



**Ohio Department
of Medicaid**

Access, Inclusion, and Reasonable Accommodation

Use the following notice moving forward for all ODM sponsored events open to the public:

“Ohio Department of Medicaid is committed to providing access, inclusion, and reasonable accommodation in its services, activities, programs, and employment opportunities in accordance with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act, and other applicable laws. To request an interpreter, written information in a language other than English or in other formats (large print, audio, accessible electronic formats, other formats), or a reasonable accommodation due to a disability, please contact ODM’s Civil Rights/ADA Coordinator at 614-995-9981/TTY 711, fax 1-614-644-1434, or ODM_EEO_EmployeeRelations@medicaid.ohio.gov. Requests should be made at least three business days prior to the scheduled event.

If you believe ODM has failed to provide these services or discriminated in another way, you can file a grievance with ODM’s civil rights coordinator and/or file a civil rights complaint with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights. Further information on these processes and ODM’s compliance with civil rights and other applicable laws can be found in their Notice of Nondiscrimination.”

Additionally, please instruct the audience about how to use the Microsoft Teams closes captioning function for ODM sponsored virtual public meetings. For GoToWebinar, please contact [Information and Technology Services \(ITS\)](#) before scheduling the event. When in doubt, email ODM_EEO_EmployeeRelations@medicaid.ohio.gov with your questions or concerns.

Behavioral Health Stakeholder Office Hours

9/10/2026



Agenda

- AmeriHealth
- Anthem
- Molina

Behavioral Health Service Thresholds for Utilization Management

Introduction



Effective Date for AmeriHealth Caritas Ohio

October 1, 2026

- Service counts begin July 1, 2026



Member-Level Service Utilization Tracking

- Provider Claims Services (PCS) staff are trained to provide service utilization information for impacted BH services.
- Provider Portal



Authorization Form Submission

- AmeriHealth Caritas Ohio aligns with ODM's service authorization forms for Substance Use Disorder (SUD) and Community Behavioral Health Center (CBHC).



Appeal Process

- Providers may file an appeal within 60 days of denial receipt using the Provider Appeal Form.
- Standard appeals resolved within 15 days, expedited within 72 hours.

Behavioral Health UM Service Thresholds

New BH Services Subject to Utilization Management

Therapeutic Behavioral Service (TBS)

- H2019
 - After 200 units (50 hours) combined TBS or PSR per calendar year
- H0019 HQ (Group)
 - After 120 units (30 hours) per calendar year
- H2020 (per diem)
 - After 30 units per calendar year

Psychosocial Rehabilitation (PSR)

- H2017
 - After 200 units (50 hours) combined TBS or PSR per calendar year

Withdrawal Management Services

- SUD Ambulatory Withdrawal Management
 - H0012, H0014 – after 7th consecutive day
- SUD Residential Clinically Managed
 - H0010 – after 7th consecutive day
- SUD Residential Medically Managed
 - H0011 – after 7th consecutive day

SUD Intensive Outpatient Program

- H0015
 - After 30 units per calendar year

Community Psychiatric Supportive Treatment (CPST)

- H0036
 - After 200 units (50 hours) per calendar year
- H0036 HQ (Group)
 - After 120 units (30 hours) per calendar year



Authorization Process



Service Authorization Forms

The service authorization forms for Substance Use Disorder (SUD) and Community Behavioral Health Centers (CBHC) available on ODM's website are accepted as a valid authorization request.

Providers must follow OAC 5160-1-31 regarding submission requirements for authorization forms.



Submission Options

Providers may submit prior authorization requests:

- via fax 1-833-329-6411,
- secure provider portal via Navinet,
- or by phone 1-833-735-7700 from 8am-5pm EST Monday to Friday and 1-833-764-7700 after hours, weekends, and holidays.



ACOH Responsibilities

ACOH must ensure accurate system configuration to enforce the limits before implementing authorization for a service.

Retroactive recoupments are prohibited if a service was paid in error due to the plan not having properly configured its system to enforce the limit.

All information for approval, denial and appeals processes can be viewed in the AmeriHealth Caritas Provider manual and on the AmeriHealth Provider Website: <https://www.amerihealthcaritasoh.com/provider>.

Behavioral Health UM Service Thresholds

Clinical Information to Submit with a Prior Authorization Request



Clinical Status of the Member

- Diagnosis
- Symptoms that support the diagnosis
- Degree of impairment that results from the symptoms
- Existence of risk issues
- Environmental Stressors
- Medical co-morbidities



Appropriateness of Treatment

- Length of treatment
- Frequency of sessions
- Individualized treatment plan with measurable goals
- Rationale for service intensity
- Evidence of progress or need for continued intensive intervention



Preferred PA Submission Timelines

- Expedited: Submit approximately 2 business days before reaching service threshold or before current authorization is exhausted.
- Standard: Submit approximately 7 business days before reaching service threshold or before current authorization is exhausted.



