2026 BEHAVIORAL HEALTH BILLING POLICY UPDATES FOR PROVIDERS

buckeye health plan®
Your Guide to Better Health™
MEDICAID • MEDICARE • MARKETPLACE

Behavioral Health Billing Updates for Providers

Introduction and Overview

Brandi Hahn, MHA, MSW, LISW-S,
Manager of Behavioral Health

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Purpose of the Policy

- New BH UM Policies establish utilization-management (UM) thresholds for select behavioral-health rehabilitative services (CPST, PSR, TBS, Peer Support, IOP/PHP combinations).
- These thresholds are not coverage limits; they serve as clinical review triggers to support appropriate medical-necessity review and reduce unwarranted service variation.
- The policy was reviewed and approved by the Ohio Department of Medicaid (ODM).

What the Policy Does

- Establishes daily unit thresholds that signal when additional review is required to confirm medical necessity.
- Requires supporting documentation only when services exceed the UM threshold.
- Aligns with OAC 5160-26-03.1 requirements for transparent, evidence-based, and non-restrictive UM practices.
- Supports consistent adjudication across providers and service types.

What the Policy Does Not Do

- Does **NOT** reduce covered benefits. Ohio Medicaid coverage rules still apply first.
- Does **NOT** impose hard caps. Services may exceed thresholds when medically necessary.
- Does **NOT** prohibit same-day combinations of services that are allowed by Ohio Medicaid.
- Does **NOT** create blanket prior authorization for rehabilitative services

Overview of Buckeye Behavioral Health Policy Changes

- **TBS:**
  - H2020- 25 units and then PA
  - H2019- 8 units/ day and 80 units/ year and then PA
- **PSR:**
  - H2017- 8 units/ day and 120 units/ year and then PA
- **IOP:**
  - H0015- 27 units/ year and then PA
- **Peer Support:**
  - H0038- 24 units/ week/ 26 weeks/ year
- **Multiple services:**
  - Limit H0036, H2019, H2017 to 16 combined units per day
  - Limit H0036, H2019, H2017 to total of 4 combined units when billed on same date as per diem codes H0015, H2020, H0015TG

Behavioral Health Billing Updates for Providers

Medical Necessity and Compliance

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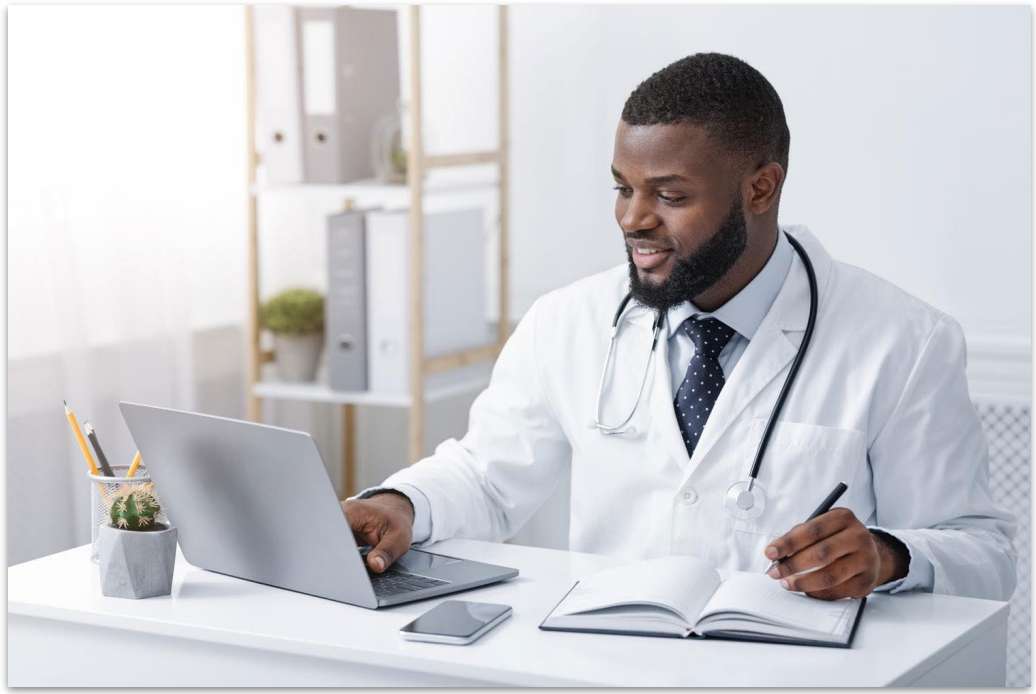
Definition and Regulatory Requirements

- **Medical Necessity Defined**
  - Medical necessity requires services to treat behavioral health conditions safely and effectively, not for convenience.
- **Regulatory Compliance**
  - Services must comply with OAC 5160-8-05 rules and meet Buckeye's criteria.
- **Documentation and Provider Qualifications**
  - Services must be documented in individualized treatment plans and delivered by qualified providers.
- **Consequences of Non-Compliance**
  - Failure to meet medical necessity leads to claim denials, audits, and corrective actions.

