2026 BEHAVIORAL HEALTH BILLING POLICY UPDATES FOR PROVIDERS

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

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.
- Per CMS expectations all Standard authorizations will be determined within 7 days

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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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
- **COMING SOON!** View Benefits Usage
- 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

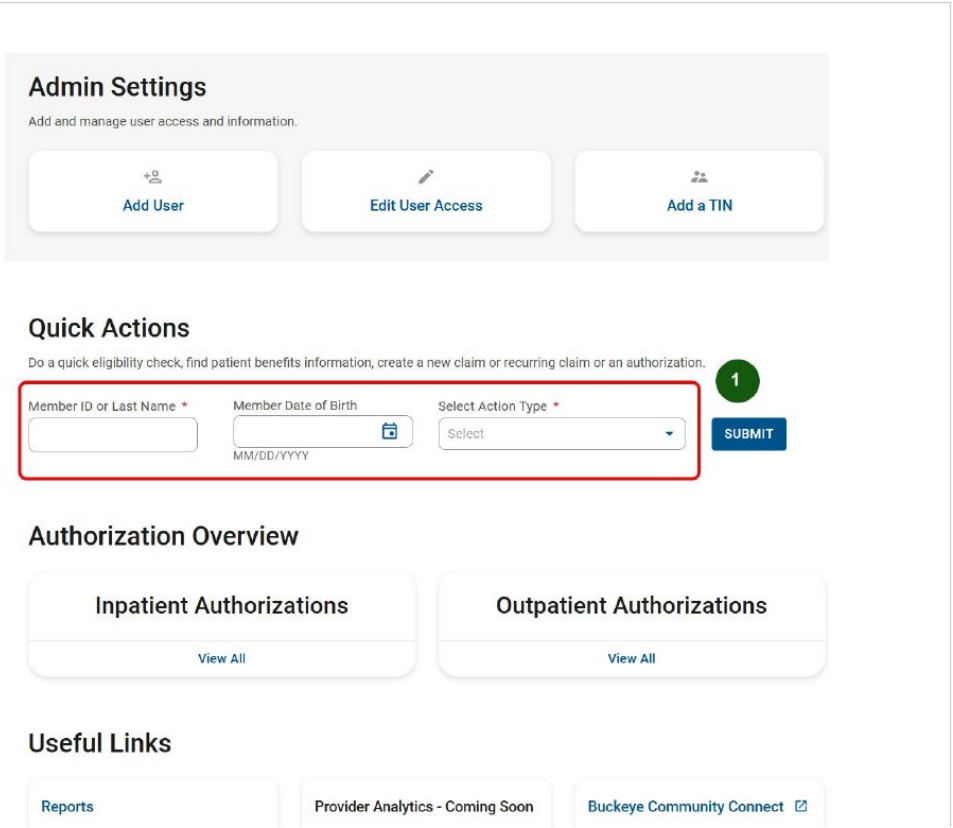
Access the Secure Provider Portal from the **Provider Home Page** (buckeyehealthplan.com/providers.html)

Buckeye Secure Provider Portal Eligibility

Step 1: How to Check Member Eligibility in the Secure Provider Portal

1. Log in to the Buckeye Secure Provider Portal.
2. Once on the landing page, locate the Quick Actions section (highlighted on the screen).
3. In the Quick Actions fields, enter:
Member ID or Last Name
Member Date of Birth
4. Select “Eligibility Check” (or the appropriate action type) from the dropdown.
5. Click Submit to view the member’s eligibility details.

The Quick Actions section on the landing page provides the fastest way to access eligibility—no additional navigation is needed.