Medical Necessity

AmeriHealth Caritas Ohio uses the following medical necessity criteria as guidelines:

- Ohio Medicaid Provider Agreement for MCO
- Ohio Administrative Code (OAC) & Rules
- Change Healthcare InterQual Level of Care Criterion
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria

When applying these criteria, staff also consider the individual member factors.

NOTE

Authorization is required **ONLY** after the clinical threshold is reached.

Behavioral Health UM Service Thresholds

Member-Level Service Utilization Tracking



Provider Claims Services (PCS)

- 1-833-644-6001
- Monday – Friday, 7:00am – 8:00pm
- Follow the prompts for claim inquiries



PCS Staff Expertise

The PCS routinely receives calls requiring look back on certain procedure codes today (H2034, H2036, PT/OT/ST, etc.) PCS staffing needs are determined through intensive forecasting and skilling measures.



Provider Portal

AmeriHealth has upgraded the functionality on our portal to accommodate member-level service utilization tracking. Will be active by Monday, September 21, 2026.



Disclaimer

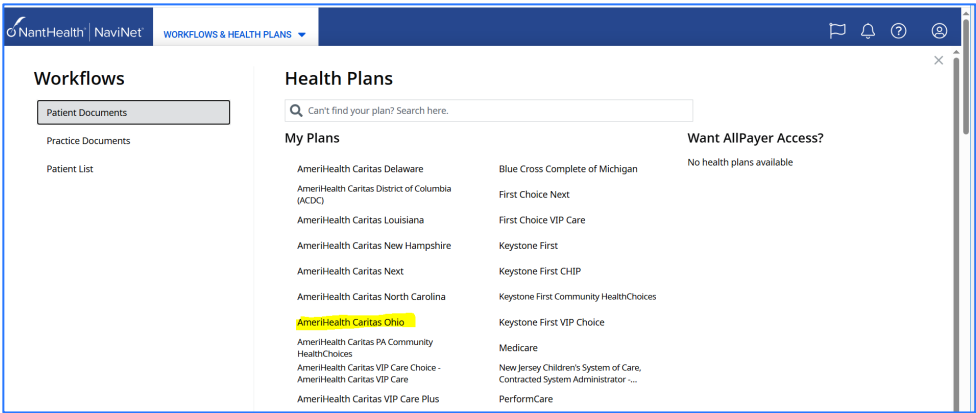
Claim information provided is based on claims received to date and may not reflect accurate real-time utilization.

NOTE

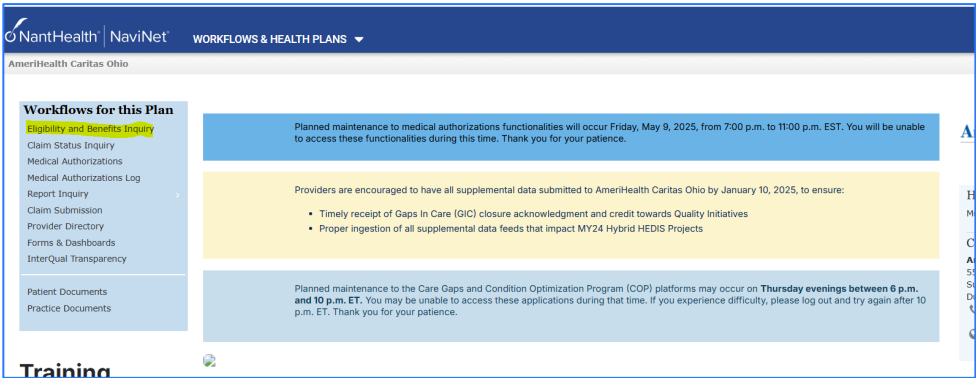
Providers are responsible for keeping track of service delivery for each recipient to ensure services rendered do not exceed the authorized threshold. If the recipient is simultaneously receiving the same service from more than one provider, the providers will need to coordinate care to prevent service duplication and reduce risk of prematurely exhausting authorized hours. It is recommended that providers routinely check in with their clients to inquire whether they are also receiving community behavioral health services elsewhere.

Member-Level Service Utilization Tracking - NaviNet

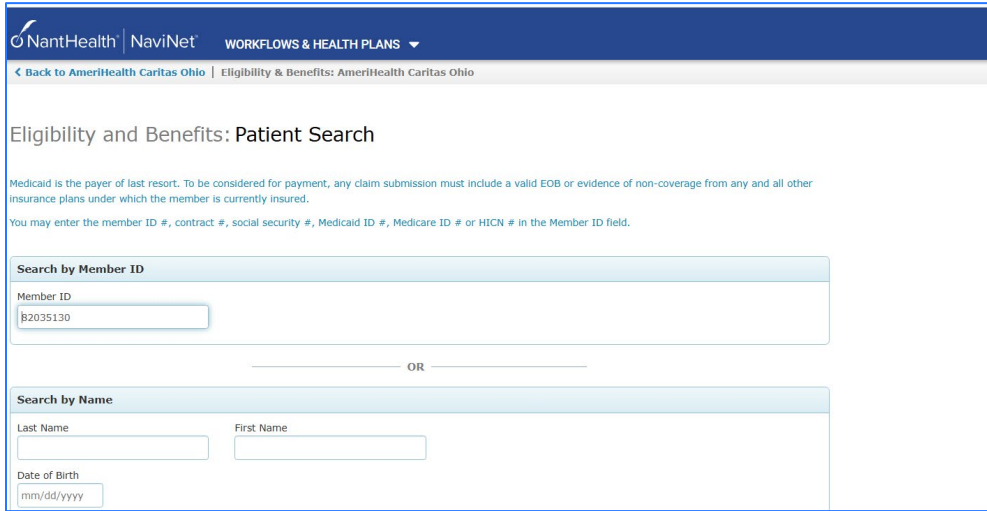
- 1. Log in to NaviNet
- 2. Choose Health Plan (AmeriHealth Caritas Ohio)



