

CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: BHPP Psychology and skilled therapy rules

Rule Number(s):

5101:3-4-26 (Rescinded/New);

5101:3-8-01 (Rescinded); 5101:3-8-02 (Rescinded); 5101:3-8-03 (Rescinded);

5101:3-8-05 (Rescinded/New);

5101:3-8-30 (New); 5101:3-8-31 (New); 5101:3-8-32 (New);

5101:3-8-33 (New); 5101:3-8-34 (New);

5101:3-34-01 (Rescinded); 5101:3-34-01.1 (Rescinded);

5101:3-34-01.2 (Rescinded); 5101:3-34-01.3 (Rescinded)

Date: September 19, 2013

Rule Type:

New

5-Year Review

Amended

Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. Please briefly describe the draft regulation in plain language.

Please include the key provisions of the regulation as well as any proposed amendments.

The provision of skilled therapy services (physical therapy, occupational therapy, speech-language pathology services, and audiology services) in non-institutional settings is currently addressed in eight rules found in three separate chapters of the Ohio Administrative Code:

- Rule 5101:3-4-26, "Covered physical medicine and rehabilitation services"
- Rule 5101:3-8-01, "Eligible providers of limited practitioner services"
- Rule 5101:3-8-02, "Covered physical therapy services and limitations"
- Rule 5101:3-8-03, "Covered occupational therapy services and limitations"
- Rule 5101:3-34-01, "Physical therapy, occupational therapy and speech-language pathology/audiology services: general provisions"
- Rule 5101:3-34-01.1, "Physical therapy, occupational therapy and speech-language pathology/audiology services: definitions"
- Rule 5101:3-34-01.2, "Physical therapy, occupational therapy and speech-language pathology/audiology services: coverage and limitations"
- Rule 5101:3-34-01.3, "Physical therapy, occupational therapy and speech-language pathology/audiology services: reimbursement"

All eight of these rules are being rescinded and replaced by five new rules:

- Rule 5101:3-8-30, "Skilled therapy: scope and definitions"
- Rule 5101:3-8-31, "Skilled therapy: providers"
- Rule 5101:3-8-32, "Skilled therapy: coverage"
- Rule 5101:3-8-33, "Skilled therapy: documentation of services"
- Rule 5101:3-8-34, "Skilled therapy: payment"

A new rule is being adopted to address physical medicine and rehabilitation services furnished by a physician or by a licensed individual under the supervision of a physician:

- Rule 5101:3-4-26, "Physical medicine and rehabilitation services"

The current rule governing psychology services, which includes references to a rescinded rule, is being rescinded:

- Rule 5101:3-8-05, "Covered psychology services and limitations"

It is being replaced by a new rule of the same number:

- Rule 5101:3-8-05, "Psychology services provided by licensed psychologists"

All changes take effect for dates of service January 1, 2014, or after.

Several aspects of the consolidation of the skilled therapy rules are particularly noteworthy:

- The content of the rules has been reorganized and streamlined. As a result, there is no longer a need for Chapter 5101:3-34 of the Ohio Administrative Code.
- Unnecessary definitions have been removed.

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- Parts of the current rules that duplicate provisions found elsewhere in the Ohio Administrative Code have been deleted.
- Speech-language pathologists and audiologists are now recognized as eligible providers who can submit claims to Medicaid on their own behalf. If they wish to do so, they may continue to receive payment for services that are reported on claims submitted through other providers, as the current rules require; the revised rules will give them an option they did not have before of becoming independent providers.
- The Medicaid requirement that therapy services be provided only by prescription is being eliminated, and all references to a "Medicaid-authorized prescriber" are being removed. Providers will continue to be bound by any licensing requirements that concern prescribing or prescriptions, but Medicaid will no longer superimpose additional prescription requirements not found in licensure law.
- For ease and consistency of administration, a defined benefit year replaces the rolling calendar year as the period within which service limits apply. The limit of thirty dates of service for any combination of physical therapy and occupational therapy is changed to thirty dates of service for each type of therapy.
- A payment-reduction provision is added that applies when more than one skilled therapy service of the same type is rendered by a non-institutional provider to an individual patient on the same date; under this provision, payment is made for the primary procedure at 100% and for each additional procedure at 50%.

There are several significant revisions in the new psychology services rule, 5101:3-8-05:

- Unnecessary references to past dates of service have been removed.
- The specification of procedure codes and modifiers has been discontinued. Descriptions of service are sufficient to indicate what is covered under Medicaid. (Descriptions are also not likely to change very much, even if code sets are revamped.) Providers are simply directed to report appropriate procedure codes and modifiers on claims, instructions for which are readily available from the department and other sources.
- Under the current rule, a doctoral-level clinical psychology intern may provide a psychology service if the licensed psychologist responsible for an individual's care furnishes direct supervision of the intern and has face-to-face contact with the individual during the visit (a phrase that has been interpreted to mean "each visit"). Psychologists have indicated that these supervision and contact requirements are overly stringent and exceed the relevant provisions set forth in the Ohio Revised Code. The new rule calls for general supervision, and face-to-face contact is required during the initial visit and no less often than once per quarter (or during each visit if visits are scheduled more than three months apart).

New rule 5101:3-4-26 maintains Medicaid coverage and payment policy for physical medicine and rehabilitation services, and it includes a reference to rules governing physical therapy, occupational therapy, speech-language pathology, and audiology.

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2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

The Ohio Department of Medicaid (ODM) is promulgating these rules under section 5111.02 of the Ohio Revised Code.

3. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?

If yes, please briefly explain the source and substance of the federal requirement.

Ohio Medicaid receives federal matching funds for coverage of medically necessary physical therapy, occupational therapy, speech-language pathology, and audiology services (addressed at 42 CFR 440.110); psychology services rendered by licensed psychologists (addressed at 42 CFR 440.60); and physician services (addressed at 42 CFR 440.50). Provisions in 42 CFR Part 447 Subpart B require each state Medicaid program to maintain documentation of the amounts it pays for supplies and services and to provide public notice of any significant proposed change in its methods and standards for establishing payment amounts. Any change that entails the addition, revision, or discontinuation of a Healthcare Common Procedure Coding System (HCPCS) code is governed by the Health Insurance Portability and Accountability Act (HIPAA).

4. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

These rules do not exceed federal requirements.

5. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment methodologies or fee schedules for the use of providers and the general public.

Medicaid is adopting the multiple-procedure payment-reduction provision for skilled therapy used by Medicare in recognition of the fact that—regardless of setting—there is no appreciable difference in overhead expense whether one procedure is performed or several procedures are performed in a single treatment session. Therefore, when multiple procedures are performed by the same provider for the same person on the same date, payment for overhead expense should be included for only one of the procedures and deducted for the others.

6. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

These rules essentially involve internal operating procedures and place no requirements on providers. The success of these rules will be measured by (1) the extent to which payment is reduced for multiple therapy procedures performed during the same treatment session and (2) the extent to which speech-language pathologists and audiologists are able to submit claims that are correctly paid.

Development of the Regulation

7. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.

If applicable, please include the date and medium by which the stakeholders were initially contacted.

The proposed changes to rule 5101:3-8-05 that allow general supervision rather than direct supervision of a psychology intern and the easing of the requirements for face-to-face contact by the supervising psychologist with the patient are being made at the recommendation of psychologists objecting that current supervision and contact requirements are overly stringent and exceed the relevant Ohio Revised Code provisions.

The proposed multiple-procedure payment-reduction provision for skilled therapy was presented as part of the Executive Budget for SFY2014 and SFY2015 and posted on the Office of Health Transformation website at <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=3l8MukSy-Uw%3d&tabid=156>. Director Greg Moody (Office of Health Transformation) and members of the Health Transformation team described them on February 14, 2013, in testimony before the House Finance and Appropriations Committee. Director John McCarthy (Ohio Department of Medicaid) presented them in testimony on February 28, 2013, before the Health and Human Services Subcommittee of the House Finance and Appropriations Committee and on April 24, 2013, before the Medicaid Finance Subcommittee of the Senate Finance Committee.

In order to solicit public comment on multiple-procedure payment reduction and on other provisions not stemming from the budget, the department will submit the proposed Administrative Code rules to the Clearance process.

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

The proposed multiple-procedure payment-reduction provision for skilled therapy was not modified in nor eliminated from Am. Sub. H.B. 59 during the legislative process. Accordingly, those legislative provisions will be implemented through the administrative rules.

Drafts of those rules are currently in Clearance. All comments received will be carefully reviewed to determine whether modifications are necessary to the rules before they are formally filed with the Joint Committee on Agency Rule Review (JCARR). Any suggestions made by stakeholders will be sent to the CSI Ohio office, along with the responses given and a description of any changes made as a result of those suggestions.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Utilization and expenditure data drawn from ODM's Decision Support System were used in projecting the fiscal impact of the proposed changes.

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

No alternatives were considered, because multiple-procedure payment-reduction was a requirement set forth in the biennial budget.

11. Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

Because these rules place no requirements on providers, the concept of performance-based regulation does not apply.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

Rules involving Medicaid providers are located exclusively in division 5101:3 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to which type of provider and item or service. In this instance, there was no duplication.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

The proposed multiple-procedure payment-reduction policy will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the applicable rule. They will therefore be automatically and consistently applied by the department's electronic claim-payment system whenever an appropriate provider submits a claim for an applicable service.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

- a. Identify the scope of the impacted business community;**
- b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**

- c. Quantify the expected adverse impact from the regulation.**

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a “representative business.” Please include the source for your information/estimated impact.

a. Changes in these rules affect professional providers of skilled therapy services rendered in non-institutional settings and, to a very small degree, psychologists.

b. These rules impose no license fees or fines. They require no additional record-keeping or reporting.

In fact, the amount of documentation that must be maintained by skilled therapy providers will be substantially reduced. For example, under the current rules, after a "Medicaid-authorized prescriber" writes a prescription for therapy, the skilled therapy provider must perform a clinical evaluation and assessment and submit a plan of care and treatment to the prescriber for approval; the skilled therapy provider must then send the prescriber a patient progress summary at the end of the treatment period. Most of this paperwork transmission is rendered unnecessary by the fact that under current Ohio law, some skilled therapists may initiate treatment without needing to obtain separate authorization from another practitioner. Therefore, although there is still a need for an evaluation and a treatment plan, there is no need for the skilled therapy provider to turn these documents into reports, and such a requirement has been omitted in the new rules.

Moreover, in response to objections from psychologists that parts of the current rule concerning interns exceed provisions of the Ohio Revised Code, we have relaxed the supervision requirement both qualitatively and quantitatively.

Most of the reporting requirements laid out in these rules are essentially billing instructions that enable providers to submit claims successfully. They are not directives to submit a claim but rather descriptions of the information to be included if a provider should submit a claim. Similarly, specifications concerning procedure codes or modifiers provide guidance rather than impose obligation.

c. Under these revised rules, speech-language pathologists and audiologists may enroll as Medicaid providers, but they are not required to do so; taking on the burden of going through the enrollment process and subsequently submitting claims is entirely voluntary. If they wish to do so, they may continue to receive payment for services that are reported on claims submitted through other providers, as the current rules require; the revised rules will give them an option they did not have before of becoming independent providers. In all other respects, the changes in these rules should have no adverse operational impact, either on individual providers or in the aggregate. On the contrary, providers should find that doing business with Medicaid will be much less onerous.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

None of the changes in these rules requires a provider to do anything. Any effort undertaken by providers to enroll in Medicaid or to update their billing systems will be the result of business decisions rather than regulatory mandate.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

These rules do not require any compliance action on the part of providers other than to submit claims when they want Medicaid payment.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

These rules impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a “trading partner”) can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5101:3-4-26

Covered physical medicine and rehabilitation services .

- (A) Physical medicine and rehabilitation services described in Chapter 5101:3-34 of the Administrative Code are covered in the office setting of a physician.
- (B) Physical medicine and rehabilitation services may be billed by eligible providers of physician services as defined in rule 5101: 3-4-01 of the Administrative Code which have executed the standard Ohio medicaid provider agreement.
- (C) The provisions in Chapter 5101:3-34 of the Administrative Code apply to physical medicine and rehabilitation services except the terms "physical or occupational therapy" shall be replaced by the term "physical medicine" and "physical or occupational therapist" shall be replaced by the term "physician."
- (D) Eligible providers of physician services may be reimbursed for covered physical medicine and rehabilitation services performed by a physician, by a licensed physical or occupational therapist employed by or under contract with the physician, or by licensed individuals who are under the direct supervision of the physician in accordance with rule 5101: 3-4-02 of the Administrative Code.
- (E) The department also covers physical medicine and rehabilitation services prescribed by a physician, but personally performed by a self-employed physical or occupational therapist, physical or occupational therapist assistant under the direct supervision of a physical or occupational therapist, physical or occupational therapy group practice, or mechanotherapist eligible to provide services under medicaid. In this case, the physician may be reimbursed for any direct medical services he provides (e.g., physical evaluation and determination of the plan of treatment), but may not be reimbursed for the services provided by a self-employed physical therapist, occupational therapist, physical therapy group, occupational therapy group, or mechanotherapist who may bill for these services directly.
- (F) Services that do not meet the provisions outlined in Chapter 5101:3-34 of the Administrative Code and do not require the professional skills of a physician to perform or supervise the services are considered non-covered services.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.021, 5111.029
Prior Effective Dates:	07/01/2002, 01/01/2008

*** DRAFT - NOT YET FILED ***

5101:3-4-26

Physical medicine and rehabilitation services.

(A) Payment may be made for covered physical medicine and rehabilitation services performed by a physician or by a licensed individual under the direct supervision of a physician in accordance with rule 5101:3-4-02 of the Administrative Code.

(B) Physical therapy, occupational therapy, speech-language pathology, and audiology are addressed in Chapter 5101:3-8 of the Administrative Code.

Replaces: Part of 5101:3-4-26

Effective:

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Certification

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Promulgated Under: 119.03
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Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.029
Prior Effective Dates: 10/01/1983 (Emer), 12/29/1983, 01/01/1986,
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09/01/1989, 12/30/1994 (Emer), 03/30/1995,
07/01/2002, 01/01/2008

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5101:3-8-01 **Eligible providers of limited practitioner services.**

- (A) Individuals licensed under state of Ohio law to practice a limited branch of medical or remedial care are eligible to participate in the medicaid program within the scope of that limited practice as defined by state law, provided that the individual is authorized by the rules of the department to be a provider for those services, and holds a currently valid provider agreement. (Reference Chapter 5101:3-1 of the Administrative Code for an explanation of conditions for a provider agreement.)
- (B) Providers of limited practitioner services may form or enter into a professional medical group in accordance with the provisions set forth in rule 5101:3-1-17 of the Administrative Code. The professional medical group may bill for practitioner services performed by limited practitioners who are a part of the medical professional medical group.
- (C) Providers of limited medical/remedial care thus eligible include:
- (1) Individual chiropractor licensed under Chapter 4734. of the Revised Code for medicaid-covered services within the scope of his or her practice as defined by state law.
 - (2) Individual physical therapist licensed under sections 4755.40 to 4755.56 of the Revised Code for medicaid-covered services within the scope of his or her practice as defined by state law. The provider must also be a participant under the medicare program and must maintain an independent practice as defined and determined under medicare.
 - (3) Individual occupational therapist licensed under sections 4755.04 to 4755.13 of the Revised Code for medicaid-covered services within the scope of his or her practice as defined by state law. The provider must also be a participant under the medicare program and must maintain an independent practice as defined and determined under medicare.
 - (4) Individual mechanotherapist licensed under section 4731.15.1 of the Revised Code for medicaid-covered services within the scope of his or her practice as defined by state law.

- (5) Individual psychologist licensed under Chapter 4732. of the Revised Code for medicaid-covered services within the scope of his or her practice as defined by state law. The provider must also be a participant under medicare.
- (D) Eligible providers of physical therapy, occupational therapy, and psychology services may also include the following Ohio medicaid providers:
- (1) Fee-for-service ambulatory health care clinics as defined in Chapter 5101: 3-13 of the Administrative Code;
 - (2) Rural health clinics as defined in Chapter 5101:3-16 of the Administrative Code;
 - (3) Outpatient health facilities as defined in Chapter 5101:3-29 of the Administrative Code;
 - (4) Federally qualified health centers as defined in Chapter 5101:3-28 of the Administrative Code;
 - (5) Hospitals as defined in Chapter 5101: 3-2 of the Administrative Code; and
- (E) The provider types listed in paragraphs (D)(1), (D)(2), and (D)(4) of this rule may also be eligible to provide chiropractic services.

Effective:

R.C. 119.032 review dates:

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01/01/2008, 08/02/2011

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5101:3-8-02 **Covered physical therapy services and limitations.**

(A) Definitions.

Additional definitions are described in Chapter 5101:3-34 of the Administrative Code.

- (1) "Direct supervision" or "directly supervised" means that the physical therapist must be present throughout the time the physical therapist assistant is providing the service and immediately available to provide assistance and direction throughout the time the physical therapist assistant is performing services.

(B) Medicaid eligible provider of physical therapy services.

- (1) Physical therapy services described in this rule may be billed by the following limited practitioners who are currently licensed and working within the scope of their practices as defined by state law and have executed the standard Ohio medicaid provider agreement:
 - (a) Physical therapists in independent practice as set forth in rule 5101:3-8-01 of the Administrative Code and licensed under Chapter 4755. of the Revised Code; and
 - (b) Mechanotherapists as set forth in rule 5101:3-8-01 of the Administrative Code and licensed under Chapter 4731. of the Revised Code.
- (2) Other independently practicing providers authorized to be reimbursed by the department for physical therapy are described in Chapter 3-34 of the Administrative Code.
- (3) Physical therapy services provided in a school, hospital, or long term care facility must be billed by the school, hospital, or long term care facility in which the services were provided.

(C) Coverage and limitations.

Medicaid coverage and limitations of physical therapy services are described in Chapter 5101:3-34 of the Administrative Code.

