Provider FAQ: Peer Support Services – Updated with MNC and Billing Details

This FAQ provides guidance on Peer Support Services, including Medical Necessity Criteria (MNC) and billing limits, in alignment with Ohio Administrative Code (OAC) and Buckeye Health Plan policy.

1) What are Peer Support Services?

Peer Support Services (PSS) are recovery-oriented, person-centered supports delivered by individuals with lived experience of mental health and/or substance use conditions who are certified/credentialed to provide structured support, mentoring, advocacy, and linkage to community resources.

2) Who can provide Peer Support?

Peer Support must be delivered by qualified, trained, and certified peer supporters employed or contracted by a Medicaid-enrolled behavioral health provider organization in accordance with applicable state administrative code and payer requirements.

3) What is the billing code for Peer Support?

The billing code commonly used for Peer Support Services is H0038 (Self-help/peer services, per 15 minutes). Modifiers may apply based on payer or program requirements.

•PA thresholds: 24 units/week, 26 weeks/year

4) Medical Necessity Criteria (MNC) for Peer Support

Peer Support Services are covered when all the following conditions are met:

- Service is part of a behavioral health treatment plan addressing MH or SUD needs.
- Goals/objectives documented in a current individualized treatment plan (OAC 5122-27-03).
- Recovery-focused, person-centered, based on a peer relationship (OAC 5122-29-15).
- Provider meets all certification and eligibility requirements (OhioMHAS/OAC).
- Service does not duplicate other behavioral health services.

Indicators of Medical Necessity include documented behavioral health needs requiring peer-based recovery support, enhancing resiliency, recovery, self-advocacy, or skill development, and documentation supporting clinical appropriateness and progress.

5) When are Peer Support Services reimbursable?

Peer Support is reimbursable when medically necessary, included in an individualized treatment/recovery plan, and documented to support goals such as enhancing engagement, building recovery skills, increasing self-efficacy, and improving community integration.

6) Are there daily limits for Peer Support?

Daily limits may apply when more than sixteen (16) units of peer support are rendered.

7) What documentation is required?

Maintain separate progress notes for each service with start/stop times, interventions provided, member response, and how activities support the recovery/treatment plan goals. Document coordination with the treatment team and any referrals or linkages completed.

8) Can Peer Support be billed on the same day as other services?

Yes, if the services are distinct, non-duplicative, and clearly documented. Services delivered during IOP/PHP/TBS program hours are considered included in the per diem and are not separately reimbursable.

9) Are there qualifications or supervision requirements?

Peer supporters must meet state certification/credentialing standards and function within their scope of practice. Providers must ensure appropriate supervision and training as required by state and payer policy.

10) Are there exceptions to unit limits?

Medically necessary exceptions may be approved by Utilization Management when explicitly authorized. Absent explicit approval, units exceeding daily limits will not be reimbursed.

11) Who can providers contact with questions?

Providers may contact Provider Services at 866-296-8731 or their assigned Provider Engagement Administrator representative.