

POLICY AND PROCEDURE

POLICY NAME: Ohio Intensive Outpatient Program Policy	POLICY ID: OH.UM.09
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):	

POLICY STATEMENT:

The policy provides an overview of Buckeye's utilization management approach for Intensive Outpatient Treatment (IOP) Services for members with substance use disorders.

PURPOSE:

This policy addresses the claim payment, eligibility, documentation and other requirements related to IOP.

For the purpose of Medicaid reimbursement, substance use disorder treatment services shall be defined by and shall be provided according to the American society of addiction medicine also known as the ASAM treatment criteria for addictive, substance related and co-occurring conditions for admission, continued stay, discharge, or referral to each level of care (LOC).

Medicaid reimburses for IOP services provided under the ASAM Level of Care 2:

Intensive outpatient/partial hospitalization including LOC 2 withdrawal management (WM). LOC 2 services are capable of meeting the complex needs of people with addiction and co-occurring conditions. They can be rendered during the day, before or after work or school, in the evening, and/or on weekends.

SCOPE:

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

POLICY:

Background:

IOP is:

- An alternative to or transition from a higher level of care for a substance use disorder or co-occurring mental health and substance use disorders; and
- A multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy.
- IOP must be individualized and focus on stabilizing a member as well as focusing on transitioning the member to a lesser level of care.

Ohio Department of Medicaid (ODM) and Ohio Administrative Code regulations including 5160-27-09 establish what constitutes IOP, IOP provider staffing and related requirements, medical necessity criteria, plan of care requirements, and medical record documentation requirements among other requirements.

IOP and IOP providers must comply with the applicable ODM and OAC regulations.

Service Activities

Intensive Outpatient Program services (IOP) must:

- Be an evidence-based practice;
- Be identified in the member's plan of care;
- Be member centric and coordinated within the context of a comprehensive, individualized plan of care developed through a member-centered planning process; and

- d. Be designed to directly contribute to the Member's individualized goals as specified in the Member's plan of care
- e. IOP must be individualized to meet the member's needs and goals as specified in the member's plan of care
- f. Members must meet criteria in the latest edition of ASAM Criteria (American Society of Addiction Medicine) Adult Outpatient Services Level 2.1
- g. The amount of IOP services provided should decrease over time as a treatment goal is for the member to demonstrates self-management skills.

Prior Authorization:

IOP H0015 should not exceed 27 per diem units/ calendar year. Services delivered above these limits are subject to utilization review and require a prior authorization.

If a provider submits a claim for IOP that exceeds either amount referenced above:

- 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 IOP is 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 established in OAC 5160-27-09.
2. A claim for IOP that exceeds 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
 - c. Clearly indicate why IOP rather than other services are medically necessary to enable the member to achieve the specific goals specified in the member's plan of care.
 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.

Evidentiary Support and Prior Authorization Requirements

Buckeye recognizes that Intensive Outpatient Programs (IOP) are most effective when delivered over multiple consecutive weeks, and that sustained member engagement—typically ranging from six (6) to twelve (12) weeks or up to ninety (90) days—is associated with improved clinical outcomes and treatment retention.

Evidence Base:

Consistent with evidence-based guidelines and published clinical literature, the Plan acknowledges that actual treatment duration varies by member need and program intensity, with many members achieving clinical goals within four (4) to eight (8) weeks of participation.

Utilization Management Approach:

To ensure appropriate balance between evidence-based care delivery and utilization oversight, Buckeye requires

prior authorization (PA) continuation review after the initial eighteen (27) IOP sessions (equivalent to approximately six [6] weeks of treatment at a frequency of three [3] sessions per week).

At the time of review, the treating provider must submit a brief clinical reassessment documenting:

1. Continued medical necessity based on current symptomatology and functional status;
2. Member progress toward established treatment goals; and
3. Transition or step-down planning, as clinically indicated.

Members who continue to meet IOP medical necessity criteria following reassessment will be authorized for an additional twelve (12) sessions without further administrative burden.

Rationale:

This approach supports member access to evidence-based, multi-week intensive treatment while promoting timely review of ongoing high-intensity services to ensure continued clinical appropriateness and efficient use of resources.

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 5160-27-09

Ohio Medicaid Behavioral Health Manual

Advisory: Clinical Issues in Intensive Outpatient Treatment for Substance Use Disorders (based on TIP 47).
Publication ID: PEP20-02-01-021. Publication date: April 2021.

Costa, M., Plant, R. W., Feyerharm, R., Ringer, L., Florence, A. C., & Davidson, L. (2020). Intensive Outpatient Treatment (IOP) of Behavioral Health (BH) Problems: Engagement Factors Predicting Subsequent Service Utilization. *The Psychiatric quarterly*, 91(2), 533–545. <https://doi.org/10.1007/s11126-019-09681-w>

McCarty, D., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Substance abuse intensive outpatient programs: assessing the evidence. *Psychiatric services (Washington, D.C.)*, 65(6), 718–726. <https://doi.org/10.1176/appi.ps.201300249>

NCBI, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (Chapter 3, Treatment Continuum)

Substance Abuse Intensive Outpatient Programs: Assessing the Evidence – McCarty D. et al., *Psychiatric Services*, 2014

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:

Ohio Department of Medicaid

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy		

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.