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Ohio Revised Code

Section 3923.30 Requiring provision of coverage of treatment of mental or nervous disorders and alcoholism.

Effective: July 10, 2014
Legislation: House Bill 232 - 130th General Assembly

Every person, the state and any of its instrumentalities, any county, township, school district, or other political subdivisions and any of its instrumentalities, and any municipal corporation and any of its instrumentalities, which provides payment for health care benefits for any of its employees resident in this state, which benefits are not provided by contract with an insurer qualified to provide sickness and accident insurance, or a health insuring corporation, shall include the following benefits in its plan of health care benefits commencing on or after January 1, 1979:

(A) If such plan of health care benefits provides payment for the treatment of mental or nervous disorders, then such plan shall provide benefits for services on an outpatient basis for each eligible employee and dependent for mental or emotional disorders, or for evaluations, that are at least equal to the following:

(1) Payments not less than five hundred fifty dollars in a twelve-month period, for services legally performed by or under the clinical supervision of any of the following:

(a) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(b) A psychologist licensed under Chapter 4732. of the Revised Code;

(c) A licensed professional clinical counselor, licensed professional counselor, independent social worker, or independent marriage and family therapist licensed under Chapter 4757. of the Revised Code;

(d) An independent chemical dependency counselor licensed under Chapter 4758. of the Revised Code;

(e) A clinical nurse specialist or certified nurse practitioner licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health.

The services may be performed in an office, in a hospital, in a community mental health facility, or in an alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the joint commission, the council on accreditation, or the commission on accreditation of rehabilitation facilities or certified by the department of mental health and addiction services;

(2) Such benefit shall be subject to reasonable limitations, and may be subject to reasonable deductibles and co-insurance costs.

(3) In order to qualify for participation under this division, every facility specified in this division shall have in effect a plan for utilization review and a plan for peer review and every person specified in this division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and effective and efficient utilization of available health facilities and services.

(4) Such payment for benefits shall not be greater than usual, customary, and reasonable.

(5)(a) Services performed by or under the clinical supervision of a health care professional identified in division (A)(1) of this section, in order to be reimbursable under the coverage required in division (A) of this section, shall meet both of the following requirements:

(i) The services shall be performed in accordance with a treatment plan that describes the expected duration, frequency, and type of services to be performed;

(ii) The plan shall be reviewed and approved by the health care professional every three months.

(b) Payment of benefits for services reimbursable under division (A)(5)(a) of the section shall not be restricted to services described in the treatment plan or conditioned upon standards of a licensed physician or licensed psychologist, which at least equal the requirements of division (A)(5)(a) of this section.

(B) Payment for benefits for alcoholism treatment for outpatient, inpatient, and intermediate primary care for each eligible employee and dependent that are at least equal to the following:

(1) Payments not less than five hundred fifty dollars in a twelve-month period for services legally performed by or under the clinical supervision of a health care professional identified in division (A)(1) of this section, whether performed in an office, in a hospital, in a community mental health facility, or in an alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the joint commission, the council on accreditation, or the commission on accreditation of rehabilitation facilities or certified by the department of mental health and addiction services;

(2) The benefits provided under this division shall be subject to reasonable limitations and may be subject to reasonable deductibles and co-insurance costs.

(3) A health care professional shall every three months certify a patient's need for continued services performed by such facilities.

(4) In order to qualify for participation under this division, every facility specified in this division shall have in effect a plan for utilization review and a plan for peer review and every person specified in this division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and efficient utilization of available health facilities and services. Such person or facilities shall also have in effect a program of rehabilitation or a program of rehabilitation and detoxification.

(5) Nothing in this section shall be construed to require reimbursement for benefits which is greater than usual, customary, and reasonable.

(C) The benefits provided by division (A) of this section for mental and emotional disorders shall not be reduced by the cost of benefits provided pursuant to section 3923.282 of the Revised Code for diagnostic and treatment services for biologically based mental illness. This section does not apply to benefits for diagnostic and treatment services for biologically based mental illnesses.