Medical Necessity Review

- **Requests over the daily threshold will be reviewed using:**
  - Ohio Medicaid coverage rules (e.g., OAC 5160-27 series)
  - Buckeye's **Medical Necessity Criteria (MNC)** for BH rehabilitative services
  - Treatment-plan alignment, progress indicators, and clinical justification
- **Documentation typically required:**
  - Updated treatment plan with measurable goals
  - Rationale for service intensity (e.g., functional impairment, safety risk, acute phase of treatment)
  - Evidence of progress or need for continued intensive intervention



Documentation Requirements

Tie Interventions to Treatment Plan

Demonstrate Medical Necessity

Ensure Non-Duplication Of Services

Meet Provider Qualifications Per Oac

Compliance

- Buckeye reserves audit rights
- Non-compliance → claim denial, recoupment, corrective action

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Service-Specific Coverage Criteria

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Peer Support, TBS, PSR, CPST, and IOP

- **Peer Support Services**
  - Recovery-focused, person-centered interventions delivered by certified providers supporting treatment goals.
- **TBS and PSR Focus**
  - Goal-directed interventions promoting social functioning, daily living skills, and crisis prevention.
- **Intensive Outpatient Treatment (IOP)**
  - Structured clinical sessions for substance use disorders, meeting ASAM Level 2 criteria via multidimensional assessment.
- **Community Psychiatric Supportive Treatment**
  - Medically necessary support to improve functioning, stability, and community integration.

Peer Support Services

- Regulatory Basis: OAC 5160-27-14, 5122-29-15
- Recovery-focused, person-centered, linked to treatment plan goals
- Provider meets certification requirements by OhioMHAS and OAC
- The service is not provided concurrently with certain high-intensity services (e.g., ACT, IHBT, SUD residential services), except when supporting admission or discharge.

Therapeutic Behavioral Services (TBS)

- Regulatory Basis OAC 5160-27-08
- Goal-directed, solution-focused interventions
- Activities: Treatment planning, crisis prevention, social skills and/or daily functioning restoration
- Linked to documented goals

Psychosocial Rehabilitation (PSR)

- Regulatory Basis: OAC 5160-27-08
- Assists with functional deficits or interpersonal barriers
- Activities: Daily functioning restoration, community integration, and rehabilitation and support to improve self-management of symptoms interfering with community success

Community Psychiatric Supportive Treatment (CPST)

- OAC Chapters 5122-29 and 5160-27
- For diagnosed mental health disorder with functional impairment
- Activities: Ongoing assessment, skill development, crisis management, ISP coordination
- Expected Benefit: Maintain/improve stability, reduce symptoms, prevent higher-level care

Intensive Outpatient Treatment (IOP)

- Regulatory Basis: OAC 5160-27-09, ASAM Level 2
- Meets ASAM multidimensional assessment
- Structured clinical approach, not concurrent with other SUD levels of care

Behavioral Health Billing Updates for Providers

Expectations of Providers

Megan Whelan, LMHC, LPC

Senior Manager, Behavioral Health Utilization Management

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Key Elements for Compliance

- **Importance of Documentation**
  - Accurate documentation demonstrates medical necessity and ensures compliance with health plan policies.
- **Individualized Treatment Plans**
  - Interventions must be linked to personalized treatment plans reflecting member's goals and progress.
- **Compliance and Standards**
  - Documentation should avoid duplication and meet provider qualification and clinical appropriateness standards.
- **Consequences of Non-Compliance**
  - Poor documentation can cause claim denials, audits, and financial recoupments.

Behavioral Health Billing Updates for Providers

Billing and Prior Authorization

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Thresholds and Submission Tips

- **Importance of Billing Accuracy**
  - Accurate billing and timely submissions are critical to ensure successful claims and avoid delays or denials.
- **Updated Submission Thresholds**
  - Providers must stay informed about updated thresholds for community-based and intensive outpatient treatments.
- **Submission Best Practices**
  - Include all required clinical documentation and submit prior authorization requests via the provider portal promptly.
- **Common Errors to Avoid**
  - Avoid incomplete treatment plans, missing medical necessity indicators, and missed submission deadlines.

No Prior Authorization Requirement

- The policy **does not require prior authorization** for standard delivery of CPST, PSR, TBS, or Peer Support up to the established thresholds.
- Services above the threshold may be reviewed prospectively or retrospectively with an **opportunity to submit documentation** to demonstrate medical necessity.
- Buckeye will follow Medicaid UM timelines for any requests requiring additional review.

Prior Authorization

Prior Authorizations are required on some services and will be submitted directly to the health plan.

