.160.

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.

TN: 15-004
Supersedes
TN: 95-016

Approval date: 9/1/15
Effective date: 3/31/2015

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 individuals with intellectual disabilities (ICF-IID). 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 Medicaid (ODM).

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, but 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. The election period would end upon revocation, allowing the individual, if eligible, to resume Medicaid coverage of the benefits waived when hospice care was initially elected. An individual may re-elect to receive hospice after a revocation at any time, provided the beneficiary is otherwise entitled to hospice care. Once hospice has been re-elected, a subsequent benefit period will ensue.

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.

TN: 16-011

Supersedes

TN: 11-003

Approval Date: 6/9/16

Effective Date: 01/01/2016

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

Other covered Hospice care 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.
- Other medical treatment and diagnostic procedures provided in relation to the terminal condition, when medically indicated.

TN: 16-011

Supersedes

TN: 11-003

Approval Date: 6/9/16

Effective Date: 01/01/2016

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).

TN No. 11-007

Supersedes

TN No. 90-38

SEP 28 2011

Approval Date

Effective Date 07/01/2011

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

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

24-a. Transportation

Appropriate ambulance services, including air ambulance services, are covered.

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

Recipients who are not residents of a nursing facility or intermediate care facility for individuals with intellectual disabilities 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.

Transportation furnished by enrolled providers 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 covered under Medicaid or ancillary to a Medicaid-coverable service.
- (iii) Claims involving trips to or from unusual locations require manual review. For each type of transport, combinations of trip origin and destination that do not require manual review are spelled out in the rate table published on the agency's website.
- (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 payment.

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.

Transmittal Number 09-010
Supersedes
Transmittal Number 90-45

Approval Date:

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-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

Transmittal Number 90-45

Approval Date:

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.

State of Ohio

Attachment 3.1-A

Item 24-f

Page 1 of 1

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.

Transmittal Number 09-010

Supersedes

Transmittal Number 90-45

Approval Date:

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-g. Critical Access Hospital (CAH) Services

This item is not applicable.

26. Telehealth

Key Definitions:

For purposes of Medicaid coverage, “Telehealth” is the direct delivery of services to a patient via secure, synchronous, interactive, real-time electronic communication that comprises both audio and video elements. The following activities are not telehealth:

- (a) The delivery of service by electronic mail, telephone call, or facsimile transmission.
- (b) Conversations between practitioners regarding the patient without the patient present either physically or via synchronous, interactive, real-time electronic communication.

For purposes of Medicaid coverage, “practitioner site” is the physical location of the treating practitioner at the time a health care service is provided through the use of telehealth. The practitioner site shall not be the same location as the patient site.

For purposes of Medicaid coverage, “patient site” is the physical location of the patient at the time a health care service is provided through the use of telehealth. The patient site may be one of the following:

- (a) The office or service location of a medical doctor, doctor of osteopathic medicine, podiatrist, licensed psychologist, physician assistant, clinical nurse specialist, certified nurse-midwife, certified nurse practitioner, licensed independent social worker, licensed independent marriage and family therapist, licensed professional clinical counselor, or licensed independent chemical dependency counselor.
- (b) The patient’s home;
- (c) School;
- (d) An outpatient hospital;
- (e) An inpatient hospital;
- (f) A nursing facility;
- (g) A federally qualified health center (FQHC);
- (h) A rural health clinic (RHC); or
- (i) Intermediate care facility for individuals with an intellectual disability (ICF/IID).

Covered Services:

The following health care services are covered when delivered through the use of telehealth:

- (a) When provided by a patient centered medical home participating in the Ohio Comprehensive Primary Care program (Ohio CPC), evaluation and management services of a new patient characterized as “office or other outpatient visit” with medical decision making not to exceed moderate complexity;
- (b) Evaluation and management services for an established patient characterized as either “office or other outpatient visit” with medical decision making not to exceed moderate complexity;
- (c) Inpatient or office consultation for a new or established patient; or
- (d) Mental health or substance use disorder services described as “psychiatric diagnostic evaluation” or “psychotherapy.”