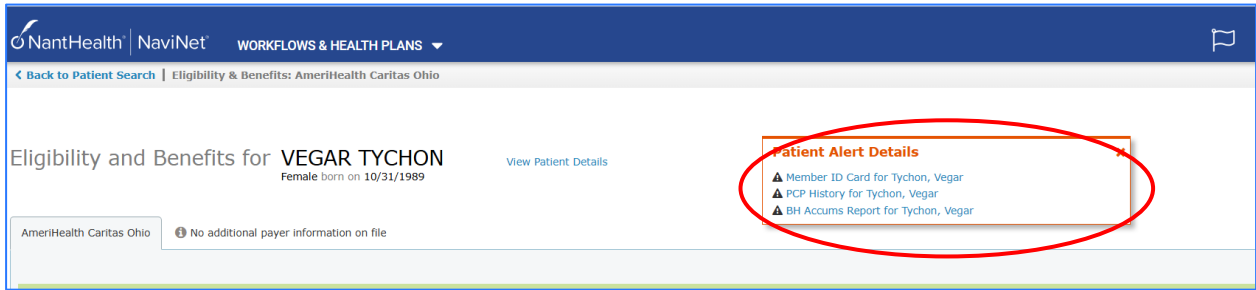
- 3. Click “Eligibility and Benefits Inquiry”



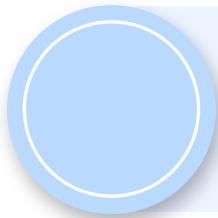
- 4. Search for Member



- 5. BH Accumulator report will be present in Patient Alert Details



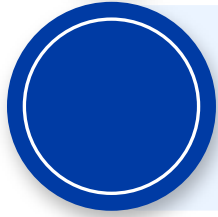
Appeals Process for Authorization Denials



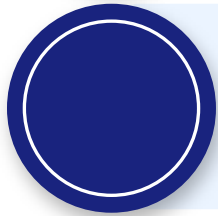
- Before issuing a denial, AmeriHealth Caritas Ohio (ACOH) makes reasonable efforts to contact the requesting provider to clarify missing information, discuss medical necessity, and try to reach agreement on an appropriate plan of care.
- When an authorization is denied or limited, the provider is informed of the opportunity for a peer-to-peer discussion with the designee involved in the determination.



ACOH issues a written Notice of Action / Adverse Benefit Determination explaining the reason for the denial, the right to request peer-to-peer review, and the available appeal rights. For denied or limited authorization requests, notice is issued simultaneously with the review decision.



A member, a member's authorized representative, or a provider may file an appeal within 60 calendar days of the notice of adverse benefit determination. Standard appeals are resolved as quickly as the member's condition requires, but no later than 15 calendar days after receipt. Expedited appeals are resolved within 72 hours of receipt.



- If an appeal is overturned, ACOH provides authorization for the service within 72 hours. ACOH may extend the appeal timeframe by up to 14 calendar days when additional information is needed or when requested by the member.
- For medical necessity denials, the appeal must be reviewed by a same-or-similar specialist, and the appeal decision must be made by a Medical Director not involved in the original denial and not subordinate to that reviewer.

Continuous Improvement



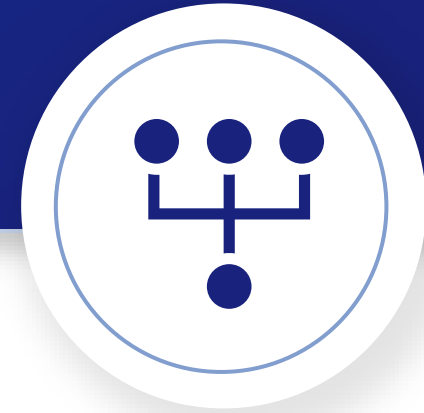
Continuity of Service Delivery

- Maintain continuity of care during UM implementation.
- Honor existing authorizations, as applicable to reduce disruption.
- Provide clear provider communication and support during transition.



Compliance

- Conduct compliance oversight monitoring.
- Provide provider education to support accurate billing and policy adherence.
- Implement corrective action and escalation processes when issues are identified.