To determine if a service needs prior authorization use our **Prior Authorization Prescreen Tool** (buckeyehealthplan.com/providers/prior-authorization/preauth-check.html)

If a service requires prior authorization, please note:

- Standard prior authorization requests should be submitted for medical necessity review at least five (5) business days before the scheduled service delivery date or as soon as the need for service is identified.
- Authorization requests should be submitted via our secure web portal and should include all necessary clinical information.

To submit a Prior Authorization for approval:

- Login to the **Secure Provider Portal** (buckeyehealthplan.com/providers.html) or **Availity** (apps.availity.com/availity/web/public.elegant.login).
  - Access the member's record.
  - Select the New Authorization option. The Authorization screen will appear with the member's data pre-populated.
  - **Complete the Authorization Form.**
- Fax Authorization request to 866-535-6974

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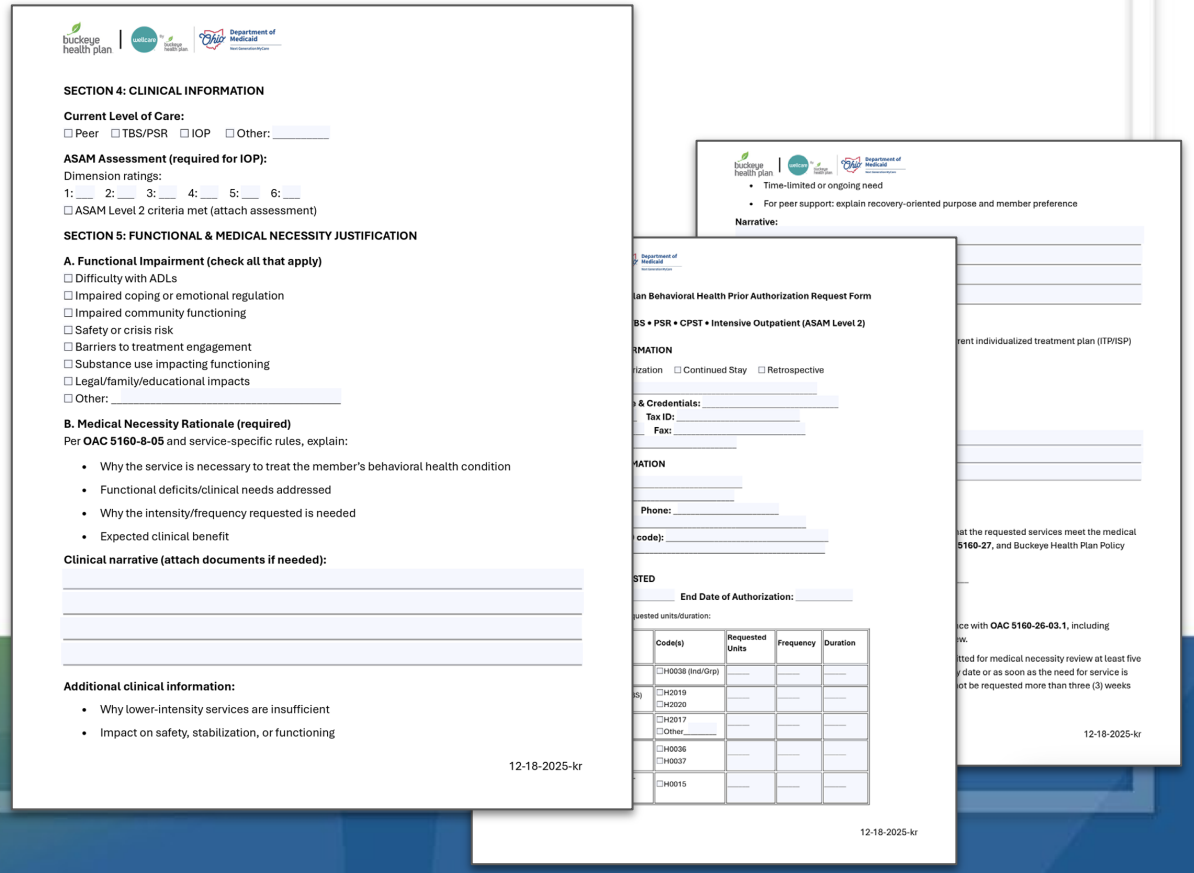
Behavioral Health Prior Authorization Request Form

- For Peer Support, TBS, PSR, CPST and Intensive Outpatient (ASAM Level 2)
- Includes fillable forms in a PDF that requests:
  - Provider information
  - Member information
  - Service requested
  - Clinical information
  - Functional and medical necessity justification
  - Treatment plan requirements
  - Provider Attestation
- Access the form at buckeyehealthplan.com/providers/prior-authorization/BHProviderAuthorizationsInformation.html