TN: 19-019

Supersedes

TN: 14-022Approval Date: 10/21/19Effective Date: 08/08/2019

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(l)(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.

TN: 12-004

Supersedes:

TN: NEW

Approval Date: 9/4/13

Effective Date: 01/01/2012

Comprehensive Primary Care (CPC). The Ohio Comprehensive Primary Care (CPC) program is Ohio's patient-centered medical home (PCMH) program.

Key definitions:

- A **Patient Centered Medical Home (PCMH)** is a team-based care delivery model led by primary care practitioners (PCPs) who comprehensively manage the health needs of individuals. Provider enrollment in the Ohio Department of Medicaid (ODM) PCMH program is voluntary. A PCMH may be a single practice or a practice partnership.
- The **CPC for Kids** program is a voluntary enhancement to the PCMH program focused on pediatric members under twenty-one years of age.
- A **Practice Partnership** is a group of practices participating as a PCMH whose performance will be evaluated as a whole. The practice partnership must meet the following requirements: a) each member practice must have an active Medicaid provider agreement; b) each member practice must have a minimum of 150 attributed Medicaid individuals determined using claims-only data; c) member practices must have a combined total of 500 or more attributed individuals determined using claims-only data at each attribution period; d) member practices must have a single designated convener that has participated as a PCMH for at least one year; e) each member practice must acknowledge to ODM its participation in the partnership; and f) each member practice must agree that summary-level practice information will be shared by ODM among practices within the partnership.
- A **Convener** is the practice responsible for acting as the point of contact for ODM and the practices that form a practice partnership.
- A **Member Practice** is any practice participating in a practice partnership.

PCMHs that have enrolled in the PCMH program provide primary care case management services under authorities of §1905(t) and 1905(a)(25) of the Social Security Act, which includes location, coordination, and monitoring of health care services. The State ensures that it will comply with the applicable beneficiary protections in §1905(t)(3) as described below, including providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies. PCMHs enroll in the PCMH program to receive per-member-per-month payments for meeting the PCMH practice characteristics and to share savings in the total cost of care for certain services.

Program Goals

The PCMH model emphasizes primary care and is intended to improve healthcare outcomes and reduce growth in total cost of care over time. An enrolled PCMH will receive PMPM payments and may have access to shared savings; the payment of savings is contingent upon meeting efficiency metrics and clinical quality of care thresholds. The measures being used to assess performance include ten activity requirements, four efficiency metrics and 20 clinical quality measures.

An enrolled PCMH that is participating in the CPC for Kids program will receive additional PMPM payments for attributed members under the age of 21 and may have access to shared savings; the payment of savings is contingent upon meeting additional efficiency metrics and clinical quality of care thresholds. Seven additional clinical quality requirements will be used to assess performance

for CPC for Kids. A PCMH participating in CPC for Kids must also pass at least one of three additional clinical quality requirements when applicable.

Additionally, the program will be monitored and evaluated as described in Attachment 4.19-B, Item 29, in the section entitled “Monitoring and Reporting.” Evaluation includes process and outcome measures based on a combination of qualitative and quantitative factors, including but not limited to claims, PCMH reporting and survey data. PCMHs may participate in the PCMH program via a provider agreement for participation in Medicaid fee-for-service (FFS). Medicaid FFS beneficiaries are free to choose from any qualified provider. Practices that enroll in the PCMH program continue to provide services and submit claims in accordance with fee-for-service requirements.

Provider Qualifications

Enrolled PCMHs participating in the PCMH program serve as primary care case managers and must meet all of the qualifications set forth in this section.

The following types of entities may participate in the Ohio PCMH program as a primary care case manager:

- i. Individual physicians and practices;
- ii. Professional medical groups;
- iii. Rural health clinics;
- iv. Federally qualified health centers;
- v. Primary care or public health clinics; or
- vi. Professional medical groups billing under hospital provider types.

Members will be attributed only to PCMH practices with providers of the following types:

- i. Medical doctor (MD) or doctor of osteopathy (DO) with primary care-related specialties or sub-specialties;
- ii. Clinical nurse specialist or certified nurse practitioner within the State’s scope of practice, with primary care-related specialties or sub-specialties;
- iii. Physician assistant within the State’s scope of practice.