- (1) Modality guidelines.
 - (a) Supervised modalities must have direct (one-on-one) provider to consumer contact. The provider must be licensed to provide the modality and must be directly supervised by a medicaid-authorized prescriber or therapist.
 - (b) The following modalities are considered part of the associated therapy procedure or medical encounter and are not separately reimbursable:
 - (i) Electrical stimulation-unattended; and
 - (ii) Iontophoresis therapy.
 - (c) Certain modalities are considered part of an associated physical therapy procedure or medical encounter and are not separately reimbursable.
- (D) Provider claims, billing, payment, and reimbursement are addressed in Chapters 5101:3-1, 5101:3-2, and 5101:3-3 of the Administrative Code.

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07/01/2002, 01/01/2008

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5101:3-8-03 **Covered occupational therapy services and limitations.**

(A) Definitions.

Additional definitions are described in rule 5101:3-34-01.1 of the Administrative Code.

- (1) "Direct supervision" or "directly supervised" means that the occupational therapist must be present throughout the time the occupational therapy assistant is providing the service and immediately available to provide assistance and direction throughout the time the occupational therapy assistant is performing services.

(B) Medicaid eligible provider of occupational therapy services.

- (1) Occupational therapy services described in this rule may be billed by occupational therapists in independent practice who are currently licensed under Chapter 4755. of the Revised Code, who are working within the scope of their practice as defined by state law and set forth in rule 5101:3-8-01 of the Administrative Code, and who have executed the standard Ohio medicaid provider agreement.
- (2) Other independently practicing providers authorized to be reimbursed by the department for occupational therapy are described in Chapter 3-34 of the Administrative Code.
- (3) Occupational therapy services provided in a school, hospital, or long term care facility must be billed by the school, hospital, or long term care facility in which the services were provided.

(C) Coverage and limitations.

Medicaid coverage and limitations of occupational therapy services are described in Chapter 5101:3-34 of the Administrative Code.

(1) Modality guidelines.

- (a) Supervised modalities must have direct (one-on-one) provider to consumer contact. The provider must be licensed to provide the

modality and must be directly supervised by a medicaid-authorized prescriber or therapist.

(b) The following modalities are considered part of the associated therapy procedure or medical encounter and are not separately reimbursable:

(i) Electrical stimulation-unattended; and

(ii) Iontophoresis therapy.

(c) Certain modalities are considered part of an associated occupational therapy procedure or medical encounter and are not separately reimbursable.

(D) Provider claims, billing, payment, and reimbursement are addressed in Chapters 5101:3-1, 5101:3-2, and 5101:3-3 of the Administrative Code.

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Prior Effective Dates: 01/01/2008

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5101:3-8-05 **Covered psychology services and limitations.**

For dates of service from January 1, 2004 through December 31, 2007, psychology services specified in paragraphs (C) to (F) of this rule were not covered medicaid services for adults twenty-one years of age and older when services were provided by an independent psychologist and independent group psychologist practices.

Psychology services not provided by independent psychologists (for example, services provided in an outpatient hospital facility) continued to be covered medicaid services.

Effective for dates of service from January 1, 2008, psychology services for adults twenty-one years of age and older when provided by an independent psychologist and independent group psychologist practices for adults are covered services subject to the coverage and limitations as specified in this rule.

(A) Definitions:

- (1) "Independent psychologist" means a psychologist licensed under Chapter 4732. of the Revised Code who provides services on his/her own, free of administrative and professional control of an employer such as an institution, physician, or agency.
 - (a) The psychologist treats his/her own patients and has a valid Ohio medicaid provider agreement to bill directly for his/her services. A psychologist practicing in an office located in an institution may be considered an "independently practicing psychologist" when both of the following conditions are met:
 - (i) The office is in a separately identifiable part of the facility which is used solely as the psychologist's office and is not viewed as extending through the entire institution; and
 - (ii) The psychologist has a private practice, e.g provides services to consumers outside of the institution as well as to institutionalized .consumers. The private practice is not owned, in part or in total by the institution.
 - (b) A psychologist seeing nursing home consumers cannot bill medicaid using his/her psychologist provider number. Services to nursing home consumers are covered through the nursing facility's cost report and

described in Chapter 5101:3-3 of the Administrative Code.

- (2) "Provider-based psychologist" means a psychologist employed by a provider listed in paragraph (D) of rule 5101:3-8-01 of the Administrative Code.
 - (3) "Psychological tests" means tests which address personality disorders, intellectual function, behavioral or addictive disorders, or screening tests for organic brain disease.
 - (4) "Neuropsychological tests" means tests for consumers suffering from cognitive defects due to neurological conditions.
 - (5) "Direct supervision" is defined in rule 5101:3-4-02 of the Administrative Code.
 - (6) "Group psychotherapy" means psychological treatment involving two or more consumers participating together in the presence of one or more psychologists who facilitate interactions to effect targeted changes in the behavior of a consumer.
- (B) Services must be personally provided by a licensed psychologist meeting the qualifications in section 4732.10 of the Revised Code. Services must be medically necessary for the diagnosis and treatment of an illness or injury to be a covered medicaid service. All services must be within the scope of practice for a licensed psychologist as defined in Chapter 4732. of the Revised Code. To be reimbursed for psychology services:
- (1) Services must be billed under the individual psychologist's provider number only when the services are provided by an independently practicing psychologist as defined in paragraph (A) of this rule.
 - (2) Services must be billed by a psychology group practice only if the psychologist is employed by a group medical practice as defined in rule 5101:3-8-01 of the Administrative Code.
 - (3) Services must be billed under the hospital's or clinic's medicaid provider number when the psychologist is provider-based as defined in paragraph (A)(2) of this rule.
 - (4) Effective with services provided on and after October 1, 2003, when billing for any service, the licensed psychologist must bill the appropriate procedure code for the service rendered and modify the code by the "AH" modifier to signify that the service was personally provided by a licensed psychologist.

- (5) When services are provided to inpatients in a hospital or to nursing home residents regardless of the billing arrangement, the psychologist cannot submit a claim as an individual psychologist or as a psychology group medical practice.

(C) Covered psychological testing services:

- (1) Psychological and neuropsychological testing are covered when performed to assist in establishing a psychological or neuropsychological disorder. The consumer's medical record must support the medical necessity of the tests performed.
- (2) For dates of service beginning on or after January 1, 2006, the department will pay in accordance with rule 5101:3-1-60 of the Administrative Code for procedure codes 96101 through 96118 for medically necessary psychological testing services personally performed by a licensed psychologist.

(D) Covered therapeutic services:

- (1) For services provided on or after July 1, 2002, the department will pay eighty-five per cent of the value listed in rule 5101:3-1-60 of the Administrative Code for each procedure code for services performed by a licensed psychologist. The following procedure codes must be billed for therapeutic services:
 - (a) For individual psychotherapy provided in the office, outpatient clinic, outpatient hospital, or home, bill the following codes:
 - (i) 90832 Psychotherapy, 30 minutes with patient and/or family member.
 - (ii) 90834 Psychotherapy, 45 minutes with patient and/or family member.
 - (iii) 90837 Psychotherapy, 60 minutes with patient and/or family member.
 - (iv) 90785 Interactive complexity (List separately in addition to the code for primary procedure).

(b) Family psychotherapy is covered only where the primary purpose of such counseling is the treatment of the consumer's condition, not the treatment of the family members. For family or group psychotherapy, bill the following codes:

(i) 90846 Family psychotherapy (without consumer present).

(ii) 90847 Family psychotherapy (with consumer present).

(iii) 90849 Multiple-family group psychotherapy.

(iv) 90853 Group psychotherapy as defined in paragraph (A)(6) of this rule (other than of a multiple-family group).

(c) Interactive complexity is covered only where specific communication factors complicate the delivery of a psychotherapy service listed in (D)(1)(a)(i) to (D)(1)(a)(iii) of this rule. For interactive complexity, bill the following code:

(i) 90785 Interactive complexity (List separately in addition to the code for primary procedure).

(E) Diagnostic evaluation

(1) For dates of service on and after October 1, 2003, a diagnostic evaluation will be a covered service.

(2) To be reimbursed, bill code 90791. This code is not time-based and can be billed only as one unit of service.

(3) The department will pay eighty-five per cent of the medicaid maximum for an evaluation personally performed by a licensed psychologist.

(F) Services provided by clinical psychology doctoral level interns completing required internships.

For services provided by clinical psychology doctoral level interns completing required internships to be reimbursed to a psychologist, the following conditions must be met:

- (1) The psychologist billing medicaid must have a letter on file covering the dates of services of the doctoral level internship from the doctoral level program;
- (2) The graduate doctoral level intern must be under the direct supervision of the licensed psychologist responsible for the consumer's care;
- (3) The licensed psychologist responsible for the consumer's care must have face-to-face contact with the consumer during the consumer's visit and must confirm that the service provided by the doctoral level intern was appropriate; and
- (4) The consumer's medical record must show that the requirements for reimbursement were met and the licensed psychologist responsible for the consumer's care reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed psychologist is responsible for the consumer's care.