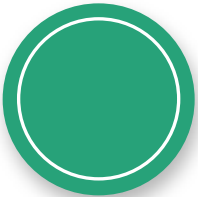
Program Integrity

- Conduct Program Integrity monitoring.
- Use audits and claim review processes to identify potential fraud, waste and abuse.
- Review billing patterns and documentation for outliers or concerns.

ODM Guidance for MCOs Beginning October 1st

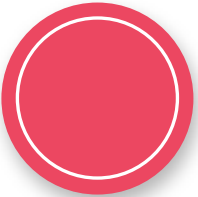
General ODM Guidance

Plans will need to ensure that providers have the ability to verify utilization and submit prior authorization requests at least 7 days prior to 10/1/2026.



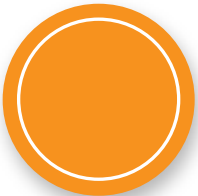
What specific date will utilization management (UM) verification be available for providers?

AmeriHealth has upgraded the functionality on our provider portal (NaviNet) to accommodate member-level service utilization tracking. Functionality should be active by Monday, September 21, 2026. Providers can also call our Provider Claims Services for utilization lookup at 1-833-644-6001.



What specific date will plan be prepared to accept PA requests?

Providers can submit prior authorization requests for these services beginning September 24, 2026.



How will providers be protected and guaranteed payment for services rendered in good faith beginning October 1

AmeriHealth Caritas Ohio must ensure accurate system configuration to enforce the limits before implementing authorization for any service. Retroactive recoupments are prohibited if a service was paid in error because we did not properly configure our system to enforce the limit.

Improving Behavioral Health Outcomes

Together

Behavioral Health Prior Authorization Changes



Provider Education
Phase I SUD:
October 1, 2026

Lottie Conner, MSW, LISW-S | BH Director



Purpose

- ❑ Educate BH providers on Anthem's phased behavioral health prior authorization (PA) requirements for Ohio Medicaid and Anthem MyCare Ohio members
- ❑ Review Phase I (SUD) thresholds, exclusions, and submission requirements
- ❑ Review commonly asked FAQs including topics such as claims/threshold limit verification process

Anthem's Implementation: Phased Approach

Phase I: Substance Use Disorder Services (SUD)

- Go-live is October 1, 2026

Phase II: Mental Health (MH)

- Go-live is January 1, 2027

Phase I SUD Changes: Effective October 1, 2026

Service Description	Service Codes	ASAM Levels of Care	Prior Auth Rules	Turnaround Time (TAT)
*SUD Acute Detoxification/Withdrawal Management	H0010 H0011 H0012	3.2 3.7 2	PA required after 7 calendar days per episode of care, cumulative across all listed codes	48 hours
SUD Acute Detoxification/Withdrawal Management	H0014 (1 hour) H0014 AT (2-3 hrs)	2	No change – H0012 and H0014 are not allowable on the same date of service. Greater than 3 hours, should be managed under H0012 Per Diem	N/A
SUD IOP	H0015 G0137 0906	2	PA required after 30 days used per member, per calendar year	Standard
SUD PHP	H0015 TG	2.5	No PA change - PA on day 1	Standard
*SUD Residential Treatment	H2034 and H2036 (with applicable modifiers)	3.1 3.3 3.5 3.7	No change: Up to 30 consecutive days without PA for the first two admissions. PA is required on day 31 for the first two admissions and on day 1 for the third or later admission in the same calendar year.	48 hours

*For consecutive step-up or step-down between acute detoxification or residential levels of care within the same provider agency, count the services as one event. A service gap greater than 24 hours starts a new admission.

Operational Details

- ☐ KX crisis modifier services do not count toward thresholds and are excluded from PA requirements
- ☐ Medical necessity Criteria : ASAM 3rd Edition and CMS criteria when Medicare is primary
- ☐ Providers are encouraged to submit requests for continued stay at least **48 hours in advance** of the existing prior authorization expiring **for expedited requests** and at least **7 calendar days in advance for standard requests**
- ☐ Failure to obtain the required PA may impact claim reimbursement
- ☐ Anthem will host Office Hours leading up to our implementation of the SUD changes in September and one in October – Click [HERE](#) to register

Phase I Utilization Verification Process

- ❑ Anthem will have a dedicated point of contact for providers to inquire on the status of a member's utilization and whether a PA is required (**Note: Threshold count begins from 7/1 through end of year*)
- ❑ **Future State:** We are working on implementing an automated self-service provider portal for providers to check the status on their own (Implementation is TBD)
- ❑ **Current State:**
 - ❑ Provider inquiries / turnaround time - Medical Management Specialists **will respond within 1 business day** to inquiries sent to the BH shared mailbox, which is monitored Monday–Friday, 8:00 a.m.–5:00 p.m.
 - ❑ Email: ohbhcasemanagement@anthem.com
 - ❑ For SUD-related threshold inquiries, Anthem will provide only the current utilization count available in Anthem's system at the time of the request. No additional detail will be shared due to 42 CFR Part 2 restrictions
- ❑ Utilization verification is based only on **claims received** by Anthem to date and will not reflect real-time utilization for services not yet billed to the MCO. Under OAC 5160-1-19, providers have 365 days to timely file a claim. Providers are encouraged to submit claims as soon as possible to support accurate threshold counts.

