

# COMMUNITY BEHAVIORAL HEALTH SERVICES UTILIZATION MANAGEMENT POLICY STATEMENT Ohio Medicaid

Policy Name & Number	Date Effective
Community Behavioral Health and Withdrawal Management Services Policy OH.UM.15	7/1/2026
Policy Type	
REIMBURSEMENT	

## A. Subject

New Utilization Management for Community Behavioral Health Services

## B. Background

To promote the delivery of clinically appropriate and medically necessary Medicaid-funded substance use disorder and community behavioral health services, the Ohio Department of Medicaid (ODM) has determined new service thresholds upon which an authorization requesting to exceed these limits can be required from the provider (see Table A-1). This measure is to ensure that Medicaid-funded services are supported by an individualized assessment that accurately summarizes the clinical presentation and presenting treatment needs. This also ensures the requested services are appropriately captured in the treatment plan to illustrate how the service will support progress toward the individualized treatment goals.

## C. Definitions

- Community Behavioral Health rehabilitative services – services that fall under this description include:
  - a. Therapeutic Behavioral Service, individual (H2019) & unit-based group (H2019 HQ)
  - b. Therapeutic Behavioral Service, Day Treatment (H2020)
  - c. Community Psychiatric Support Treatment, individual (H0036) & group (H0036 HQ)
  - d. Psychosocial Rehabilitation Service (H2017)

## D. Policy

1. The Next Generation Medicaid and Next Generation MyCare Ohio plans can opt to apply service thresholds to designated community behavioral health services, but no more stringent than what ODM has included in Table A-1. When a Next Generation Medicaid or Next Generation MyCare Ohio plan decides to implement service authorizations for a

community behavioral health service that does not reflect current authorization requirements found in OAC Chapter 5160-27 or the applicable Provider Agreement, the following conditions apply:

- a. The service authorization forms for Substance Use Disorder (SUD) and Community Behavioral Health Centers (CBHC) available on ODM's website must be accepted as a valid authorization request.
- b. Utilization Review Process

To determine if a service requires prior authorization, please use our Prior Authorization Prescreen Tool.

([buckeyehealthplan.com/providers/prior-authorization/preauth-check.html](http://buckeyehealthplan.com/providers/prior-authorization/preauth-check.html))

Authorizations can be submitted by

- Fax: 866-535-6974
- Availity
- Buckeye Provider Portal ([buckeyehealthplan.com/providers.html](http://buckeyehealthplan.com/providers.html))

Prior authorization requests should be submitted for medical necessity review at least (5) business days before the scheduled service delivery date or as soon as the need for service is identified.

Authorization requests should include all necessary clinical information to determine medical necessity.

Documentation typically includes an updated treatment plan with measurable goals, rationale for service intensity, and evidence of progress or need for continued intensive intervention.

## Appeals Process

Information for appeals process can be accessed from the denial letter issued or on the Buckeye website under Provider Resources.

- c. The plan must ensure accurate system configuration to enforce the limits before implementing authorization for a service. Retroactive recoupments are prohibited if a service was paid in error due to the plan not having properly configured its system to enforce the limit.
2. Recipient Level Utilization Verification - Upon request by a CBHC provider, the Next Generation Medicaid and MyCare Ohio plan must provide recipient's utilization to date if a service authorization is required.

- a. Buckeye’s Provider Portal provides service utilization threshold counters for each of the services in Table A-1. If a provider is not registered in Buckeye’s Care Coordination portal, service utilization thresholds can be provided by calling Buckeye’s Provider Services team at 866-296-8731 or by contacting their assigned Provider Engagement Administrator. This information is based on claims received to date and may not reflect accurate real-time utilization.
- b. CBHC providers are responsible for keeping track of service delivery for each recipient to ensure services rendered do not exceed the authorized threshold. If the recipient is simultaneously receiving the same service from more than one provider, the providers will need to coordinate care to prevent service duplication and reduce risk of prematurely exhausting authorized hours. It is recommended that providers routinely check in with their clients to inquire whether they are also receiving community behavioral health services elsewhere.

**Table A-1: New Services Subject to Utilization Management**

<b>Service Name</b>	<b>Service Code</b>	<b>Service Threshold at which authorization is required</b>	<b>Expected turnaround time by the MCE/MCOP</b>
Therapeutic Behavioral Service - Individual	H2019	200 units (50hrs) combined TBS or PSR per calendar year	7 days
Therapeutic Behavioral Service - Group	H2019 HQ	120 units (30hrs) per calendar year	7 days
Therapeutic Behavioral Service Day Treatment – per diem	H2020	After 30 units per calendar year	7 days
Community Psychiatric Support Treatment – Individual	H0036	200 units (50hrs) per calendar year	7 days
Community Psychiatric Support Treatment – Group	H0036 HQ	120 units (30hrs) per calendar year	7 days
Psychosocial Rehabilitation Service	H2017	200 units (50hrs) combined TBS or PSR per calendar year	7 days
SUD Ambulatory Withdrawal Management	H0012 H0014	After 7 <sup>th</sup> consecutive day of H0012 per diem or H0014/H0014AT hourly based claims	48 hours
SUD Intensive Outpatient Program	H0015	After 30 units per calendar year	7 days
SUD Residential Clinically Managed -WM	H0010	After 7 <sup>th</sup> consecutive day	48 hours
SUD Residential Medically Managed -WM	H0011	After 7 <sup>th</sup> consecutive day	48 hours

**E. Conditions of Coverage**

1. Providers must follow OAC 5160-1-31 regarding submission requirements for authorization forms
2. Providers must adhere to the following authorization request submission timelines to ensure a determination is made prior to the expiration or exhaustion of the current authorization:
  - a. Expedited: Submission must be received at least 2 days prior
  - b. Standard: Submission must be received at least 7 days prior
3. Services rendered with the KX crisis modifier are excluded from service thresholds.
4. Behavioral health nursing (TD and TE modifiers) rendered in accordance with OAC 5160-27-11 are excluded
5. Due to the chronic nature of severe and persistent mental illness and the vulnerability of many who require reliable access to support, the following additional requirements apply to behavioral health rehabilitation services:
  - a. The coverage period for an approved service is a minimum of 90 days unless a shorter duration is specifically requested by the provider
  - b. The authorization is valid until the approved service limit is exhausted OR the authorization period has expired
  - c. Children and youth enrolled in the OhioRISE plan or in the custody of an Ohio Public Child Welfare Agency (identified on the 834 report with a living arrangement code of FC, AA, or KG) are excluded from service authorization requirements for all community behavioral health rehabilitative services identified in this policy.