



**Ohio Department  
of Medicaid**

# Behavioral Health Office Hours

*Week 2*

*Question and Answer*

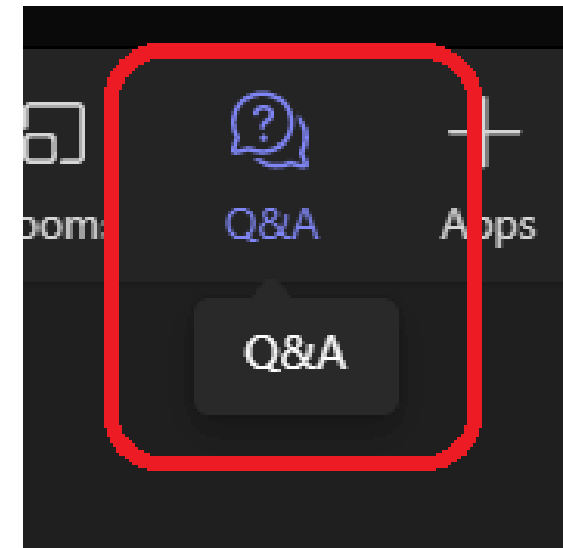
# Access, Inclusion, and Reasonable Accommodation

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# Housekeeping

- All participants are muted and the chat is disabled
- If you would like to submit a question you may use the Q&A feature at the top of the TEAMS webinar
- AI bots used for recording or note taking will be removed



# Tentative Office Hour Topics

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✓ **Week 1:** Introduction

**Week 2:** Q&A - Addressing initial questions specific to new utilization management thresholds implementation

**Week 3:** Authorization forms, including utilization of new accompanying tools for SUD form

**Week 4:** Authorization forms/CCPs - walk through MCE processes for submitting authorizations and verifying utilization

**Week 5:** Q&A - Level set following first month of office hours

**Week 6:** Redefining the community rehabilitative services package (TBS, PSR, CPST)

**Week 7:** SUD services Part 1

**Week 8:** ABA Implementation

**Week 9:** SUD Services Part 2

**Week 10:** Enrollment and Workforce

# Agenda

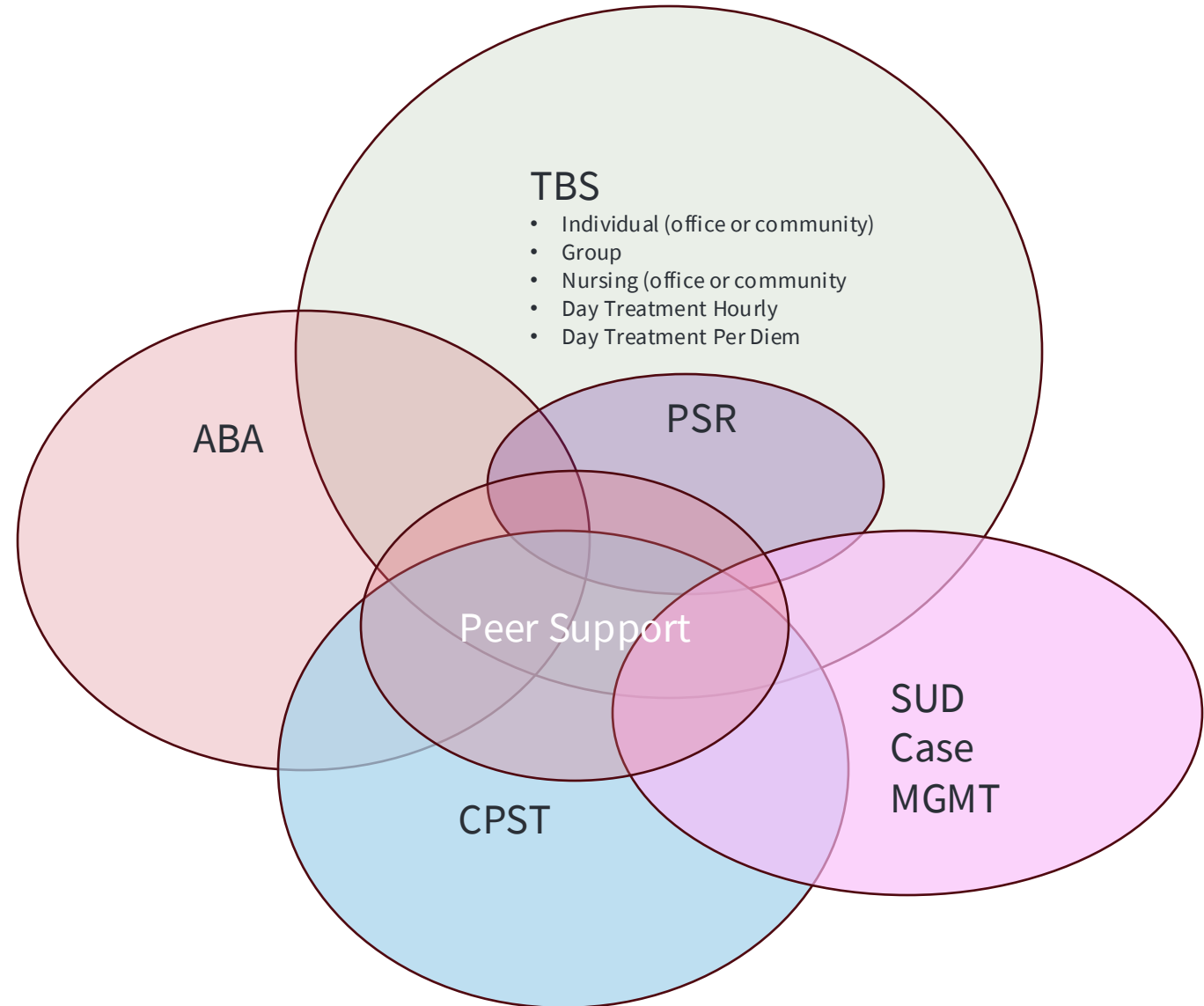
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Answering the most frequently asked questions from:

- First office hours
- Q&A submissions from the initial Office Hours registration link

# Background

- Steady and significant increase in the volume of BH services billed since BH redesign
  - Confusion around when to use CPST, TBS and PSR given the broad service definitions and overlapping application
- Increase of program integrity referrals for BH services where it has been found that medical necessity was not substantiated
- ARPA funding ended in early 2026 allowing MCEs to implement their own UM strategies
  - ODM worked with plans and providers to develop uniform UM across plans to reduce provider burden
- Need to balance access to services with medical necessity of services



# Exclusions

## **BH Rehab Services (H2019,H2017, H0036, H2020)**

- Children/Youth enrolled in OhioRISE (criteria for enrollment is unchanged)
- Children/Youth in custody of an Ohio Public Children's Service Agency\*
- Members in Crisis (Services with KX modifier)

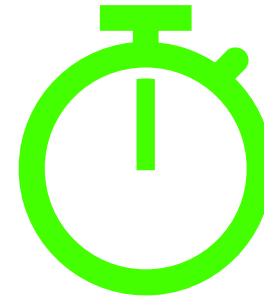
## **BH Nursing services are not subject to UM thresholds (OAC 5160-27-11)**

## **OhioRISE enrollees and children in PCSA custody ARE subject to UM thresholds for the following services:**

- ASAM II and III (IOP, PHP, Residential, Withdrawal Management)

# Start Dates

- **All utilization management threshold counts begin on July 1**
- **UM Thresholds are not prorated for the remainder of 2026**
- **MCEs will have the opportunity to go live on 7/1 or 10/1. Final go live dates for each plan will be communicated.**



# UM Tracking and Coordination

- Thresholds are per member per calendar year and will reset yearly on January 1
- UM thresholds will initially only apply to members enrolled in MCEs
- It is the expectation that providers will coordinate with other treating providers and MCEs to track utilization
  - MCE will make available a designated point of contact or self-service portal
  - Timely claims submission is encouraged
- Utilization and authorizations follow the member if they switch plans.
- UM is not a hard cap. MCE approval and denial rates will be tracked by ODM
- PAs effective a minimum of 90 days for unit based community rehabilitation services with no limit on allowable renewal requests per year

# Accountability and Oversight

- If an MCE fails to respond to a PA request on time, or a provider feels a PA was incorrectly denied, the provider may file an appeal within 60 calendar days from the date that the notice of action was issued.
- If a provider does not agree with a plan's decision to deny, limit, reduce, suspend, or terminate a covered service for **lack of medical necessity**, and they have exhausted the plan's internal appeals process, they may request an External Medical Review.
- Providers can challenge MCE claim payments or denials through the MCE's established Provider Claim Dispute Resolution Process.
- If a provider disagrees with a claim payment/denial or authorization denial and if **after working directly with the MCE** they still don't agree with or understand their decision, they can file a Managed Care Provider Complaint with ODM.
- MCEs currently report their prior authorization and appeal statistics to ODM. ODM will continue tracking this activity.

# Prior Authorization and Medical Necessity

- PA and Medical Necessity are the topics for 5/28/26
- Please continue to submit questions for this topic area to be covered next week
- Questions arising after that presentation will be addressed in the following weeks

# THANK YOU

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