(G) Non-covered psychological services:

The following psychologists' services are not covered by the Ohio medicaid program:

- (1) All services listed in paragraph (F) of rule 5101:3-4-29 of the Administrative Code describing mental and emotional disorders;
- (2) Self-administered or self-scored tests of cognitive function;
- (3) Services provided by a school psychologist in facilities regulated by the state board of education;
- (4) Biofeedback therapy;
- (5) Services which are not personally performed by a psychologist with whom the department has a provider agreement and who is licensed under Chapter 4732. of the Revised Code;
 - (a) With the exception of the provisions stated in paragraph (F) of this rule, services provided by licensed individuals with whom the department does not have an individual provider agreement are not reimbursable even though the covered services are provided under the personal supervision of licensed psychologist with whom the department does

have a provider agreement.

- (b) Services provided by unlicensed individuals under the personal supervision of a licensed psychologist are not reimbursable.
- (6) Services provided to nursing home residents are reimbursable through the nursing facility's cost report and shall not be billed directly by the psychologist as specified in Chapter 5101:3-3 of the Administrative Code;
- (7) Services provided to consumers in an inpatient or outpatient hospital setting are not covered in this rule but are covered in Chapter 5101:3-2 of the Administrative Code;
- (8) Services unrelated to the treatment of a specific medical complaint or services which are not medically necessary as defined in Chapter 5101:3-1 of the Administrative Code;
- (9) Services determined by another third-party payer (especially medicare Title XVIII) as not medically necessary are not covered;
 - (a) All psychological services denied by medicare; and
 - (b) The thirty-seven point five per cent outpatient psychiatric payment limitation subtracted from medicare claims.

(H) Limitations:

- (1) Psychological testing is limited to a maximum of eight hours per twelve-month period per consumer in a non-hospital setting.
- (2) Therapeutic visits and diagnostic interview examinations in excess of a combined twenty-five dates of service per consumer in a twelve-month period in an non-hospital setting are not covered.
- (3) Diagnostic interview examinations will be limited to one per consumer per twelve month period and may not be billed on the same date of service as a therapeutic visit.

(I) Documentation:

The consumer's medical record must support the medical necessity of the tests

and/or therapies performed. The records should contain the following documentation at a minimum:

- (1) The date the service was provided;
- (2) The type of tests and/or type of therapies performed, including test results;
- (3) The face-to-face time spent with the consumer on testing or therapy;
- (4) Time spent interpreting and reporting for testing codes specified in rule 5101:3-1-60 of the Administrative Code under the title "Central Nervous System (CNS) Test";
- (5) A written interpretation by a psychologist of the tests and/or psychotherapy sessions should be in the consumer's record;
- (6) The discipline and signature of the professional providing the service; and
- (7) All documentation provisions for therapeutic services outlined in paragraph (H) of rule 5101:3-4-29 of the Administrative Code shall apply to therapeutic services provided by a psychologist with the exception that a psychologist does not need to have the treatment plan signed and dated by a physician prior to initiating therapy.

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5101:3-8-05

Psychology services provided by licensed psychologists.

(A) Scope. This rule sets forth provisions governing payment for psychology services provided by licensed psychologists in non-institutional settings. Provisions governing payment for psychology services as the following service types are set forth in the indicated part of the Administrative Code:

(1) Hospital services, Chapter 5101:3-2;

(2) Nursing facility services, Chapter 5101:3-3;

(3) Physician services, Chapter 5101:3-4;

(4) Clinic services rendered by the following providers:

(a) Fee-for-service ambulatory health care clinics, Chapter 5101:3-13;

(b) Rural health clinics, Chapter 5101:3-16;

(c) Federally qualified health centers, Chapter 5101:3-28; or

(d) Outpatient health facilities, Chapter 5101:3-29;

(5) Medicaid school program services, Chapter 5101:3-35; and

(6) Intermediate care facility services, Chapter 5123:2-7.

(B) The following definitions apply to this rule:

(1) "Psychologist" is a person licensed under Chapter 4732. of the Revised Code to practice as a psychologist.

(2) "Independent psychologist" is a psychologist who is not subject to the administrative and professional control of an employer such as an institution, physician, or agency. A psychologist practicing in an office that is located within an entity is considered to be independent when both of the following conditions are met:

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

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

entity.

(3) "General supervision" has the same meaning as in rule 5101:3-4-02 of the Administrative Code.

(C) Providers.

(1) Independent psychologists either must participate in the medicare program or, if they limit their practice to pediatric treatment and do not serve medicare beneficiaries, must meet all other requirements for medicare participation.

(2) Rendering providers. The following eligible providers may render a psychology service:

(a) A psychologist; or

(b) A doctoral-level psychology intern completing a required internship, if the following conditions are met:

(i) The intern provides the service under the general supervision of the psychologist responsible for the patient's care;

(ii) The psychologist responsible for the patient's care has face-to-face contact with the patient during the initial visit and no less often than once per quarter (or during each visit if visits are scheduled more than three months apart);

(iii) The psychologist responsible for the patient's care obtains and keeps information from the intern's training program documenting the internship, including the beginning and ending dates; and

(iv) The psychologist responsible for the patient's care includes in the patient's medical record documentation that appropriate service was provided by a doctoral-level psychology intern under general supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met.

(3) Billing ("pay-to") providers. The following eligible providers may receive medicaid payment for submitting a claim for a psychology service on behalf of a rendering provider:

(a) An independent psychologist;

(b) A professional medical group;

(c) A hospital, rules for which are set forth in Chapter 5101:3-2 of the

Administrative Code:

- (d) An ambulatory health care clinic, rules for which are set forth in Chapter 5101:3-13 of the Administrative Code;
- (e) A rural health clinic, rules for which are set forth in Chapter 5101:3-16 of the Administrative Code;
- (f) A federally qualified health center, rules for which are set forth in Chapter 5101:3-28 of the Administrative Code; or
- (g) An outpatient health facility, rules for which are set forth in Chapter 5101:3-29 of the Administrative Code.

(D) Coverage.

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

(a) Psychological and neuropsychological testing;

(b) Therapeutic services:

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

(a) Psychotherapy, 30 minutes with patient and/or family member;

(b) Psychotherapy, 45 minutes with patient and/or family member;

(c) Psychotherapy, 60 minutes with patient and/or family member; and

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

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

(a) Family psychotherapy without patient present;

(b) Family psychotherapy with patient present;

(c) Group psychotherapy;

(d) Multiple-family group psychotherapy; and

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

(c) Diagnostic evaluation, one unit.

(2) The following payment limitations apply to psychology services provided to an individual in a non-hospital setting:

(a) For psychological testing, a maximum of eight hours per twelve-month period;

(b) For diagnostic evaluation, one date of service per twelve-month period, not on the same date of service as a therapeutic visit; and

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

(3) The following psychology-related items and services are not covered by medicaid:

(a) Services that are not medically necessary in accordance with Chapter 5101:3-1 of the Administrative Code;

(b) Services rendered by an by unlicensed individual, even if the services are provided under the personal supervision of a psychologist;

(c) Services rendered by licensed psychologist who lacks a current medicaid provider agreement, even if the services are provided under the personal supervision of a psychologist who has a current medicaid provider agreement;

(d) Psychology-related services listed as non-covered in rule 5101:3-4-29 of the Administrative Code;

(e) Services unrelated to the treatment of a specific medical complaint;

(f) Services determined by a third-party payer not to be medically necessary;

(g) Any psychology service for which payment is denied by medicare;

(h) The outpatient psychiatric exclusion from medicare payments;

(i) Self-administered or self-scored tests of cognitive function; and Biofeedback therapy.

(E) Documentation of services. The patient's file must substantiate the medical necessity of services performed. Each record should include the signature and professional discipline of the provider. The following items illustrate the types of information to be included:

- (1) A description of the patient's symptoms and functional impairment;
- (2) Relevant medical and psychiatric diagnoses;
- (3) Evidence that the patient has sufficient cognitive capacity to benefit from treatment;
- (4) A treatment plan that specifies treatment goals, tracks responses to ongoing treatment; and presents a prognosis;
- (5) The type, duration, and frequency of treatment, with dates of service;
- (6) Medications taken by or prescribed for the patient;
- (7) The amount of time spent by the provider face-to-face with the patient;
- (8) The amount of time spent by the provider in interpreting and reporting on procedures represented by Central Nervous System Testing codes;
- (9) Test results, if applicable, with interpretation; and
- (10) Summaries of and notes on psychotherapy sessions.

(F) Claim payment.

- (1) Providers must report appropriate procedure codes and modifiers on claims.
- (2) The maximum fee for a psychology service performed by a psychologist is the lesser of the provider's submitted charge or eighty-five per cent of the amount for the service specified in Appendix DD to rule 5101:3-1-60 of the Administrative Code.
- (3) A psychology service performed during a hospital stay is treated as a hospital service.
- (4) Payment for a psychology service rendered to a resident of a nursing facility (NF) is made to the NF through the facility per diem. An independent psychologist who renders a psychology service to a NF resident must seek payment from the NF.
- (5) A psychologist may be reported on a claim as the billing provider only if the

psychologist is independent. If a psychologist is a member of a professional medical group or is employed by a hospital or clinic, then the medical group, hospital, or clinic must be reported as the billing provider.

