POLICY AND PROCEDURE

POLICY NAME: Multiple Behavioral Health Services on Same Day Policy	**POLICY ID:** OH.UM.06
BUSINESS UNIT: Buckeye Health Plan	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 1/1/2026	**PRODUCT(S):** Medicaid, MyCare
REVIEWED/REVISED DATE: 10/2025	
REGULATOR MOST RECENT APPROVAL DATE(S): 10/24/2025	

POLICY STATEMENT:
To ensure appropriate utilization, prevent duplication of services, and maintain program integrity within the Ohio Medicaid behavioral health benefit, this policy establishes limits on billing multiple rehabilitative behavioral health services for the same member on the same date of service.

PURPOSE:
This policy applies to all contracted behavioral health providers and provider types delivering rehabilitative behavioral health services under the Ohio Medicaid Managed Care benefit, including but not limited to community mental health centers (provider type 84 and 95), and independent practitioners.

SCOPE:
This policy applies to all directors, officers, employees of Buckeye Health Plan, and external providers.

POLICY:

Background:

Behavioral Health Rehabilitative Services: Services that are structured, goal-directed interventions that support recovery, promote skill-building, and reduce the need for higher levels of care. They are typically non-physician, non-therapy services provided by qualified behavioral health practitioners under a treatment plan. They are designed to restore or enhance an individual's functioning and ability to live independently, including but not limited to Psychosocial Rehabilitation (PSR), and Therapeutic Behavioral Services (TBS).

Multiple/ Duplicative Services: Services that overlap in purpose, time, or clinical intent, and do not represent distinct, medically necessary interventions.

Types of Behavioral Health Rehabilitative Services:

Psychosocial Rehabilitation (PSR H2017) Services
- **Purpose:** Help individuals develop or restore social and daily living skills to improve community functioning.
- **Examples:**
  - Building coping, communication, or problem-solving skills
  - Improving self-care, money management, or medication adherence
  - Practicing social or vocational skills
- **Staff:** Qualified behavioral health specialists or paraprofessionals under supervision

Therapeutic Behavioral Services (TBS H2020 and H2019)
- **Purpose:** Provide individualized, intensive behavioral interventions to reduce symptoms and improve functioning, often for children and youth.
- **Examples:**
  - Skill development for managing anger or anxiety

    - Behavioral coaching in the home or community
    - Crisis prevention planning
- **Staff:** Qualified mental health specialists or case managers trained in behavioral interventions

Community Psychiatric Supportive Treatment (CPST H0036))

- **Purpose:** Assist individuals with achieving treatment goals and improving stability through ongoing community-based support.
- **Examples:**
    - Coordinating services and supports
    - Developing coping and daily living skills
    - Providing education on mental health or substance use management
- **Staff:** Qualified mental health specialists under supervision

Disallowance Of Multiple/ Duplicative Services:

Unit based (non-per diem) rehabilitative behavioral health services—including but not limited to Community Psychiatric Supportive Treatment (CPST H0036), Therapeutic Behavioral Services (TBS H2019), and Psychosocial Rehabilitation (PSR H2017) shall not be reimbursed when more than 16 units of any combination of services is rendered to the same member by the same or different provider organizations on the same date of service, unless specifically authorized under an approved treatment plan and clinically justified.

1. Clinical Exception:
   Multiple rehabilitative services may be allowed on the same date of service only when:
    - The services are distinct in purpose and function (e.g., CPST addressing symptom management and PSR addressing skill development);
    - The documentation clearly supports separate and non-overlapping service delivery, time, and intervention goals; and
    - The combined service duration does not exceed reasonable daily limits or clinical necessity as determined by the plan's utilization management criteria.
2. Documentation Requirements:
    - Each service must include separate progress notes reflecting distinct goals, activities, and outcomes.
    - Documentation must demonstrate coordination among providers to avoid redundancy.
3. Claims Processing:
    - Claims submitted for multiple rehabilitative services for the same member, same date of service, and same billing provider (or related providers under common ownership) will be subject to claim denial or post-payment review.

Overlapping Rehabilitative Services with Per Diem Services:

Buckeye shall limit reimbursement for behavioral health rehabilitative services to a maximum of four (4) units per member per date of service when such services are rendered on the same date as a per diem Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), or Therapeutic Behavioral Services (H2020). This limitation supports appropriate clinical integration and ensures that rehabilitative services do not overlap with the intensive treatment structure already included in the per diem IOP (H0015), PHP (H0015 TG), or TBS (H2020) rate.

Rehabilitative services are not separately reimbursable when Substance Use Disorder (SUD) Residential Treatment Center (RTC 2036, H2034) and Withdrawal Management Services (H0010-14) are billed on same day and will be denied.

Prior Authorization Process:

If a provider submits a claim for services that exceed the amounts referenced above without a prior authorization:

a. Buckeye will deny the claim; and
b. The provider must:
    i. Submit medical records in accordance with Buckeye's prior authorization process to demonstrate that additional services are medically necessary and appropriate based on the member's diagnosis; and
    ii. Submit documentation such as the member's plan of care and progress notes to demonstrate that the additional amount complies with plan of care and health record regulatory requirements.

2. A claim for rehabilitative services that exceed the limits above for a member must:
    a. Clearly indicate why additional services are medically necessary to enable the member to achieve the specific goals specified in the member's plan of care;
    b. Clearly indicate how the additional services will directly contribute to the member achieving the goals specified in the member's plan of care; and
3. If the provider does not submit medical records and documentation requested within 30 days of the request, the claim will remain denied.
4. If the provider submits medical records and documentation within 30 days of the request, and the medical records demonstrate that the additional services were medically necessary and appropriate based on the member's diagnosis and meets the regulatory requirements, Buckeye will adjust the claim for payment (provided that CMS, NCCI, and other standing coding guidelines are met).
5. If the provider submits medical records and documentation that do not demonstrate that additional services were medically necessary and appropriate based on the member's diagnosis or does not demonstrate that regulatory requirements were met, the claim will remain denied.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

REFERENCES:

Ohio Administrative Code (OAC) 5160-27-01: Definitions
OAC 5160-27-03: Coverage and Limitations for Behavioral Health Services
OAC 5160-27-04: Intensive Outpatient and Partial Hospitalization Services
OAC 5160-27-05: Rehabilitative Services
ODM Behavioral Health Coding and Reimbursement Manual
Managed Care Provider Agreement, Attachment F: Behavioral Health Services

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:

Ohio Department of Medicaid

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy	10/2025	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their

representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.