SUD PA Submission: Provider Documentation

REAUTHORIZATION / CONTINUED STAY

1 Core documents — include with every PA request

1 Diagnostic assessment
Most recent; completed within the last 12 months

2 Current treatment plan
Most recent version

3 Progress notes
Outpatient: last 30 days
Higher intensity: last 2 weeks

4 Additional clinical information
As applicable: tests, laboratory results and other pertinent findings

! Incomplete submissions may delay the PA review.
Confirm that every document is current, complete and included.

2 SUD-specific requirement

UPDATED ASAM ASSESSMENT

Dimensions 1–6 • Required at every SUD reauthorization/continued stay request that is dated within:

7 days • Residential / Inpatient / Detox

14 days • PHP / IOP

30 days • Outpatient

OR

Within 24–72 hours of a significant clinical change affecting medical necessity or level of care

SUD Medical Necessity Criteria & Considerations

- ☐ ASAM Third Edition is the required criteria to be used, and Ohio Administrative Code (OAC) Substance Use Disorder Treatment Services - <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-09>
- ☐ For the withdrawal management codes (H0010, H0011, H0012, H0014) – Use the ASAM, Withdrawal Management Criteria to evaluate medical necessity
- ☐ Prior to submission of PA forms for requested services, ensure that the number of days/units requested align to the requested start and end dates
- ☐ Ensure that the number of days/units requested also aligns to the requested service (i.e. Provider requesting PHP, but the number of days/hours requested are less than 20 hours per week)

Which SUD Service Should Be Requested?



A practical match-up guide: assess medical necessity first, then confirm the service intensity being delivered.

COMMUNITYBASED / NONRESIDENTIAL

1.0 Outpatient SUD services —H0005

Lower LOC

Use when structured service intensity is below IOP: <9 hrs/week adults or <6 hrs/week youth. Do not request IOP/PHP if the documented program hours do not meet the threshold.

2.1 IOP— H0015 / G0137/0906

IOP

Use for 9–19.9 hrs/week for adults or 6–19.9 hrs/week for youth. Anthem PA threshold: after 30 days used per calendar year.

2.5 PHP— H0015 TG

PHP

Use for ≥20 hrs/week in a structured 24-hour setting. Ohio Medicaid PHP requires at least 20 hours/week; PA remains day 1/unchanged.

2-WM Level 2 withdrawal mgmt. — H0012

WM

Use when ASAM assessment supports non-residential withdrawal management. Anthem PA threshold: after 7 days per episode, cumulative with H0010/H0011/H0012.

WITHDRAWAL MANAGEMENT / RESIDENTIAL

3.1 Low-intensity residential — H2034/H2036

Residential

24-hour living support plus ≥5 hrs/week of low-intensity treatment.

3.2 Clinically managed WM — H0010

Detox

24-hour residential withdrawal-management setting when medical complications are not expected to require continuous medical/nursing care.

3.3/3.5 Residential high -intensity — H2034/H2036

Residential

24-hour setting; 3.3 is population-specific/cognitive; 3.5 is high-intensity residential for members who cannot be safely/effectively treated at a lower level. Daily clinical services

3.7 Medically monitored inpatient/WM — H0011

Inpatient/WM

24-hour medically monitored care due to severe/significant withdrawal symptoms requiring medical/nursing monitored care. Daily clinical services

If the member is not receiving the required hours, the request should be for a lower -intensity service. If the member needs more monitoring than the current setting can deliver, a step up in the ASAM LOC should be considered.

Frequently Asked Questions

Q: When can providers submit utilization verification requests?

A: Providers can submit a request at any time to our shared mailbox, however, should consider sending the request 7–10 days in advance of the 10/1/2026 go-live to receive the most up-to-date claims information. *Utilization verification is based only on claims received by Anthem to date and will not reflect real-time utilization for services not yet billed

Q: When can providers begin submitting PA requests?

A: Providers can submit a prior auth request at any time, however, should only send them if the threshold is met or soon to be met. Anthem requests that providers consider sending the request 7 days in advance for standard requests and 48 hours in advance for expedited/urgent requests (see slide 4)

Q: What happens if the required prior authorization is not obtained or was not required at the time we verified utilization counts?

A: The claim may not be eligible for reimbursement. However, may be resubmitted for retrospective review via our Claims Payment Dispute process, outline in the Provider Manual on our website [HERE](#)

Frequently Asked Questions

Q: How can providers ensure reimbursement for services rendered prior to October 1st and those services rendered after October 1st?

A: Providers are encouraged to submit their claims for dates of services through 9/30/2026. All claims will be reimbursed accordingly through this date. If the provider anticipates continued service delivery beyond 10/1 and the threshold has been met/soon to be met, a prior authorization request should be submitted in advance of 10/1 to ensure continuity of care.