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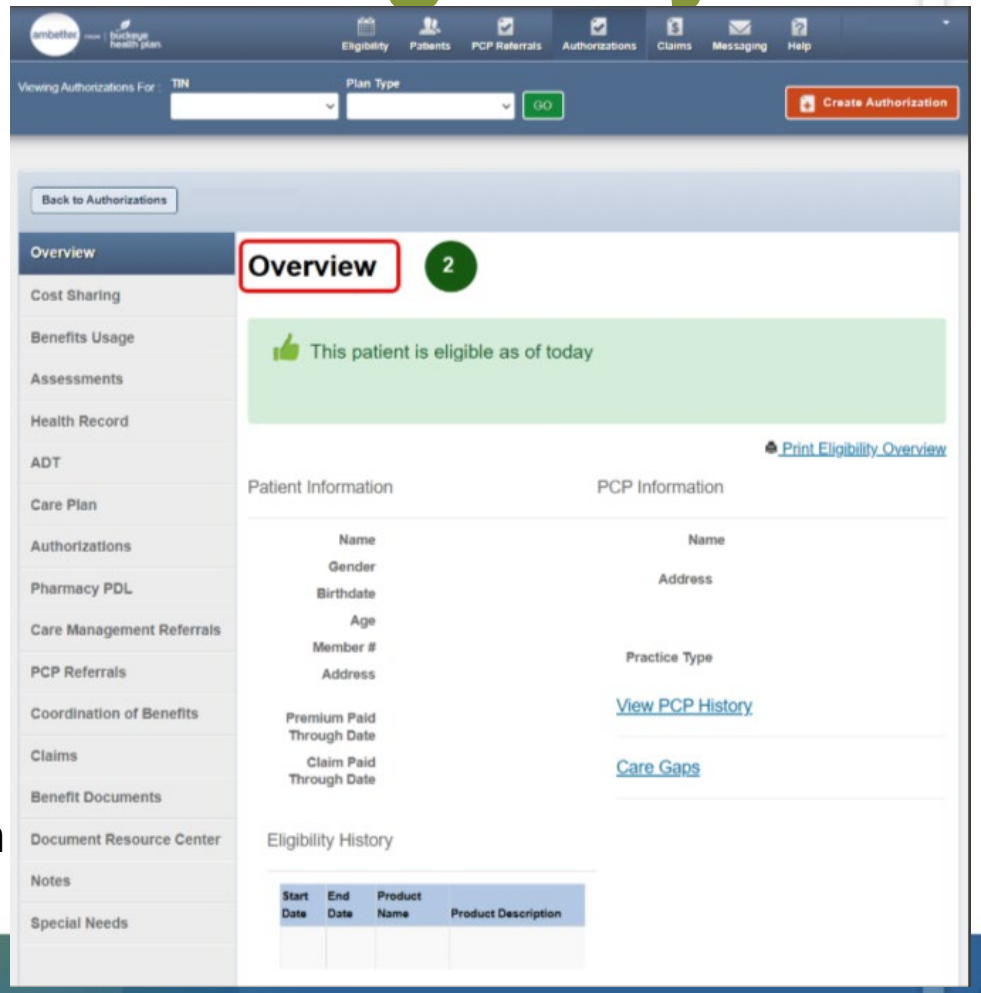
Buckeye Secure Provider Portal Eligibility

Step 2: Review the Eligibility Overview Page
After selecting the eligibility check, you will be directed to the member's Eligibility Overview page (shown on this slide).

At the top of the page, you will see a confirmation message indicating the member's current eligibility status (e.g., "This patient is eligible as of today").

Within the Overview section, you can review key member details, including:
Member demographic information
Eligibility effective dates
PCP (Primary Care Provider) information

Use the left-hand navigation menu to access additional details such as Cost Sharing, Benefits Usage, Authorizations, and Claims.