SECTION 4: CLINICAL INFORMATION

Current Level of Care:
☐ Peer ☐ TBS/PSR ☐ IOP ☐ Other: _____

ASAM Assessment (required for IOP):
Dimension ratings:
1: ___ 2: ___ 3: ___ 4: ___ 5: ___ 6: ___
☐ ASAM Level 2 criteria met (attach assessment)

SECTION 5: FUNCTIONAL & MEDICAL NECESSITY JUSTIFICATION

A. Functional Impairment (check all that apply)
☐ Difficulty with ADLs
☐ Impaired coping or emotional regulation
☐ Impaired community functioning
☐ Safety or crisis risk
☐ Barriers to treatment engagement
☐ Substance use impacting functioning
☐ Legal/family/educational impacts
☐ Other: _____

B. Medical Necessity Rationale (required)
Per **OAC 5160-8-05** and service-specific rules, explain:

- Why the service is necessary to treat the member's behavioral health condition
- Functional deficits/clinical needs addressed
- Why the intensity/frequency requested is needed
- Expected clinical benefit

Clinical narrative (attach documents if needed):

Additional clinical information:

- Why lower-intensity services are insufficient
- Impact on safety, stabilization, or functioning

12-18-2025-kr

- Time-limited or ongoing need
- For peer support: explain recovery-oriented purpose and member preference

Narrative:

12-18-2025-kr

ian Behavioral Health Prior Authorization Request Form

BS • PSR • CPST • Intensive Outpatient (ASAM Level 2)

RMATION

ization ☐ Continued Stay ☐ Retrospective

& Credentials: _____
Tax ID: _____
Fax: _____

MATION

Phone: _____
code): _____

STED

End Date of Authorization: _____

quested units/duration:

	Code(s)	Requested Units	Frequency	Duration
	☐H0038 (Ind/Grp)			
BS)	☐H2019 ☐H2020			
	☐H2017 ☐Other_____			
	☐H0036 ☐H0037			
	☐H0015			

12-18-2025-kr

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Behavioral Health Billing Updates for Providers

Appeals and Denial Processes

Charlene Brubaker, MHA

Manager, Provider Network, Provider Engagement

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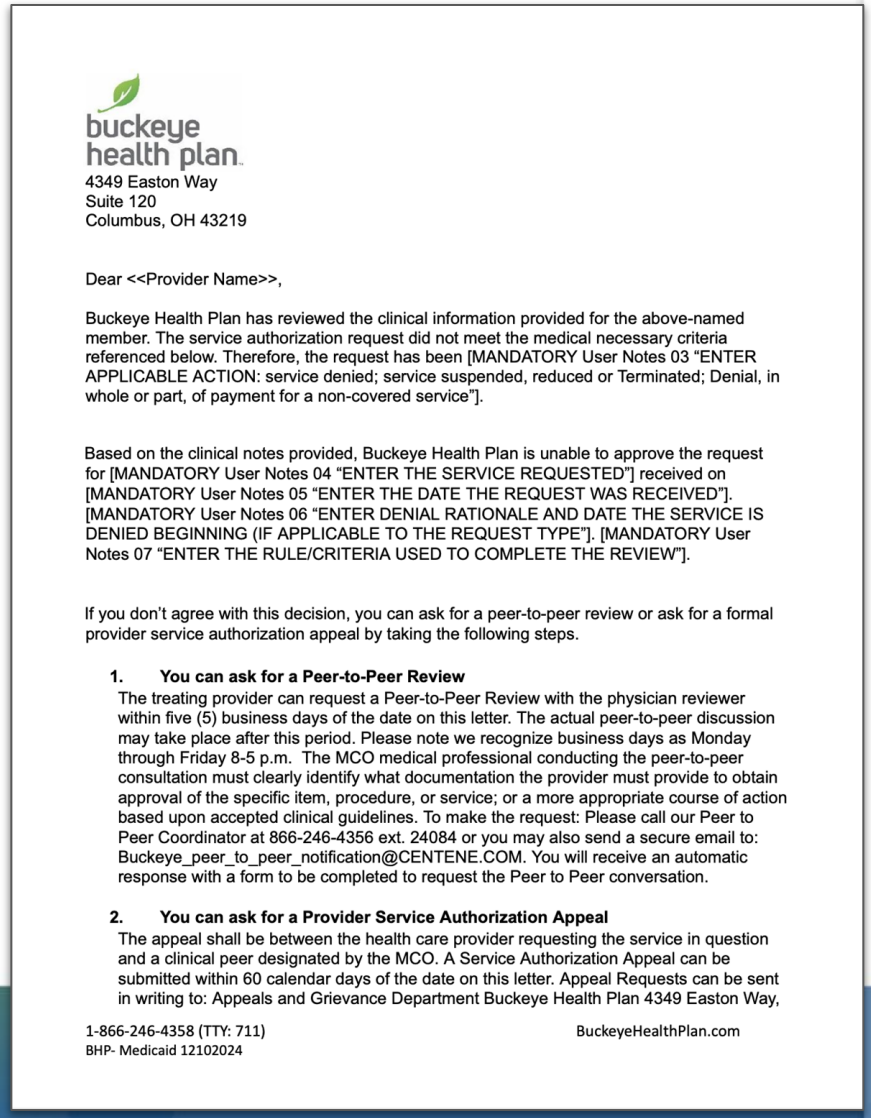
Steps for Resolution