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5101:3-8-30

Skilled therapy: scope and definitions.

(A) Rules 5101:3-8-31 to 5101:3-8-34 of the Administrative Code set forth provisions governing payment for skilled therapies as non-institutional professional services. Provisions governing payment for skilled therapies as the following service types are set forth in the indicated part of the Administrative Code:

(1) Hospital services, Chapter 5101:3-2;

(2) Nursing facility services, Chapter 5101:3-3;

(3) Home health services, Chapter 5101:3-12;

(4) Clinic services rendered by the following providers:

(a) Fee-for-service ambulatory health care clinics, Chapter 5101:3-13;

(b) Rural health clinics, Chapter 5101:3-16;

(c) Federally qualified health centers, Chapter 5101:3-28; or

(d) Outpatient health facilities, Chapter 5101:3-29;

(5) Medicaid school program services, Chapter 5101:3-35; and

(6) Intermediate care facility services, Chapter 5123:2-7.

(B) The following definitions apply to rules 5101:3-8-31 to 5101:3-8-34 of the Administrative Code:

(1) "Audiologist" is a person who holds a valid license under Chapter 4753. of the Revised Code as an audiologist and who is eligible for or meets the educational requirements for a certificate of clinical competence in audiology granted by the American speech-language-hearing association.

(2) "Audiology aide" is a person who holds a valid license as an audiology aide under Chapter 4753. of the Revised Code.

(3) "Conditionally-licensed audiologist" is a person who holds a conditional license to practice audiology in accordance with section 4753.071 of the Revised Code.

(4) "Conditionally-licensed speech-language pathologist" is a person who holds a conditional license to practice speech-language pathology in accordance with section 4753.071 of the Revised Code.

- (5) "Developmental services" are skilled therapy services rendered, in accordance with developmental milestones established by the American academy of pediatrics, to enable individuals younger than seven years of age to attain a level of age-appropriate functionality that they have not yet achieved but are expected to achieve.
- (6) "Developmental disability" has the same meaning as in section 5123.01 of the Revised Code.
- (7) "Direct supervision" is a person's physical presence and immediate availability to provide assistance and direction while a subordinate performs a service.
- (8) "Eligible provider" has the same meaning as in rule 5101:3-1-17 of the Administrative Code.
- (9) "Maintenance services" are skilled therapy services rendered to individuals for the purpose of maintaining but not improving functionality.
- (10) "Mechanotherapist" is a person who holds a valid license as a mechanotherapist under Chapter 4731. of the Revised Code and works within the scope of practice defined by state law.
- (11) "Non-institutional setting" is a location that is not a hospital or long-term care facility and that is appropriate to the delivery of physical therapy services. Examples include but are not limited to practitioners' offices, clinics, licensed child day care centers, adult day care centers, and public facilities such as community centers.
- (12) "Occupational therapist" is a person who holds a valid license as an occupational therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.
- (13) "Occupational therapist assistant" is a person who holds a valid license as an occupational therapist assistant under Chapter 4755. of the Revised Code.
- (14) "Occupational therapy" has the same meaning as in section 4755.04 of the Revised Code.
- (15) "Physical therapist" is a person who holds a valid license as a physical therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.
- (16) "Physical therapist assistant" is a person who holds a valid license as a physical therapist assistant under Chapter 4755. of the Revised Code.
- (17) "Physical therapy" has the same meaning as in section 4755.40 of the Revised

Code.

- (18) "Rehabilitative services" are skilled therapy services rendered to individuals for the purpose of improving functionality.
- (19) "Skilled therapist" is a collective term encompassing physical therapist, occupational therapist, speech-language pathologist, and audiologist.
- (20) "Skilled therapy" is a collective term encompassing physical therapy, occupational therapy, speech-language pathology, and audiology.
- (21) "Speech-language pathologist" is a person who holds a valid license under Chapter 4753. of the Revised Code as a speech-language pathologist and who is eligible for or meets the educational requirements for a certificate of clinical competence in speech-language pathology granted by the American speech-language-hearing association.
- (22) "Speech-language pathology aide" is a person who holds a valid license as a speech-language pathology aide under Chapter 4753. of the Revised Code.
- (23) "Standardized test" is a diagnostic tool or procedure that has a standardized administration and scoring process, the results of which can be compared to an appropriate normative sample. Standardized tests must be norm-referenced, age-appropriate, and specific to areas of deficit.
- (24) "Supplemental test" is a non-diagnostic screening or criterion-referenced tool that is used to provide further documentation of deficits and to corroborate the results of a standardized test. A supplemental test may not be used in place of a standardized test.

Replaces: Part of 5101:3-34-01.1, part of 5101:3-34-01.2

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5101:3-8-31

Skilled therapy: providers.

(A) Rendering providers.

(1) Independently practicing skilled therapists either must participate in the medicare program or, if they limit their practice to pediatric treatment and do not serve medicare beneficiaries, must meet all other requirements for medicare participation.

(2) The following eligible providers may render a physical therapy service:

(a) A physical therapist;

(b) A physical therapist assistant who is licensed to provide the particular service and who provides the service to only one person at a time under the direct supervision of an eligible provider;

(c) A physical therapy student who is completing an internship, if the following conditions are met:

(i) The student provides the service under the direct supervision of the eligible provider responsible for the patient's therapy;

(ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;

(iii) The eligible provider responsible for the patient's therapy keeps on file documentation from the student's clinical program of the student's internship, including the beginning and ending dates; and

(iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided by a student under direct supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met; or

(d) A mechanotherapist.

(3) The following eligible providers may render an occupational therapy service:

(a) An occupational therapist;

- (b) An occupational therapist assistant who is licensed to provide the particular service and who provides the service to only one person at a time under the direct supervision of an eligible provider; or
- (c) An occupational therapy student who is completing an internship, if the following conditions are met:
 - (i) The student provides the service under the direct supervision of the eligible provider responsible for the patient's therapy;
 - (ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;
 - (iii) The eligible provider responsible for the patient's therapy keeps on file documentation from the student's clinical program of the student's internship, including the beginning and ending dates; and
 - (iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided by a student under direct supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met.
- (4) The following eligible providers may render a speech-language pathology service:
 - (a) A speech-language pathologist;
 - (b) A speech-language pathology aide who is licensed to provide the particular service and who provides the service to only one person at a time under the direct supervision of an eligible provider; or
 - (c) A speech-language pathology student who is completing an internship or a person holding a conditional license to practice speech-language pathology, if the following conditions are met:
 - (i) The student provides the service under the direct supervision of the eligible provider responsible for the patient's therapy;
 - (ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;

(iii) The eligible provider responsible for the patient's therapy keeps on file documentation from the student's clinical program of the student's internship, including the beginning and ending dates, or a copy of the conditionally-licensed speech-language pathologist's plan of supervised professional experience as required by section 4753.071 of the Revised Code; and

(iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided by a student under direct supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met.

(5) The following eligible providers may render an audiology service:

(a) An audiologist;

(b) An audiology aide who is licensed to provide the particular service and who provides the service to only one person at a time under the direct supervision of an eligible provider; or

(c) An audiology student who is completing an internship or a person holding a conditional license to practice audiology, if the following conditions are met:

(i) The student provides the service under the direct supervision of the eligible provider responsible for the patient's therapy;

(ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;

(iii) The eligible provider responsible for the patient's therapy keeps on file documentation from the student's clinical program of the student's internship, including the beginning and ending dates, or a copy of the conditionally-licensed audiologist's plan of supervised professional experience as required by section 4753.071 of the Revised Code; and

(iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided by a student under direct supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met.

(B) Billing ("pay-to") providers.

(1) The following eligible providers may receive medicaid payment for submitting a claim for a skilled therapy service on behalf of a rendering provider:

(a) A hospital, rules for which are set forth in Chapter 5101:3-2 of the Administrative Code;

(b) A provider of physician services, rules for whom are set forth in Chapter 5101:3-4 of the Administrative Code;

(c) A professional medical group;

(d) An ambulatory health care clinic, rules for which are set forth in Chapter 5101:3-13 of the Administrative Code;

(e) A rural health clinic, rules for which are set forth in Chapter 5101:3-16 of the Administrative Code;

(f) A federally qualified health center, rules for which are set forth in Chapter 5101:3-28 of the Administrative Code; or

(g) An outpatient health facility, rules for which are set forth in Chapter 5101:3-29 of the Administrative Code.

(2) The following eligible providers may receive medicaid payment either for rendering a skilled therapy service themselves or for submitting a claim for a skilled therapy service on behalf of a rendering provider:

(a) A skilled therapist; or

(b) A mechanotherapist.

Replaces: Part of 5101:3-8-01, part of 5101:3-8-02, part of 5101:3-8-03, part of 5101:3-34-01.2

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5101:3-8-32

Skilled therapy: coverage.

(A) Payment may be made for a skilled therapy service if the following conditions are met:

(1) The service is medically necessary, in accordance with rule 5101:3-1-01 of the Administrative Code.