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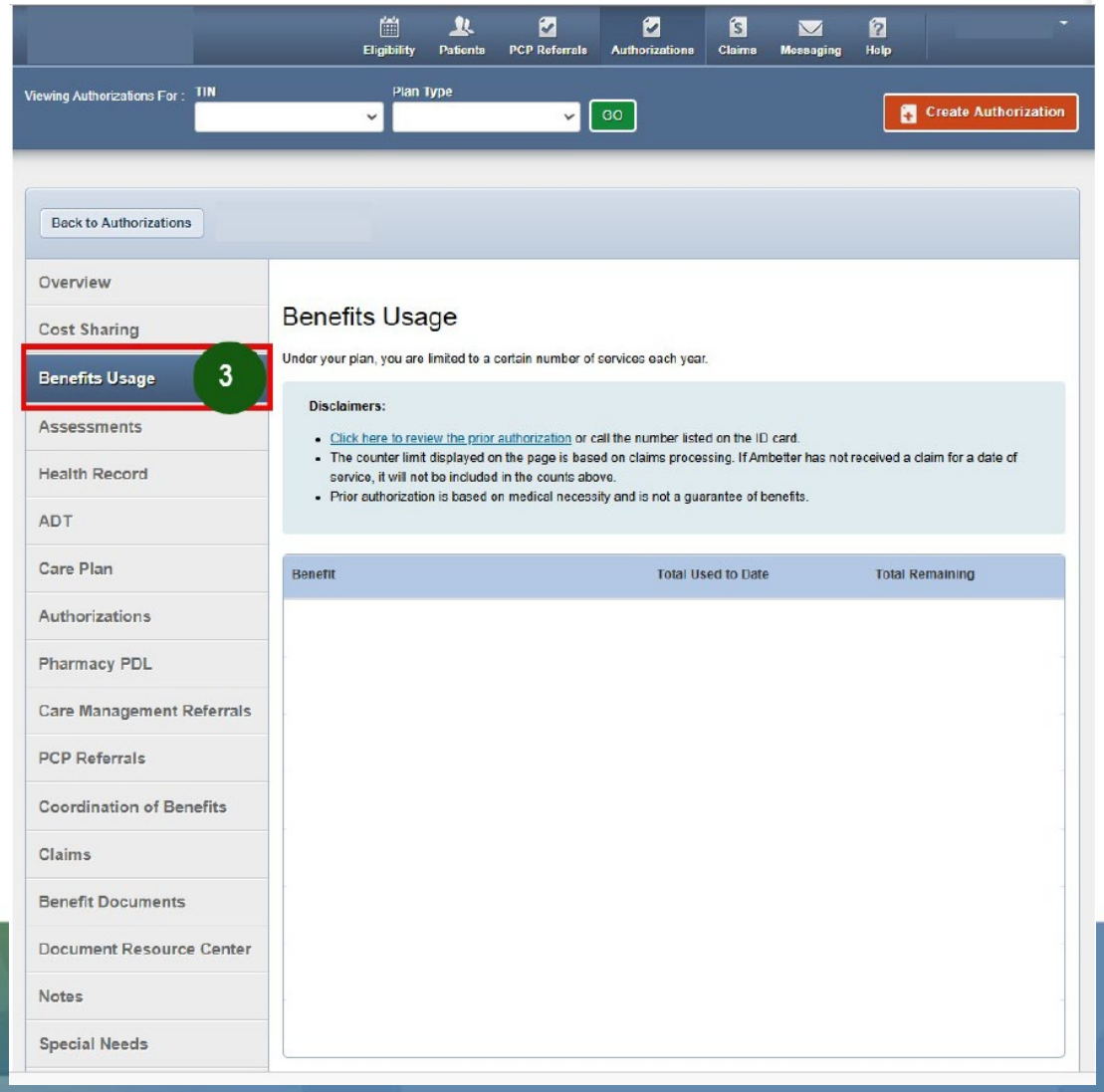
Buckeye Secure Provider Portal Benefits Usage

Step 3: Review Benefits Usage Information
From the Eligibility Overview page, select “Benefits Usage” from the left-hand navigation menu (highlighted on this slide).

The Benefits Usage page will display a summary of the member’s benefit utilization under their current plan.

What information is available:

- **Services used to date** – Shows how many covered services the member has already utilized
- **Remaining benefits** – Indicates how many services are still available within the benefit limit
- **Annual or service limits** – Reflects any caps on services based on the member’s plan
- **Disclaimers and notes** – Provides important reminders regarding claims processing and prior authorization requirements



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Buckeye Secure Provider Portal Benefits Usage

Important reminders for providers:

- Always verify eligibility and benefits at the time of service
- Benefit usage is based on processed claims, so recent services may not yet be reflected
- Prior authorization is based on medical necessity and is not a guarantee of payment
- Providers can contact Provider Services at 1-866-296-8731 to obtain Benefit Usage Data