- **Review Denial Notices**
  - Providers should carefully review denial notices to identify missing documentation or unmet criteria promptly.
- **Submit Corrected Appeals**
  - Appeals must include corrected or additional information showing compliance with medical necessity and coverage requirements.
- **Timely Submission**
  - Submitting appeals within designated time frames is critical to ensure consideration and resolution of claims.
- **Provider Support**
  - Buckeye offers resources and guidance to help providers navigate the appeals process and prevent future denials.



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4349 Easton Way
Suite 120
Columbus, OH 43219

Dear <<Provider Name>>,

Buckeye Health Plan has reviewed the clinical information provided for the above-named member. The service authorization request did not meet the medical necessary criteria referenced below. Therefore, the request has been [MANDATORY User Notes 03 "ENTER APPLICABLE ACTION: service denied; service suspended, reduced or Terminated; Denial, in whole or part, of payment for a non-covered service"].

Based on the clinical notes provided, Buckeye Health Plan is unable to approve the request for [MANDATORY User Notes 04 "ENTER THE SERVICE REQUESTED"] received on [MANDATORY User Notes 05 "ENTER THE DATE THE REQUEST WAS RECEIVED"]. [MANDATORY User Notes 06 "ENTER DENIAL RATIONALE AND DATE THE SERVICE IS DENIED BEGINNING (IF APPLICABLE TO THE REQUEST TYPE"]. [MANDATORY User Notes 07 "ENTER THE RULE/CRITERIA USED TO COMPLETE THE REVIEW"].

If you don't agree with this decision, you can ask for a peer-to-peer review or ask for a formal provider service authorization appeal by taking the following steps.

1. **You can ask for a Peer-to-Peer Review**
   The treating provider can request a Peer-to-Peer Review with the physician reviewer within five (5) business days of the date on this letter. The actual peer-to-peer discussion may take place after this period. Please note we recognize business days as Monday through Friday 8-5 p.m. The MCO medical professional conducting the peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines. To make the request: Please call our Peer to Peer Coordinator at 866-246-4356 ext. 24084 or you may also send a secure email to: Buckeye_peer_to_peer_notification@CENTENE.COM. You will receive an automatic response with a form to be completed to request the Peer to Peer conversation.

2. **You can ask for a Provider Service Authorization Appeal**
   The appeal shall be between the health care provider requesting the service in question and a clinical peer designated by the MCO. A Service Authorization Appeal can be submitted within 60 calendar days of the date on this letter. Appeal Requests can be sent in writing to: Appeals and Grievance Department Buckeye Health Plan 4349 Easton Way,

1-866-246-4358 (TTY: 711) BuckeyeHealthPlan.com
BHP- Medicaid 12102024

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Resources and References

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Buckeye Secure Provider Portal

Take care of business on YOUR schedule. The Provider Portal is yours to use 24 hours a day, seven days a week to accomplish several tasks.

- Easily check member eligibility
- View, manage, and download your member list
- View and submit claims
- View and submit service authorizations
- Communicate with us through secure messaging
- Maintain multiple providers on one account
- Control website access for your office
- View historical member health records
- Submit assessments to provide better member care
- And much more