(2) The service is rendered on the basis of a clinical evaluation and assessment and in accordance with a treatment plan. (Audiology must meet this condition in order to be considered skilled therapy for purposes of this chapter.) The performance of a clinical evaluation and assessment and the development of a treatment plan are discrete services; payment for them is made separately from payment for skilled therapy. The clinical evaluation and assessment and the treatment plan are described in rule 5101:3-8-33 of the Administrative Code; copies must be kept on file by the provider.

(3) The amount, frequency, and duration of treatment is reasonable. For rehabilitative services, the maximum treatment period without reevaluation is sixty days; for developmental services, the maximum treatment period without reevaluation is six months.

(B) The following limitations and additional requirements are placed on the provision of skilled therapy services:

(1) For dates of service January 1, 2014, and after, payment for skilled therapy services rendered without prior authorization in a non-institutional setting is subject to the following limits:

(a) For physical therapy services, a total of no more than thirty visits per benefit year;

(b) For occupational therapy services, a total of no more than thirty visits per benefit year; and

(c) For speech-language pathology and audiology services, a total of no more than thirty visits per benefit year.

(2) Payment for additional skilled therapy visits in a non-institutional setting can be requested through the prior authorization process, which is described in Chapter 5101:3-1 of the Administrative Code.

(3) For each type of skilled therapy, payment for evaluation services can be made not more than once per injury or condition.

- (4) For each type of skilled therapy, payment for reevaluation of rehabilitative services cannot be made more often than once every sixty days.
- (5) For each type of skilled therapy, payment for reevaluation of developmental services cannot be made more often than once every six months.
- (6) No payment is made for the following services as skilled therapy:

 - (a) Services reported on a claim submitted by an entity that neither is nor acts on behalf of an eligible provider of skilled therapy services;
 - (b) Services not rendered by nor under the direct supervision of a physician or skilled therapist;
 - (c) Services that do not meet current accepted standards of practice;
 - (d) Services rendered in a non-approved location;
 - (e) Additional rehabilitative services for a patient who fails to demonstrate progress within a sixty-day treatment period;
 - (f) Additional developmental services for a patient who fails to demonstrate progress within a six-month treatment period;
 - (g) Consultations with family members or other non-medical personnel; and
 - (h) Services rendered in non-institutional settings and listed as non-covered in rule 5101:3-4-28 or in Appendix DD to rule 5101:3-1-60 of the Administrative Code.

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5101:3-8-33

Skilled therapy: documentation of services.

(A) A clinical evaluation and assessment of the need for skilled therapy services includes the following elements:

- (1) A diagnosis of the type and severity of the disorder or a description of the deficit in physical or sensory functionality;
- (2) A review of the individual's current physical, auditory, visual, motor, and cognitive status;
- (3) A case history, including, when appropriate, family perspectives on the individual's development and capacity to participate in therapy;
- (4) The outcomes of standardized tests and any non-standardized tests that use age-appropriate developmental criteria;
- (5) Other test results and interpretation;
- (6) An evaluation justifying the provision of skilled therapy services, which may be expressed as one of two prognoses of the patient's rehabilitative or developmental potential:
 - (a) The patient's functionality is expected to improve within sixty days after the evaluation because of the delivery of rehabilitative skilled therapy services or within six months after the evaluation because of the delivery of developmental skilled therapy services, and the patient is expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months; or
 - (b) The patient is not expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months, but a safe and effective maintenance program may be established; and
- (7) Any recommendations for further appraisal, follow-up, or referral.

(B) A treatment or maintenance plan for skilled therapy services is based on the clinical evaluation and assessment. It should be coordinated, when appropriate, with services provided by non-medicaid providers or programs (e.g., child welfare, child care, or prevocational or vocational services), and it should provide a process for involving the patient or the patient's representative in the provision of services. A complete treatment or maintenance plan includes the following elements:

- (1) The patient's relevant medical history;

- (2) Specification of the amount, duration, and frequency of each skilled therapy service to be rendered; the methods to be used; and the areas of the body to be treated;
- (3) A statement of specific functional goals to be achieved, including the level or degree of improvement expected within the appropriate time period;
- (4) The date of each treatment;
- (5) The signature of the practitioner responsible for the treatment plan;
- (6) Documentation of participation by the patient or the patient's representative in the development of the plan;
- (7) Specific timelines for reevaluating and updating the plan;
- (8) A statement of the degree to which the patient has made progress; and
- (9) A recommendation for one of several courses of action:
 - (a) The development of a new or revised treatment plan;
 - (b) The development of a maintenance plan; or
 - (c) The discontinuation of treatment.

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5101:3-8-34

Skilled therapy: payment.

(A) If more than one skilled therapy service of the same type is rendered by a non-institutional provider to an individual patient on the same date, then the service with the highest amount specified in appendix DD to rule 5101:3-1-60 of the Administrative Code is considered to be the primary procedure. The maximum fee for a skilled therapy service is the lesser of the provider's submitted charge or a percentage of the amount specified in Appendix DD to rule 5101:3-1-60 of the Administrative Code, determined in the following manner:

(1) For a single skilled therapy service or a primary procedure, it is one hundred per cent.

(2) For each additional procedure, it is fifty per cent.

(B) Services reported on claims must correspond to the services listed in the treatment plan.

(C) Providers must report appropriate procedure codes and modifiers on claims.

(D) Unattended electrical stimulation and iontophoresis therapy are considered to be part of the associated therapy procedure or medical encounter; no separate payment is made.

(E) Skilled therapy performed during a hospital stay is treated as a hospital service.

(F) Payment for skilled therapy services rendered to a resident of a nursing facility (NF) is made to the NF through the facility per diem. A non-institutional provider that renders a skilled therapy service to a NF resident must seek payment from the NF.

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5101:3-34-01 **Physical therapy, occupational therapy and speech-language pathology/audiology services: general provisions.**

Rules 5101:3-34-01, 5101:3-34-01.1, 5101:3-34-01.2, and 5101:3-34-01.3 of the Administrative Code address physical therapy, occupational therapy, and speech-language pathology/audiology services. Mental health, behavioral health, and addiction services are addressed under separate policy.

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5101:3-34-01.1 **Physical therapy, occupational therapy and speech-language pathology/audiology services: definitions.**

Definitions in this rule apply to Chapter 5101:3-34 of the Administrative Code.

(A) "Audiology," as defined in accordance with Chapter 4753. of the Revised Code, is the application of principles, methods, or procedures related to hearing and the disorders of hearing.

(B) "Department" is the Ohio department of job and family services (ODJFS).

(C) "Developmental" describes physical therapy, occupational therapy, and/or speech-language pathology/audiology services provided to individuals aged birth through six years for the purpose of attaining a level of functionality that the child has not yet achieved, but is expected to achieve, based on age, in accordance with developmental milestones established by the American academy of pediatrics. Such services are skilled therapy.

(D) "Developmental delay" means:

(1) For children aged birth to three years, a 1.5 standard deviation or twenty-five percent delay (based on the use of an evidence-based tool and/or through informed clinical opinion) in physical (development or maturation, including communication) or sensory development of individuals, with the expectation that the delay is:

(a) Not permanent;

(b) Not likely to continue indefinitely; and

(c) Expected to last for less than twelve months; or

(2) For children at least three years of age but under seven years of age, two deficits and 1.5 standard deviation from the norm or one deficit and 2.0 standard deviation from the norm (based on the use of an evidence-based tool and/or through informed clinical opinion) in physical (development or maturation, including communication) or sensory development, with the expectation that the delay is:

- (a) Not permanent;
- (b) Not likely to continue indefinitely; and
- (c) Expected to last for less than twelve months.

(E) "Developmental disability" in accordance with section 5123.01 of the Revised Code, means a severe, chronic disability that is:

- (1) Attributable to a mental or physical impairment or a combination of mental and physical impairments (other than a mental or physical impairment solely caused by mental illness);
- (2) Manifested before age twenty-two;
- (3) Likely to continue indefinitely; and
- (4) Results in:
 - (a) In the case of a person under three years of age, at least one developmental delay or an established risk;
 - (b) In the case of a person at least three years of age but under six years of age, at least two developmental delays or an established risk;
 - (c) In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age:
 - (i) Self-care;
 - (ii) Receptive and expressive language;
 - (iii) Learning; and
 - (iv) Mobility.
 - (v) If the person is at least sixteen years of age, capacity for economic self sufficiency.