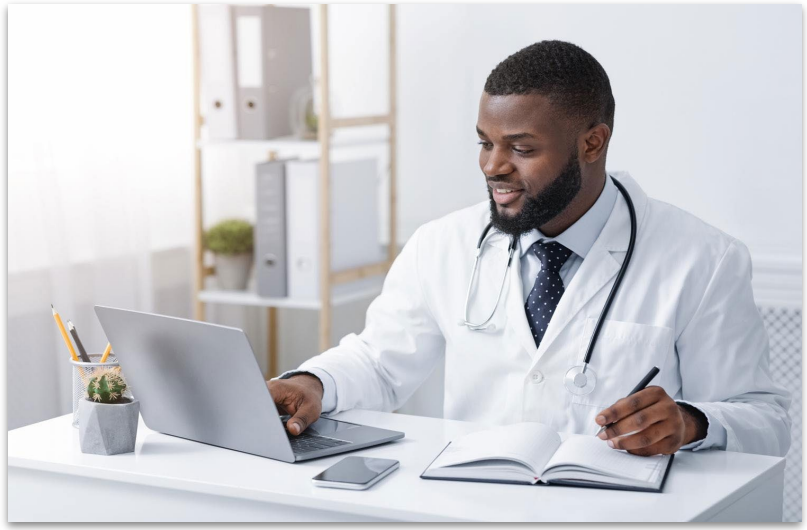
Why this matters:
The Benefits Usage section helps providers understand how much of a member's benefit has been utilized and what remains available—supporting accurate treatment planning and billing.

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.

Medical Necessity Review

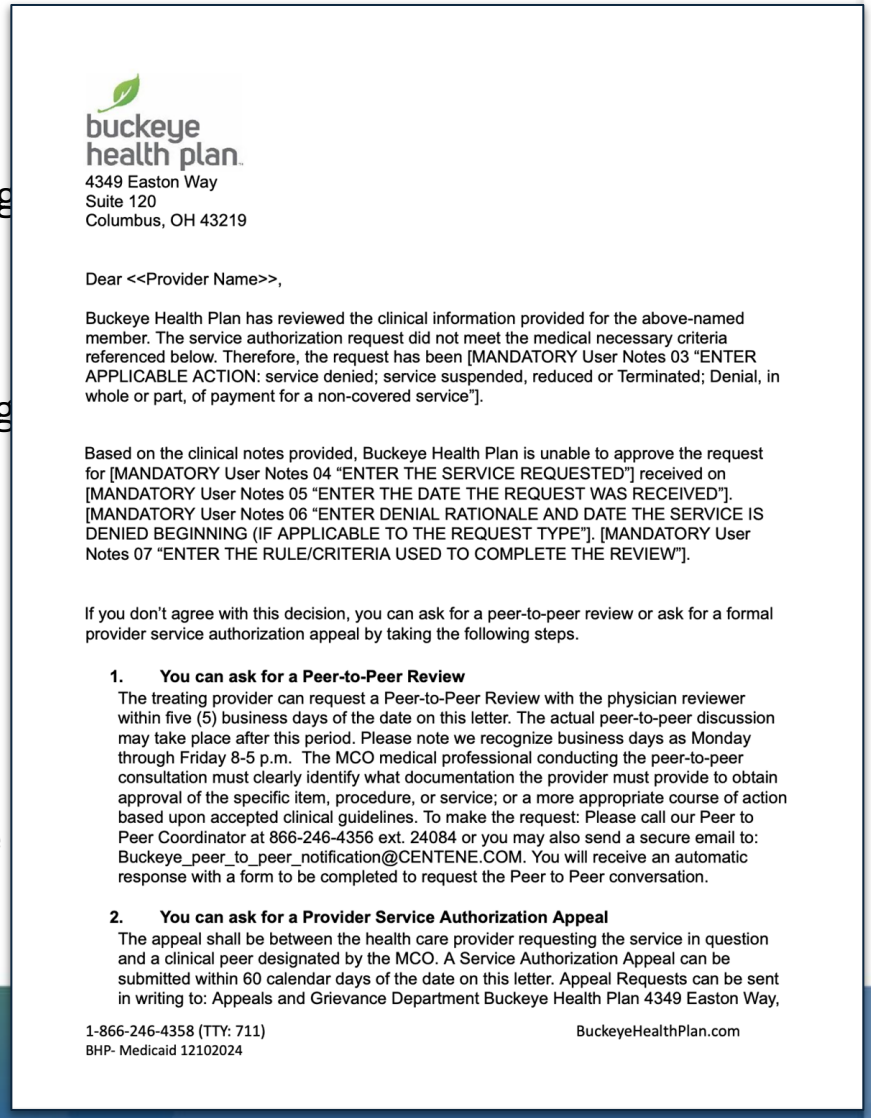
- **Requests will be reviewed using:**
  - Ohio Medicaid coverage rules (e.g., OAC 5160-27 series) **Medical Necessity Criteria (MNC)** for BH rehabilitative services
  - Treatment-plan alignment, progress indicators, and clinical justification



- **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

Steps for Denial 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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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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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.