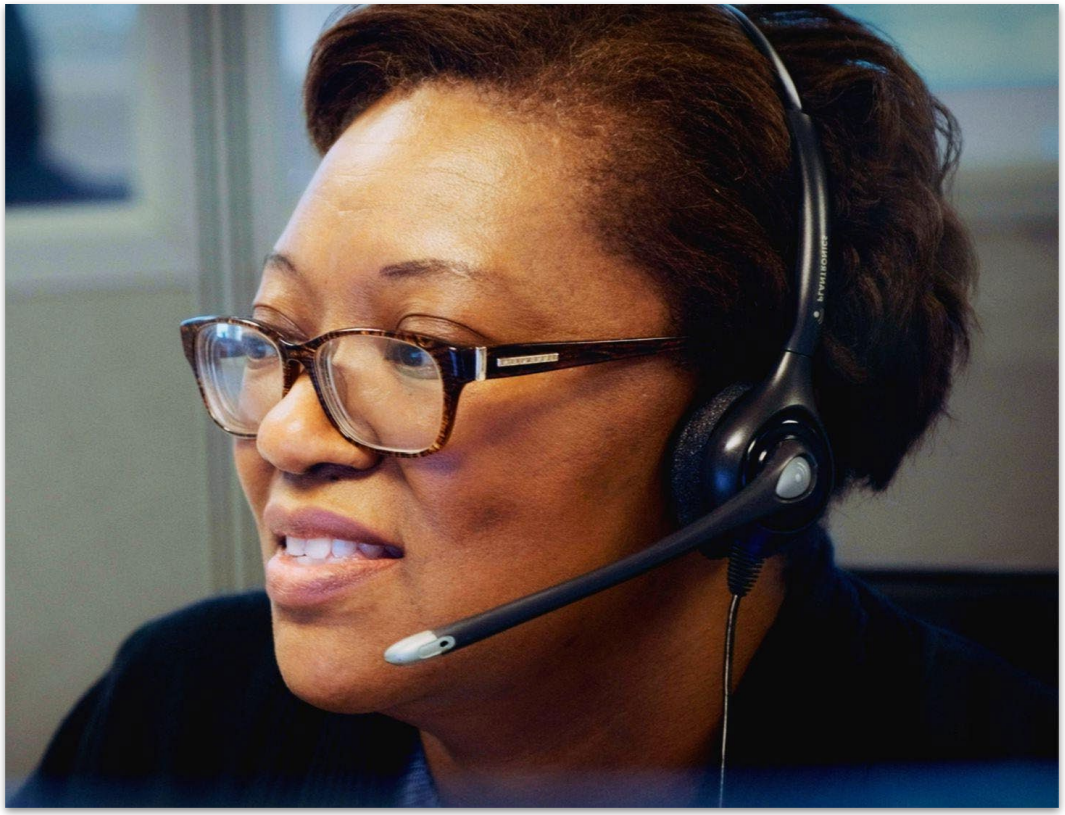
Access the Secure Provider Portal from the **Provider Home Page** (buckeyehealthplan.com/providers.html)

Availity Essentials

- Buckeye has chosen **Availity Essentials** (availity.com/providers/)as its new, secure provider portal. Starting January 20, 2025, providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials.
- Our current **Secure Provider Portal** (buckeyehealthplan.com/providers.html) is still available for other functions that providers use today.
- For providers new to Availity Essentials, getting their Essentials account is the first step toward working with Buckeye on Availity.
  - The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
  - Administrators can **Register and Get Started with Availity Essentials** (availity.com/documents/learning/LP_AP_GetStarted/index.html#/).
  - Providers needing additional assistance with registration can call Availity Client Services at
  - **1-800-AVAILITY (282-4548)**, Monday through Friday, 8 a.m. – 8 p.m. ET.
  - For general questions, providers can reach out to their health plan Provider Engagement representative.

Provider Services

- Our Provider Services staff is your first stop in your quest for information. They are available to you and your staff to answer questions, listen to your concerns, assist with patients, respond to your Buckeye inquiries, and connect you to your Buckeye Provider Engagement Administrator.
- Provider Services hours of operation: Monday-Friday 7:00 a.m.-8 p.m. (EST)
- Contact the Provider Services Toll Free Help Line at 866-296-8731.



Provider Engagement

Our Provider Engagement team is dedicated to making your experience with Buckeye a positive one by serving as your advocate within the organization. We are responsible for providing the services listed below which include but are not limited to:

- Maintenance of existing Buckeye Provider Manual.
- Network performance engagement.
- Physician and office staff orientation.
- Hospital and ancillary staff orientation.
- Ongoing provider education, updates, and training.