- (5) Causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.
- (F) "Developmental milestones" means the general developmental trends in patients aged birth through six years of age, as developed by the American academy of pediatrics ("Caring for Baby and Young Child: Birth to Age 5"; fourth edition American academy of pediatrics).
- (G) "Direct supervision" is defined in accordance with rules 5101:3-4-02, 5101:3-8-02, and 5101:3-8-03 of the Administrative Code.
- (H) "Disability," in accordance with rule 5101:1-39-03 of the Administrative Code, means:
- (1) For an individual age eighteen or over, a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months that results in the individual's inability to engage in any substantial gainful activity.
 - (2) For an individual under age eighteen, a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.
- (I) "Evidence-based" describes, for the purposes of this chapter, health care services that:
- (1) Are based on a clearly articulated and empirically-supported theory;
 - (2) Have a detailed description of the intervention and measurement design (what outcomes were produced in what populations with what intervention);
 - (3) Have measurable outcomes that have been assessed with psychometrically strong measures, including long-term follow-up, where indicated;
 - (4) Have been tested in a scientifically-sound way with comparison conditions, optimally through randomized controlled studies;

- (5) Uniformly apply the standards of evidence gained from the scientific method, to certain aspects of medical practice;
 - (6) Apply judgments about the inductive quality of evidence, to those aspects of medicine which depend on rational assessments of risks and benefits of treatments (including lack of treatment);
 - (7) Integrate individual clinical expertise with the best available external clinical evidence from systematic research;
 - (8) Integrate the best research evidence with clinical expertise and patient values; and
 - (9) Include conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.
- (J) "Habilitation," as defined in section 5126.01 of the Revised Code, means the process by which the staff of a facility or agency assists an individual with mental retardation or other developmental disabilities in acquiring and maintaining those life skills that enable the individual to cope more effectively with the demands of the individual's own person and environment, and in raising the level of the individual's personal, physical, mental, social, and vocational efficiency. Habilitation services, in accordance with rule 5101:1-34-01.2 of the Administrative Code, are covered only when provided to residents of an intermediate care facility for persons with mental retardation or under a federally approved home and community-based services waiver for individuals with mental retardation/developmental disability.
- (K) "Licensed audiologist" means a person holding a valid license under Chapter 4753. of the Revised Code as an audiologist and who is eligible for or meets the educational requirements for a certificate of clinical competence in audiology granted by the "American speech-language-hearing association."
- (L) "Licensed audiology aide" means a person holding a valid license under Chapter 4753. of the Revised Code as an audiology aide.
- (M) "Licensed mechanotherapist" means a person holding a valid license under Chapter 4731. of the Revised Code as a mechanotherapist.
- (N) "Licensed occupational therapist" means a person holding a valid license under Chapter 4755. of the Revised Code as an occupational therapist.

- (O) "Licensed occupational therapy assistant" means a person holding a valid license under Chapter 4755. of the Revised Code as an occupational therapy assistant (OTA).
- (P) "Licensed physical therapist" means a person holding a valid license under Chapter 4755. of the Revised Code as a physical therapist.
- (Q) "Licensed physical therapist assistant" means a person holding a valid license under Chapter 4755. of the Revised Code as a physical therapist assistant (PTA).
- (R) "Licensed speech-language pathologist" means a person holding a valid license under Chapter 4753. of the Revised Code as a speech-language pathologist and who is eligible for or meets the educational requirements for a certificate of clinical competence in speech-language pathology granted by the "American speech-language-hearing association."
- (S) "Licensed speech-language pathology aide" means a person holding a valid license under Chapter 4753. of the Revised Code as a speech-language pathology aide.
- (T) "Licensed therapist" means a licensed physical therapist, licensed mechanotherapist, licensed occupational therapist, licensed speech-language pathologist, or licensed audiologist.
- (U) "Licensed therapy aide" means a licensed audiology aide or a licensed speech-language pathology aide.
- (V) "Licensed therapist assistant" means a licensed physical therapist assistant, or a licensed occupational therapy assistant.
- (W) "Maintenance," describes physical therapy, occupational therapy, and/or speech-language pathology/audiology services provided to individuals for the purpose of maintaining a level of functionality, not improvement of functionality. Although the development of a maintenance plan is considered part of developmental and rehabilitation services, the services furnished under a maintenance plan are not skilled therapy.
- (X) "Medicaid authorized prescriber" means a physician (M.D. or D.O.), podiatrist, dentist, or advanced practice nurse working within his or her scope of practice as defined by state law.
- (Y) "Medicaid eligible provider" is, in accordance with rule 5101:3-1-17 of the

Administrative Code, any individual, group practice, corporation, or institution that:

- (1) Meets the specific provider requirements and standards in division 5101:3 of the Administrative Code; and
- (2) Is approved for participation in the medicaid program by the department, as evidenced by the issuance of both a signed provider agreement and an Ohio medicaid legacy number.

(Z) "Medically necessary services," are health care services that:

- (1) Meet the requirements established in rule 5101:3-1-01 of the Administrative Code;
- (2) Are evidence-based, in accordance with paragraph (I) of this rule; and
- (3) Are provided with the expectation that:
 - (a) The patient's condition will improve within a sixty-day period of treatment for rehabilitative services or six-month period of treatment for developmental services; and
 - (b) The patient will attain or substantially progress toward the maximum possible expected milestones or be restored to or substantially progress toward the maximum possible level of functionality within twelve months of treatment, beginning with the evaluation.

(AA) "Natural environments" means settings that are natural or normal for the patients, and includes home and community settings in which patients without disabilities participate.

(BB) "Occupational therapy" is the evaluation and treatment of patients whose functioning is impaired by developmental deficiencies, physical injury or illness, through techniques specified in section 4755.04 of the Revised Code.

(CC) "Physical therapy" is the evaluation and treatment of patients by physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of correcting, or alleviating any disability, as specified in section 4755.40 of the Revised Code.

(DD) "Rehabilitation" describes physical therapy, occupational therapy, and/or

speech-language pathology/audiology services provided to individuals for the purpose of restoring the individual to the maximum possible level of functionality after a loss of functionality. Such services are considered skilled therapy. Although the development of a maintenance plan is considered part of rehabilitation services, the services furnished under a maintenance plan are not skilled therapy.

- (EE) "Skilled therapy" means physical therapy, occupational therapy, and speech-language pathology/audiology services of such complexity and sophistication that the service can be safely and effectively performed only by or under the direct supervision of licensed therapists, licensed therapy aides, licensed therapist assistants, or licensed mechanotherapists practicing within the scope of their licensure. Skilled therapy does not include maintenance services, habilitative services, or services provided by non-licensed persons.
- (FF) "Speech Language Pathology," as defined in accordance with Chapter 4753. of the Revised Code, is the application of principles, methods, or procedures related to the development and disorders of human communication.

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5101:3-34-01.2 **Physical therapy, occupational therapy and speech-language pathology/audiology services: coverage and limitations.**

(A) Medicaid covered skilled therapies are:

- (1) Physical therapy;
- (2) Occupational therapy;
- (3) Speech language pathology/audiology.

(B) Medicaid providers authorized to be reimbursed by the department for skilled therapy are:

- (1) Eligible providers of physician services, defined in accordance with rule 5101:3-4-01 of the Administrative Code, for skilled therapy performed by the physician; a licensed physical therapist, licensed occupational therapist, licensed speech-language pathologist, or licensed audiologist employed by or under contract with the physician; a licensed physical therapist assistant under the direct supervision of a licensed physical therapist employed by or under contract with the physician; a licensed occupational therapy assistant under the direct supervision of a licensed occupational therapist employed by or under contract with the physician; a licensed speech-language pathology aide under the direct supervision of a licensed speech-language pathologist employed by or under contract with the physician; or a licensed audiology aide under the direct supervision of a licensed audiologist employed by or under contract with the physician:
 - (a) Physicians, in accordance with Chapter 5101:3-4 of the Administrative Code;
 - (b) Ambulatory health care clinics;
 - (i) Fee-for-service ambulatory health care clinics, in accordance with Chapter 5101:3-13 of the Administrative Code;
 - (ii) Cost-based ambulatory health care clinics;

- (a) Federally-qualified health centers, as defined in Chapter 5101:3-28 of the Administrative Code;
 - (b) Outpatient health facilities, as defined in Chapter 5101:3-29 of the Administrative Code; and
 - (c) Rural health clinics, as defined in Chapter 5101:3-16 of the Administrative Code;
 - (2) Advanced practice nurses, in accordance with Chapter 5101:3-8 of the Administrative Code;
 - (3) Practitioners authorized to bill for skilled therapy services, as specified in accordance with Chapter 5101:3-8 of the Administrative Code;
 - (4) Intermediate care facilities for persons with mental retardation (ICFs/MR), in accordance with Chapter 5101:3-3 of the Administrative Code;
 - (5) Hospitals, in accordance with Chapter 5101:3-2 of the Administrative Code; and
 - (6) Nursing facilities, in accordance with Chapter 5101:3-3 of the Administrative Code.
- (C) Coverage and limitations of skilled therapy services, unless otherwise indicated under specific program rules such as for institutional providers and the medicaid school program:
 - (1) Skilled therapy services are allowable for medicaid reimbursement only if all the following criteria are met:
 - (a) A medicaid authorized prescriber prescribes therapies for a reasonable amount, frequency, and maximum duration of sixty-day period of treatment or less for rehabilitative services or a maximum duration of six-month period of treatment or less for developmental services, with the period of treatment beginning with the evaluation and concluding with a re-evaluation. In accordance with paragraph (C)(1)(e) of this rule, the re-evaluation includes development of either a new/revised plan of care and treatment or a maintenance plan. The prescribed therapy services:

- (i) Are medically necessary, in accordance with rule 5101:3-34-01.1 of the Administrative Code;
 - (ii) Are of such level of complexity and sophistication, or the condition of the patient is such that the service can be safely and effectively performed only by or under the direct supervision of a licensed therapist; and
- (b) A physician or licensed therapist conducts and documents a clinical evaluation and assessment that indicates that the patient has a deficit in physical, occupational and/or speech-language/audiology functionality, and:
- (i) Potential exists for the patient's condition to improve within a sixty-day period of treatment for rehabilitative services or six-month period of treatment for developmental services and for the patient to attain or make significant progress toward expected milestones (developmental) or restore functionality (rehabilitative) within twelve months of treatment, beginning with the evaluation; or
 - (ii) Potential does not exist for the patient to attain or make significant progress toward expected milestones or restore the individual's functionality within twelve months, but a safe and effective maintenance program may be established in accordance with paragraph (C)(1)(e) of this rule;
 - (iii) Documented evaluation and assessment must include, at a minimum:
 - (a) The diagnosis, including current physical status, type and severity of the disorder;
 - (b) Review of auditory, visual, motor, and cognitive status;
 - (c) Case history information including parental/family perspectives on the patient's development and capacity to participate in therapy services;
 - (d) Standardized and/or non-standardized methods such as instruments that examine age-appropriate developmental

criteria;

(e) Test results and interpretation;

(f) Prognosis (developmental or rehabilitative potential)

(g) Recommendations including the need for further appraisal, follow-up, or referral; and

(c) A physician or licensed therapist develops, documents, and forwards to the medicaid authorized prescriber a written, goal oriented plan of care and treatment for the patient that must:

(i) Be based on the clinical evaluation and assessment of the patient's condition;

(ii) As appropriate, be coordinated with services provided by non-medicaid providers or programs (e.g., child welfare, child care, prevocational and vocational services);

(iii) Provide a process to involve the patient and other responsible persons in the provision of services;

(iv) Be included as part of the patient's medical record;

(v) Be signed by the physician or licensed therapist who develops the plan of care and treatment;

(vi) Includes, at a minimum:

(a) Specific services, procedures, and methods to be used, and the amount, duration and frequency of each service;

(b) Specific functional goals to be achieved, including the level or degree of improvement expected within sixty days for rehabilitative services or within six months for developmental services;

(c) The prescription for services, as established by the medicaid authorized prescriber, in accordance with paragraph (C)(1)(a) of this rule;

within thirty days; or

- (b) If the therapy patient progress summary indicates development of a maintenance program and instruction of the consumer (and the consumer's family/caregivers, if applicable) regarding the maintenance program, the development of the maintenance plan and instruction is covered as part of therapy, but services furnished under a maintenance plan are not covered; and
- (f) The licensed therapist furnishing the prescribed therapy services must document, in the patient's record:
- (i) The evaluation and assessment that supports the use of therapy intervention as described in paragraph (C)(1)(b) of this rule;
 - (ii) The plan of care and treatment as described in paragraph (C)(1)(c) of this rule;
 - (iii) The number, frequency, and type of treatment services furnished as described in paragraph (C)(1)(d) of this rule;
 - (iv) The patient progress summary as described in paragraph (C)(1)(e) of this rule;
 - (v) The patient's history;
 - (vi) Type of treatment used, including body areas treated;
 - (vii) The date therapy was initiated and the date of each treatment;
 - (viii) The prescription, including the name of the medicaid authorized prescriber who prescribed the services, in accordance with paragraph (C)(1)(a) of this rule; and
- (g) The prescribed services are billed by a medicaid provider authorized to bill the department for skilled therapy services, in accordance with paragraph (B) of this rule.

(2) Non-covered services include:

- (a) Services billed by anyone who is not authorized by the department in accordance with Chapter 5101:3-1 of the Administrative Code, to be a provider of therapy services;
 - (b) Services not furnished by or under the direct supervision of a physician or licensed therapist;
 - (c) Services rendered by non-licensed persons;
 - (d) Services furnished under a plan of care and treatment that has not been approved by a medicaid-authorized prescriber in accordance with paragraph (C)(1) of this rule;
 - (e) Services not furnished in approved places of service;
 - (f) Therapy services when a patient fails to demonstrate progress within a sixty-day period of treatment for rehabilitative services or six-month period of treatment for developmental services;
 - (g) Consultations with family members or other non-medical personnel;
 - (h) Maintenance services;
 - (i) For non-institutional settings, services listed as not covered in rules 5101:3-4-28 and 5101:3-1-60 of the Administrative Code. Certain modalities are considered part of an associated therapy procedure or medical encounter and are not separately reimbursable.
 - (j) A universal hearing screening for newborns described in Chapter 3701-40 of the Administrative Code will be covered during the newborn's hospital stay through the hospital program as described in Chapter 5101:3-2 of the Administrative Code. A newborn screen is not a separately reimbursable clinic service.
- (3) Limitations/exclusions regarding therapy services:
- (a) Habilitation services are covered under medicaid only when:
 - (i) Provided for residents in an intermediate care facility for persons with mental retardation (ICF/MR); or

- (ii) Included under a federally approved home and community-based services (HCBS) waiver for individuals with mental retardation/developmental disability, and are medically necessary services identified in an enrollee's particular HCBS waiver. Special education and related services that otherwise are available to the individual through a local educational agency and vocational rehabilitation services that otherwise are available to the individual through a program funded under 29 U.S.C. 730 (release date: September 29, 2005) are not reimbursable through federally approved HCBS waivers.

- (b) Allowable non-institutional "places of service" for skilled therapy services include, but are not limited to:
 - (i) Licensed child day care centers;
 - (ii) Adult day care centers; and
 - (iii) Natural environments.

- (c) Limits.
 - (i) Non-institutional settings, per twelve month period:
 - (a) Thirty dates of service per twelve month period for any combination of physical and occupational therapy services; and
 - (b) Thirty dates of service per twelve month period for any combination of speech-language pathology and audiology services; although
 - (c) Additional therapy services can be requested through prior authorization in accordance with Chapter 5101:3-1 of the Administrative Code.
 - (ii) Institutional settings, in accordance with Chapters 5101:3-2 and 5101:3-3 of the Administrative Code.

- (d) The department does not directly reimburse the following health care

providers, even when their services are prescribed by a medicaid authorized prescriber:

- (i) A self-employed audiologist or audiologist group practice;
 - (ii) An audiologist aide under the direct supervision of a self-employed audiologist or audiologist group practice;
 - (iii) A self-employed speech-language pathologist or speech-language pathology group practice;
 - (iv) A speech-language pathologist aide under the direct supervision of a self-employed speech language pathologist or speech language pathology group practice.
- (e) Services provided by therapy students completing internships must meet all of the following conditions to be reimbursed:
- (i) The service must be billed by a medicaid provider:
 - (a) Who is authorized to bill for the specified services; and
 - (b) Who has a letter on file from the student's clinical program stating the dates of the student's internship;
 - (ii) The student must be under the direct supervision of the licensed therapist responsible for the patient's care;
 - (iii) The licensed therapist responsible for the patient's therapy must have face-to-face contact with the patient during the patient's visit and must confirm that the service provided by the student was appropriate;
 - (iv) The patient's medical record must contain documentation that the service was provided by a student under the direct supervision of a licensed therapist; and
 - (v) The patient's medical record must show that the requirements for reimbursement were met and the licensed therapist responsible for the patient's therapy reviewed, countersigned, and dated the notes in the medical records at least once a week so that it is

documented that the licensed therapist is responsible for the patient's care.

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5101:3-34-01.3 **Physical therapy, occupational therapy and speech-language pathology/audiology services: provider claims, billing, payment and reimbursement.**

(A) Provider claims, billing, payment and reimbursement are addressed in division 5101:3 of the Administrative Code.

(B) The medicaid maximum amount payable to non-institutional providers is specified in rule 5101:3-1-60 of the Administrative Code.

(1) When a non-physician practitioner provides and bills the department for a service, a physician may be reimbursed for any direct services provided (e.g., physical evaluation and approval of plan of treatment), but may not be reimbursed for the services provided by a licensed therapist or group therapy practice eligible to bill for these services directly.

(2) Providers must select and bill the appropriate code in accordance with code definitions. Codes that do not include time descriptions are considered a single service and cannot be billed for more than one unit of service per date of service.

(3) Evaluation services cannot be billed more than once per injury or condition.

(4) Re-evaluation services cannot be billed more than once per sixty day period of treatment for rehabilitative services or once per six-month period of treatment for developmental services.

(5) Skilled therapy cannot be billed for dates of service beyond twelve months of the initial evaluation or re-evaluation, per injury or condition.

(6) The services billed must correspond to the services listed in the documented plan of care and treatment, described in paragraph (C)(1)(c) of rule 5101:3-34-01.2 of the Administrative Code.

(C) The medicaid amount payable to hospital providers is specified in Chapter 5101:3-2 of the Administrative Code.

(D) Therapy services are not directly reimbursable for consumers residing in a nursing

facility (NF) as defined in section 5111.20 of the Revised Code. Such services are the responsibility of the NF and are reimbursed to the NF through the facility per diem. The provisions in Chapter 5101:3-34 of the Administrative Code do not apply to therapy services supplied to the residents of nursing facilities.

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