☐ Expedited requests = at least 48 hours in advance

☐ Standard requests = at least 7 calendar days in advance

Q: Can a provider request a peer-to-peer discussion if disagrees with the outcome?

A: Yes. The treating provider may request a discussion within seven calendar days of the decision by calling 844-441-1506

Q: How long do providers have to submit an appeal?

A: Provider service authorization appeals must be submitted within 60 calendar days of the adverse decision

Provider Readiness Checklist

- ☐ **Verify** the member's plan and whether an exclusion applies
- ☐ **Check** member-level utilization before the threshold is reached
- ☐ **Submit claims promptly** so threshold counts are as accurate as possible
- ☐ **Prepare** current diagnostic, treatment-plan, progress-note, and supporting clinical documentation
- ☐ **Submit standard requests** at least 7 days in advance and expedited requests at least 48 hours in advance
- ☐ **Use Availity Essentials** whenever possible and track both approved units and authorization dates

What happens if I disagree with a decision?

DISAGREEING WITH AN AUTHORIZATION DECISION

Ohio Medicaid Managed Care

1 PEER-TO-PEER REVIEW

First step – Quick discussion with a physician reviewer



2 PROVIDER SERVICE AUTHORIZATION APPEAL

If the decision is still upheld, file an appeal



3 EXTERNAL MEDICAL REVIEW (EMR)

If the appeal is upheld, request an external review

1 PEER-TO-PEER REVIEW



Q: Can a provider request a peer-to-peer review?
A: Yes. The treating provider may request a peer-to-peer discussion with a physician reviewer within 7 calendar days of the decision.



Q: What number should providers call for a peer-to-peer review?
A: 844-441-1506



Q: What are the hours for peer-to-peer review requests?
A: Monday through Friday, 8 a.m.–5 p.m. ET.



Q: How quickly will the peer-to-peer discussion be scheduled?
A: A discussion will be scheduled within 24 hours of the request at a mutually agreed upon time.



Q: What occurs during the peer-to-peer review?
A: The MCO medical professional may:

- Clarify required documentation needed for approval
- Recommend an alternative course of action based on clinical guidelines



Q: How long do providers have to submit an appeal?
A: Appeals must be submitted within **60 calendar days** of the decision.



Q: Who may file an appeal?
A: Appeals may be filed by:

- The provider
- The member
- An attorney
- An authorized representative with member consent



Q: How can appeals be submitted?
A: Appeals may be submitted:

- Online through Availity Essentials
- By fax: 866-587-3316
- By email: ohioga@anthem.com



Q: What are the appeal processing timelines?
A: Anthem will:

- Acknowledge the appeal within 3 business days
- Issue a decision within:
 - **10 calendar days** for standard appeals
 - **48 hours** for urgent appeals



Q: What is an External Medical Review (EMR)?
A: An EMR is an independent review process available when providers disagree with a denial based on medical necessity.



Q: Who conducts the External Medical Review?
A: Permedion.



Q: Is there a cost for the EMR process?
A: No. The review is provided at no cost.



Q: When can providers request an EMR?
A: Providers may request an EMR after completing the appeal and/or peer-to-peer process.



Q: How long do providers have to request an EMR?
A: Requests must be submitted within **30 calendar days** of the upheld appeal decision.



Q: Does EMR apply to all denials?
A: No. EMR only applies to denials related to medical necessity.



Q: What documentation is needed for an EMR request?
A: Providers should submit:

- The completed Ohio Medicaid MCE External Review Request form
- All adverse decision letters
- Supporting medical records or additional documentation



Q: Where can providers find the EMR request form?
A: Providers can access the form through the Gainwell Technologies website under the Ohio Medicaid section.



IMPORTANT NOTES

- Follow the steps in order: Peer-to-Peer Review → Appeal → External Medical Review (EMR)
- Keep copies of all documentation and correspondence
- Submit requests within the required timeframes
- Contact Anthem if you have questions about the process



Questions?

Contact Anthem Provider Services or visit Availity Essentials for more information.

Quick Reference Contact Information

Topic	Contact Information
Utilization Verification	ohbhcasemanagement@anthem.com
Peer-to-Peer Review	844-441-1506
Expedited/Urgent PA Fax	866-577-2184
Standard PA Fax	866-577-2183
Appeal Fax	866-587-3316
Appeal Email	ohioga@anthem.com
Availability Essentials	Availability Portal Login
Anthem MyCare Provider Call Center	833-727-2170
Anthem Medicaid Provider Call Center	844-912-1226
Anthem Provider Services Email	Ohiomedicaidprovider@anthem.com

Questions?