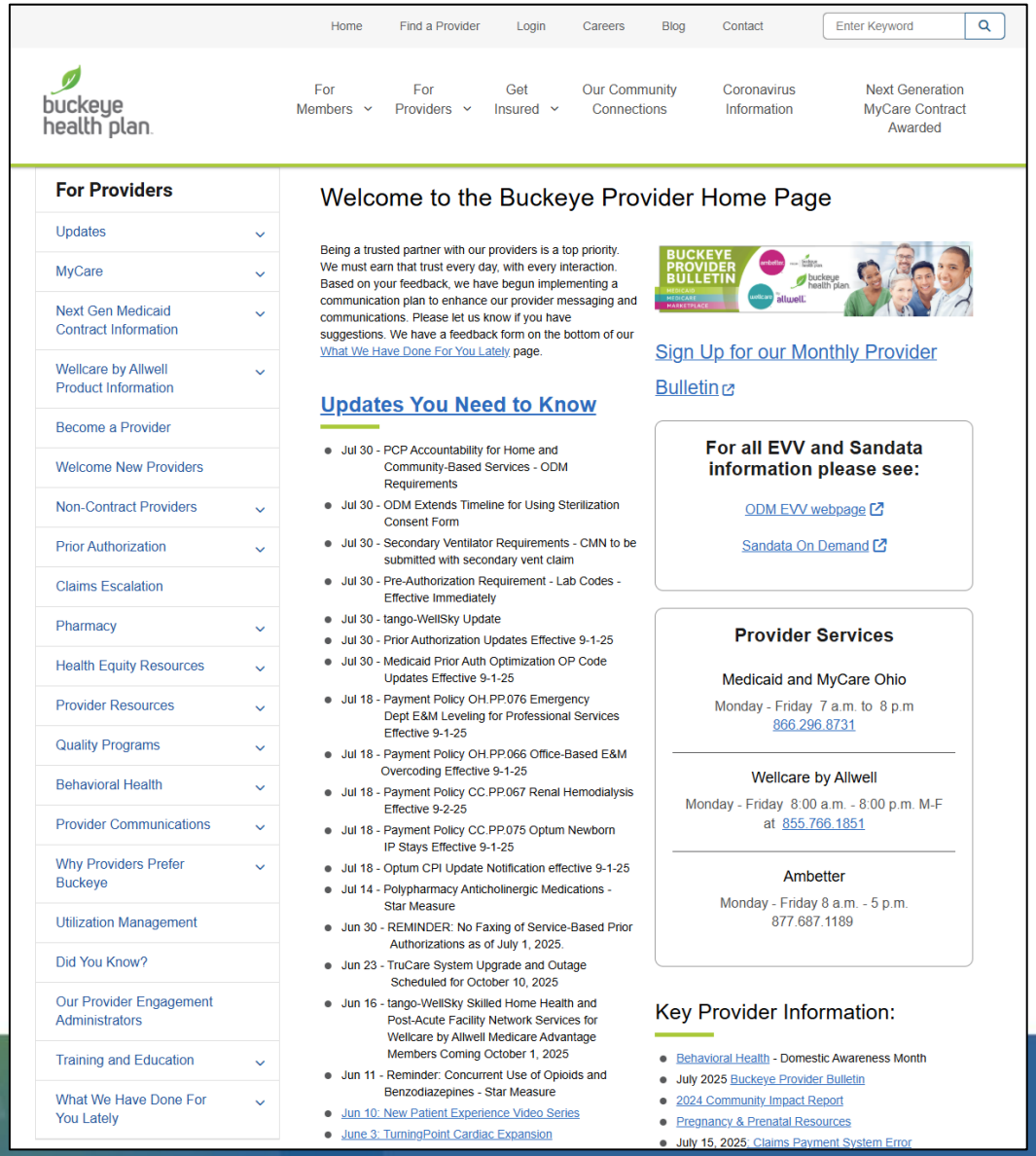
The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Buckeye enrolled membership.

You can find your assigned Provider Engagement representative by accessing our **Provider Engagement page** (buckeyehealthplan.com/providers/our-provider-engagement-adm.html) or reach out to **Provider Services** at 866-296-8731.

Provider Home Page

Our website **Provider Home Page** (buckeyehealthplan.com/providers.html) is a one-stop shop to find access to information you need.

- Latest updates on doing business with Buckeye.
- Find-a-Provider search with mapping from member's address
- Provider manuals
- Clinical guidelines
- Online tool to verify prior authorization requirements
- **Downloadable forms including:**
  - Change of PCP
  - Provider Action Request
  - Member Connections



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Website Resources

Buckeye Key Information Highlights

Buckeye's **Provider Home Page** (buckeyehealthplan.com/providers.html) provides links to key resources, provider updates, communications, and trainings.

Provider Resources are located via the left hand side of the **Provider Home Page**.

- **Provider Manuals** buckeyehealthplan.com/providers/resources/forms-resources.html
- **Provider Bulletin** buckeyehealthplan.com/providers/provider-communications/provider-update-newsletter.html
- **Provider Training and Education** buckeyehealthplan.com/providers/training-and-education.html
- **Buckeye Pre-Auth Check tool** buckeyehealthplan.com/providers/prior-authorization/preauth-check.html

Provider Services Support:

Medicaid
Monday - Friday 7 a.m. to 8 p.m
866-296-8731

WellCare by Buckeye Health Plan / Next Generation MyCare Program
Monday-Friday 8 a.m. to 8 p.m. EST
833-998-4892

Buckeye Contract Coordination:
Ohiocontracting@centene.com

Contract Negotiators:
OHNegotiators@centene.com

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Provider Network Operations

- Providers should submit updates to **demographic data** to **OhioContracting@Centene.com** within 30 days of the data change becoming effective.
- **Forms** to **add new practitioners** can be found on our **website** (buckeyehealthplan.com/providers/resources/forms-resources.html) and should be submitted along with all credentialing documentation to **OhioContracting@Centene.com**.
- Enrollments are effective 30 days from the date all clean documents are received by Buckeye.