To be eligible for enrollment in the PCMH program for payment beginning January 1st of each program year, the PCMH must:

- i. Have at least 500 attributed Medicaid individuals determined using claims-only data, attest that it will participate in learning activities as determined by ODM or its designee, and share data with ODM and contracted MCPs; or
- ii. Be a practice that participated in the 2017 program year.

To be eligible for enrollment in the CPC for Kids program for payment beginning January 1st of each program year, the PCMH must:

1. Be a PCMH that participates in the PCMH program; and
2. Have at least 150 attributed Medicaid pediatric individuals determined using claims-only data.

PCMH Characteristics

An enrolled PCMH must meet activity requirements within the timeframes below and have written policies where specified. Further descriptions of these activities can be found on the ODM website, www.medicaid.ohio.gov. Upon enrollment and on an annual basis, the PCMH must attest that it will:

- Meet the “twenty-four-seven and same-day access to care” activity requirements in which the PCMH must: offer at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include, but is not limited to, e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings and weekends; within 24 hours of initial request, provide access to a primary care practitioner with access to the patient’s medical record; and make patient clinical information available through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other clinicians outside the practice when the office is closed;
- Meet the “risk stratification” activity requirements in which the PCMH must have a developed method for documenting patient risk level that is integrated within the patient record and has a clear approach to implement this across the patient panel;
- Meet the “population health management” activity requirements in which the PCMH must identify patients in need of preventive or chronic services and begin outreach to schedule applicable appointments or identify additional services needed to meet the needs of the patient;
- Meet the “team-based care delivery” activity requirements in which the PCMH must define care team members, roles, and qualifications and provide various care management strategies in partnership with payers, ODM and other providers as applicable for patients in specific patient segments identified by the PCMH;
- Meet the “care management plans” activity requirements in which the PCMH must create care plans that include necessary elements for all high-risk patients as identified by the PCMH’s risk stratification process;
- Meet the “follow-up after hospital discharge” activity requirements in which the PCMH must have established relationships with emergency departments and hospitals from which it frequently receives referrals and establish a process to ensure a reliable flow of information;
- Meet the “tests and specialist referrals” activity requirements in which the PCMH must have established bi-directional communication with specialists, pharmacist, laboratories and imaging facilities necessary for tracking referrals; and
- Meet the “patient experience” activity requirements in which the PCMH must orient all patients to the practice and incorporate patient preferences in the selection of a primary care provider to build continuity of patient relationships throughout the entire care process.

- Meet the “community services and supports integration” activity requirements in which the practice uses screening tools to identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services.
- Meet the “behavioral health integration” activity requirements in which the PCMH identifies, refers, and tracks follow-ups for patients in need of behavioral health services, and has a planned improvement strategy for behavioral health outcomes.

Assurances

The following beneficiary protections in §1905(t) apply to this program:

- Services are provided according to the provisions of 1905(t) of the Social Security Act (the Act);
- §1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment;
- §1905(t)(3)(B), which restricts enrollment to nearby providers, does not apply to this program because there is no enrollment of new Medicaid beneficiaries as part of this program;
- §1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high quality care in a prompt manner;
- §1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment;
- §1903(d)(1) provides for protections against fraud and abuse;
- Any marketing and/or other activities will not result in selective recruitment and enrollment of individuals with more favorable health status, pursuant to Section 1905(t)(3)(D) of the Act, prohibiting discrimination based on health status, marketing activities included; and
- The state will notify Medicaid beneficiaries of the PCMH program. The notification will include a description of the attribution process, calculation of payments, how personal information will be used and of payment incentives, and will be made publicly available, including to those beneficiaries who are attributed to an enrolled PCMH.

Enrolled PCMHs are those that meet all eligibility criteria outlined above, have applied via the ODM website, and have had their application accepted by ODM. At the end of each performance year, in order to continue participation in Ohio’s PCMH program, an enrolled PCMH must re-attest to meeting all activity requirements, data sharing with ODM and MCPs, and participation in learning activities, and must be meeting other program requirements.