Office Hours Utilization Management Presentation

Community Behavioral Health and SUD Services

09/10/2026

Community Behavioral Health Service

New Prior Authorization Effective 7/1/26



New Services Subject to Utilization Management

Service Name	Service Code	Service Threshold at which authorization is required	Effective Date
Therapeutic Behavioral Service - Individual	H2019	200 units (50hrs) combined TBS or PSR per calendar year	7/1/26
Therapeutic Behavioral Service - Group	H2019 HQ	120 units (30hrs) per calendar year	7/1/26
Therapeutic Behavioral Service Day Treatment – per diem	H2020	After 30 units per calendar year	7/1/26
Community Psychiatric Support Treatment – Individual	H0036	200 units (50hrs) per calendar year	7/1/26
Community Psychiatric Support Treatment – Group	H0036 HQ	120 units (30hrs) per calendar year	7/1/26
Psychosocial Rehabilitation Service	H2017	200 units (50hrs) combined TBS or PSR per calendar year	7/1/26

Exclusions:

Crisis Services as indicated by the KX modifier

BH Nursing rendered in accordance with OAC Rule 5160-27-11

Children and youth enrolled with OhioRise

Children and youth in custody of a Public Child Welfare Agency

Substance Use Disorder

New Prior Authorization Effective 10/1/26

SUD Services – **New Prior Authorization Requirements**

Service Name	Service Code	Service Threshold at which authorization is required	Effective Date
SUD Ambulatory Withdrawal Management	H0012 H0014	After 7 th consecutive day of H0012 per diem or H0014/H0014AT hourly based claims	10/01/2026
SUD Intensive Outpatient Program	H0015	After 30 units per calendar year	10/01/2026
SUD Residential Clinically Managed -WM	H0010	After 7 th consecutive day	10/01/2026
SUD Residential Medically Managed -WM	H0011	After 7 th consecutive day	10/01/2026

SUD Services – **Current (no change)**

Service Name	Service Code	Service Threshold at which authorization is required	
SUD Residential Treatment (level 3.1)	H2034	After 30 days and/or 3 or more stays per calendar year	Current PA (No Change)
SUD Residential Treatment (level 3.3)	H2036 HI	After 30 days and/or 3 or more stays per calendar year	Current PA (No Change)
SUD Residential Treatment (level 3.5)	H2036	After 30 days and/or 3 or more stays per calendar year	Current PA (No Change)
SUD Residential Treatment (level 3.7)	H2036 TG	After 30 days and/or 3 or more stays per calendar year	Current PA (No Change)

To ensure continuity of care, providers may begin requesting threshold information on 9/20/26. Providers may submit PA requests on 9/20/26 for dates of service on or after 10/1/26.

Prior Authorization Request

Need a Prior Authorization?

[Code LookUp Tool](#)

Health Care Professionals

Medicaid

Medicare

MyCare Ohio

Marketplace

Provider Portal

[Prior Auth LookUp Tool](#)

- ☐ Submit a prior authorization per Molina's standard process via the Availity portal.

Utilize the [PA Lookup Tool](#) on our [Provider Website](#) and [Provider Portal](#) to determine if a PA is required.

- ☐ Include medical records demonstrating the medical necessity for additional services.

Recommended documentation:

- ✓ Member's care plan
- ✓ Including measurable goals
- ✓ Progress notes clearly demonstrate how the additional services will directly contribute to the member achieving specific goals in the care plan.
- ✓ Documentation indicating why the requested service, rather than other less intensive services, will enable the member to reach specific goals.
- ✓ The need for exceeding service limits to achieve specific goals, and service activities as outlined in OAC Rules.



- ☐ ODM's standard service authorization forms will be accepted, but not mandated.
- ☐ Molina will authorize the following services for a duration of 90 days when the service is approved and is valid until the service limit is exhausted or the authorized period expires.
 - H2019 TBS Individual and Group
 - H2017 PSR
 - H0036 CPST Individual and Group

TBS Day Treatment Per Diem and all SUD services will require more frequent submissions with more individually tailored unit/day requests to ensure approved services accurately capture current clinical presentation. The 90 day authorization period does not apply to these services.



Timeframe for Initial and Continuing Auth Requests

OAC Rule 5160-26-3.1

Standard Request:

- ☐ Seven **(7) calendar days** from the receipt of a request

Expedited Request:

- ☐ Appropriate when following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function
- ☐ **48 hours** from the receipt of a request

OAC Rule 5160-26-8.4

d) For untimely prior authorization, appeal, or grievance resolution, the MCO or SPBM shall give notice simultaneously with the MCO or SPBM becoming aware of the untimely resolution. Service authorization decisions not reached within the time frames specified in rule [5160-26-03.1](#) of the Administrative Code constitutes a denial and is thus considered to be an adverse benefit determination. Notice shall be given on the date the authorization decision time frame expires.

Continuation of Service Requests should be received prior to the delivery of the service.

Expedited: must be received at least 48 hours prior

Standard: must be received at least 7 days prior

- Thresholds were designed to allow a “pass-through” of services needed immediately
- All requests should be sent prior to delivery of the service



Thresholds

Thresholds are calculated using Paid Claims data for the CPT Code requested
The information available is only as accurate as paid claims on file.