Please send the following items to **OhioContracting@Centene.com**:

- Contract Clarification
- Demographic information updates
- Initiate credentialing of a new practitioner
- Inquiries related to the status of a new practitioner or Join Our Network request

Provider Communications

We believe that communication is vital to a successful partnership and our goal is to communicate essential information, on a consistent basis, to earn your trust and make working with Buckeye easier.

Our newsletter is delivered electronically to all providers each month. This communication covers essential operational and procedural topics to help them do business with Buckeye. In addition, it delivers training and education opportunities and include some of Buckeye's provider-based initiatives. All editions of the newsletter will be available on the **website**:(buckeyehealthplan.com/providers/provider-communications/provider-update-newsletter.html).

Provider Communications Sign-Up

Whether you are an office manager, licensed staff, physician, billing or front desk worker, or serve in another role within our provider locations, Buckeye would like to share relevant, timely information that makes it easier to do business with us. Please **sign up for Provider Communications** (app.hatchbuck.com/OnlineForm/21925554957). Even if you have received our email communications in the past, please sign up for future communications.

Contact Buckeye

Brandi Hahn, MHA, MSW, LISW-S,
Manager of Behavioral Health

buckeye health plan.

Contact Us

Our helpful Provider Services representatives are available to take your call at **866-296-8731** Monday through Friday from 7 a.m. to 8 p.m.

Send a secure message on our portal:

1. **Log in to the portal** (buckeyehealthplan.com/providers.html)
2. Select “Message” from the top banner.
3. Complete your message. Allow 3 to 5 business days for a reply.

Questions

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Frequently Asked Questions

What services are covered in this FAQ?

- Psychosocial Rehabilitation (PSR)
- Therapeutic Behavioral Services (TBS)
- Peer Support Services
- Community Psychiatric Supportive Treatment (CPST)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)

These services must meet Ohio Administrative Code requirements and Buckeye policy.

Frequently Asked Questions

What does “medically necessary” mean for these services?

Across all services, medical necessity means:

- The member has a documented behavioral health diagnosis with functional or clinical needs.
- Services are tied to goals in an individualized treatment plan.
- Interventions are clinically appropriate and not duplicative.
- Services are provided by qualified staff and properly documented.

If these elements are missing, services may be denied or recouped. .

Frequently Asked Questions

What are the key service definitions (high level)?

- **Psychosocial Rehabilitation (PSR):** Focuses on building and restoring daily living, social, and community functioning skills. Billing code: H2017 (15-minute units)
- **Therapeutic Behavioral Services (TBS):** Provides intensive, goal-directed interventions to reduce severe behavioral symptoms and improve functioning. Billing codes: H2019, H2020
- **Peer Support Services:** Recovery-focused support provided by a certified peer with lived experience. Billing code: H0038 (15-minute units)
- **Intensive Outpatient Program (IOP):** A structured treatment program with multiple hours of therapy per day, several days per week.Billing code: H0015 (per diem)

Frequently Asked Questions

Can rehabilitative services be billed on the same day as IOP, PHP, or TBS per diem?

Yes, but limits apply. When IOP, PHP, or TBS per diem is billed:

- No more than 4 total units combined of rehabilitative services may be billed on the same day.
- This includes PSR, TBS, and CPST combined.
- Services must be delivered outside program hours.

Services provided during program hours are included in the per diem and cannot be billed separately.

Frequently Asked Questions

What are the daily limits on non-IOP/PHP days?

When no IOP, PHP, or TBS per diem is billed:

- A maximum of 16 total units per member per day
- Applies to all rehabilitative services combined
- Applies even if multiple provider organizations are involved

Exceeding this limit without authorization will result in denial or recoupment.

Frequently Asked Questions

Can multiple rehabilitative services be provided on the same day?

Yes, if all of the following are met:

- Each service has a different purpose
- Services do not overlap in time
- Each service is documented separately
- Each service supports a different treatment plan goal

Example: CPST for care coordination and PSR for skill development may both be allowed.

Frequently Asked Questions

What documentation is required?

For every service billed, providers must maintain:

- Separate progress notes
- Start and stop times
- Clear clinical justification
- Linkage to the individualized treatment plan
- Evidence services are non-duplicative

Poor or missing documentation may result in claim denial or recoupment.

Frequently Asked Questions

Are there exceptions to unit limits?

Yes, but only with explicit authorization from Utilization Management.

- Medical necessity must be clearly documented
- Approval must be received before billing above limits
- Units billed without approval will not be reimbursed

Frequently Asked Questions

Does it matter if different providers deliver the services?

No.

- Unit limits apply per member per day
- Limits apply even when services are delivered by:
  - Different agencies
  - Related organizations
  - Multiple rendering providers

Frequently Asked Questions

Who should providers contact with questions?

Providers may contact:

- Buckeye Provider Services: 866-296-8731
- Their assigned Provider Engagement Administrator

Please put your questions in the Q&A.

Thank you

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