Provider FAQ: Intensive Outpatient Program (IOP)

This FAQ consolidates the original IOP Frequently Asked Questions with Buckeye Health Plan's Medical Necessity Criteria (MNC) for TBS, PSR, CPST, PRS, and IOP. It is intended to help providers quickly confirm coverage, documentation, and billing expectations in alignment with Ohio Administrative Code (OAC) and ASAM criteria.

1) What is IOP?

Intensive Outpatient Program (IOP) is a structured behavioral health treatment program delivering multiple hours of therapeutic services per day, several days per week, for individuals who need intensive support but do not require 24-hour inpatient care. Services are organized, scheduled, and part of a structured clinical approach.

2) Who can provide IOP?

IOP must be delivered by qualified behavioral health professionals employed or contracted by an Ohio Medicaid-enrolled provider organization, consistent with OAC 5160-27-09 and applicable service-specific rules.

3) Medical Necessity: core criteria

Coverage is limited to medically necessary services that comply with OAC and ASAM. The individualized treatment/service plan (ITP/ISP) must document needs, goals, and interventions; services must be clinically appropriate, non-duplicative, and delivered by eligible, qualified providers. For IOP (SUD) specifically, admission and continued stay must meet ASAM Level 2 criteria based on multidimensional assessment; for CPST, TBS, PSR, and PRS, interventions must be tied to functional/clinical needs and treatment plan goals.

4) What is the billing code for IOP and are there limits?

Billing code: H0015 (Alcohol and/or drug services; intensive outpatient treatment, per diem). Buckeye will require PA upon reaching threshold for H0015.

Threshold for H0015: Up to 27 units per calendar year; PA required after 27 units

5) When is IOP reimbursable?

IOP is reimbursable when medically necessary, authorized under a current individualized treatment plan, aligned with ASAM Level 2 standards for admission/continued stay/discharge, and not concurrent with mutually exclusive SUD levels of care.

6) Documentation requirements

Maintain separate progress notes with start/stop times, clinical justification, linkage to the treatment plan, and evidence the service is distinct and non-duplicative. Documentation must demonstrate medical necessity, progress, provider qualifications, and adherence to OAC service delivery standards.

7) Can IOP be billed with other services (CPST, TBS, and PSR)?

Yes—if services are clinically distinct, not duplicative, and documented separately. Rehabilitative services delivered during IOP program hours are bundled into the IOP per diem and are not separately reimbursable; outside program hours, the combined daily limit of four (4) units applies for these rehabilitative services.

8) Service-specific MNC snapshots (for quick reference)

8a) CPST – Medical Necessity

CPST is medically necessary when a diagnosed mental health disorder causes functional impairment and the member requires assessment, skill development, symptom monitoring, coordination/linkage, crisis stabilization support, or interventions to improve coping, daily living, education/employment, or community integration.

8b) TBS – Medical Necessity

TBS provides goal-directed, solution-focused interventions addressing behavioral/emotional needs, including participation in strengths-based planning, strategy identification, evidence-based emotional/behavioral management, restoration of social skills and daily functioning, and crisis prevention/amelioration; activities must be tied to treatment plan goals/objectives.

8c) PSR – Medical Necessity

PSR assists individuals to implement treatment plan interventions to compensate for or eliminate functional deficits, restore daily functioning and routines, and restore skills for successful functioning in home, school, work, and community settings; not recreational or custodial and must be clinically appropriate.

8d) IOP (SUD) – Medical Necessity

Admission and continued stay require ASAM Level 2 criteria based on multidimensional assessment (severity, functioning, risks, strengths, supports). The level of care must be clinically appropriate (not higher or lower than needed), scheduled/structured, and not concurrent with another mutually exclusive SUD level of care.

9) Are there exceptions to daily limits or coverage rules?

Exceptions may be approved by Utilization Management based on documented medical necessity; providers should submit adequate clinical rationale with requests.

10) Who can providers contact with questions?

Contact Buckeye Provider Services at 866-296-8731 or your assigned Provider Engagement Administrator.

11) Key regulatory references (quick list)

OAC 5160-27-02, 5160-8-05, 5160-27-08, 5160-27-09, 5160-27-14; OAC 5122-27-03; OAC 5122-29-15; OAC 5122-29-18; ASAM Criteria (latest edition).