Molina is working with our Availity partners to build a provider facing tool to provide threshold data. Timing Tbd.

IMPORTANT:

CBHC providers are responsible for keeping track of service delivery for each recipient to ensure services rendered do not exceed the authorized threshold.

- ✓ If the recipient is simultaneously receiving the same service from more than one provider, the providers will need to coordinate care to prevent service duplication and reduce risk of prematurely exhausting authorized hours.
- ✓ It is recommended that providers routinely check in with their clients to inquire whether they are also receiving community behavioral health services elsewhere.

Recommendations

- ✓ Submit billing with one date per service line to improve accuracy for current utilization information.
- ✓ Submit claims timely.

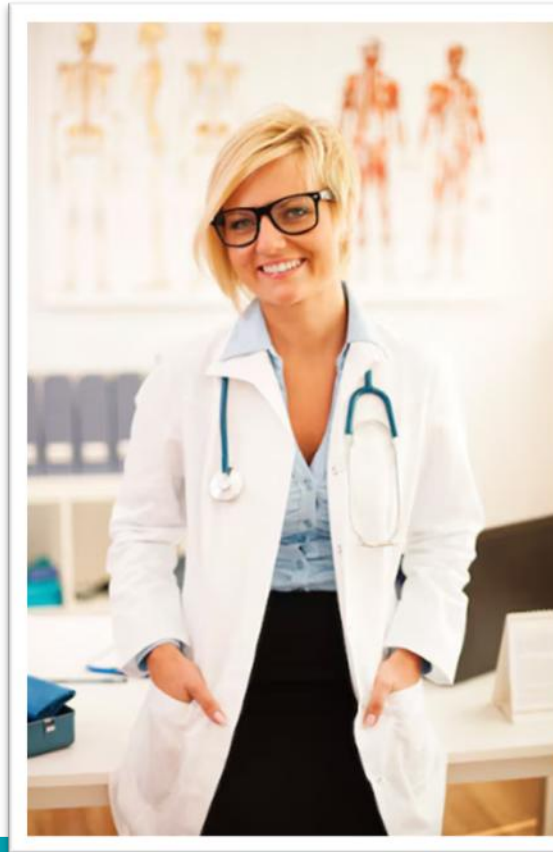
Contact Molina

** Molina will provide utilization information based on claims received to date and may not reflect accurate real-time utilization.

Providers may contact Molina to obtain benefit utilization data.**

Utilization Management (855) 322-4079

Which Service are you calling about? Say Line of Business
How may I help you today? Say “Benefit Verification”



Continuity of Care

COC is accomplished through coordinated, connected service delivery across providers and health plans.

Did you know:

- Ohio Medicaid and MyCare Members are allowed to change health plans
- When health plans are notified of a member's change in enrollment both the exiting and receiving health plan have the responsibility to share pertinent information.
 - Ensuring the member remains connected regardless of network status for a transition period
 - Their individual needs are met
 - Addressing potential unnecessary layering of services (integrated not duplicative)
 - Oversight/ Monitoring of Overutilization

Instructions

External Medical Review

Provider Appeal

Peer to Peer

Member Appeal

Appeal Rights

External Medical Review

Provider Appeal

Peer to Peer

- **Member may request or**
- **Member Appeal request with Authorized Representation**
- **Within 60 days after date on denial letter**

Member Appeal

External Medical Review

Provider Appeal

- Provider may request
- Within 5 days of denial

Peer to Peer

Member Appeal

External Medical Review

- Provider may request
- Within 60 days after date on denial letter
- Does not interfere with P2P

Provider Appeal

Peer to Peer

Member Appeal

- Provider may request
- Within 30 days from date on Provider Appeal Upheld

External Medical Review

Provider Appeal

Peer to Peer

Member Appeal

Denial Letters include how members and providers can initiate their appeal rights.

Also located in the member handbook and provider manual.

External Medical Review

Provider Appeal

Peer to Peer

Member Appeal

Compliance and Program Integrity Audits

Molina monitors, audits, and investigates to safeguard program integrity.

- **Ongoing Monitoring**
- **Formal Audits**
- **Utilization Pattern Surveillance**
- **Identification of Fraud Indicators**
- **Risk-Based Auditing**

Key Resources

Ohio Administrative Code 5160-27: Mental health therapeutic behavioral services and psychosocial rehabilitation

Ohio Administrative Code 5122-29-18: Therapeutic behavioral services and psychosocial rehabilitation

Ohio Administrative Code 5160-1-31: Prior authorization

Ohio Medicaid Behavioral Health Manual Version 1.28.1 eff 03/24/2026

Provider Manual: [2026 Medicaid Ohio Provider Manual: March 2026](#)
[2026 MyCare Ohio Provider Manual: March 2026](#)

Code LookUp Tool: <https://www.molinahealthcare.com/members/oh/en-us/health-care-professionals/home.aspx>

Molina's Reimbursement Policies:

[CBHS - Effective 7/1/2026](#)

[Substance Use Disorder - Effective 10/1/2026](#)