



**Ohio Department
of Medicaid**

Behavioral Health Office Hours

Week 3

Prior Authorization

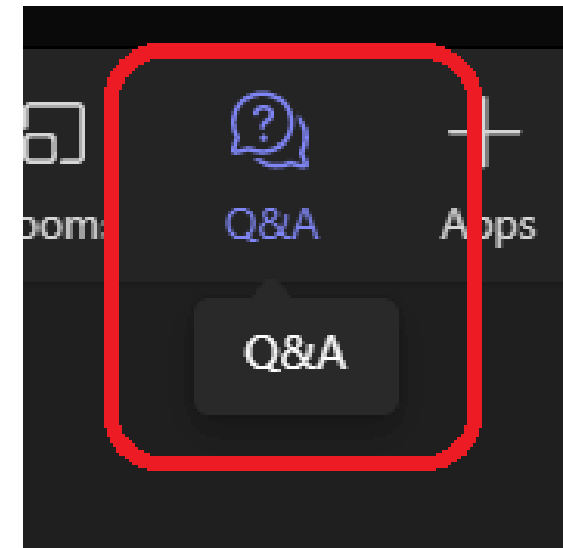
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Housekeeping

- 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

- ✓ **Week 1:** Introduction
- ✓ **Week 2:** Q&A - Addressing initial questions specific to new utilization management thresholds implementation
- Week 3:** Q&A – Addressing authorization questions, Community Behavioral Health Rehabilitative Services Authorization Request Form
- Week 4:** Authorization forms/CCPs - walk through MCE processes for submitting authorizations and verifying utilization
- Week 5:** SUD Authorization Form
- 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

Commonly Asked Questions

Prior Authorization - Specific Questions

Review of Community BH Rehabilitative Services Authorization Request Form

Commonly Asked Questions

Will the slides from these meetings be posted?

Yes, on the ODM behavioral health website, along with other materials relevant to the UM initiative.

[Manuals, Rates, and Resources | Medicaid](#)

How will we know how many units our clients have used?

The MCEs will be setting up designated systems for the purpose of verifying *known* member-level utilization data (see Week 4 slides). Providers can and should use these systems to determine which external providers (if any) they may need to contact to coordinate care, verify utilization, and prevent service duplication.

Who is exempt from these new utilization management requirements?

Children in PCSA custody and OhioRISE members are exempt from UM for behavioral health rehabilitative services: CPST, TBS, TBS Day Treatment Per Diem, and PSR. Crisis services with the KX modifier are also exempt.

Will this apply to the MyCare plans?

Yes, these UM thresholds will also apply to members enrolled in MyCare.

90-day Authorization Period

What services are subject to a 90-day authorization period?

- 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.

What if we run out of units before the 90 day period ends?

Submit a new request for more units to be authorized for the remainder of that 90 day period. When making this new request, take into consideration how many units you will need for the time remaining in the authorization period.

What happens to unused units after the 90 day period ends?

Units do not rollover once the 90 day authorization period has expired. Failure to utilize all requested units will be taken into consideration by the MCEs when reviewing subsequent requests.

How many units can I request on each submission? What happens to the 90 days if I need to request more units before the 90 days expires? Does the 90 day count restart?

- Request the number of units that are medically necessary and align with the frequency of services described in the member's treatment plan.
- For services subject to the 90 day authorization period:
 - The 90 day count only restarts at the end of the authorized 90 day period. If you exhaust your approved units prior to the end of that authorized 90 days, you must submit a request for sufficient units to carry you to the end of the initial 90 days authorization period. You will need to submit an additional authorization as you approach the end of that initial 90 day authorization period that reflects the number of units you anticipate utilizing over the next 90 day period.
 - The 90 day authorization period **does not** reset when additional units are requested.

Form Submission Timelines

How many prior authorization requests can we submit for each member during a calendar year?

There are no hard limits, but you must ensure that each request clearly demonstrates medical necessity and reflects the member's current clinical presentation and treatment plan.

How soon can I submit an authorization request?

Ensure that you don't run out of the units you have remaining by taking into consideration that the MCEs can take up to 7 calendar days to respond to a standard request and 2 days for urgent requests (OAC 5160-26-03.1). Requests need to reflect the client's current clinical presentation. Therefore, requests should not be submitted so far in advance that medical necessity may have changed.

How long do I have to wait before I can submit an authorization request? Do I need to get a denial first?

Please do not wait for a denial! The MCEs expect that requests will be submitted for their review prior to the service limit being reached and doing so is sound clinical practice to prevent service disruption for the member.

What if I haven't received a response after 7 days?

Providers should follow the procedures found in the Managed Care Provider Manuals and utilize the individual managed care plan provider support lines for follow up with MCEs

Will we be permitted to submit requests for retroactive authorizations?

Providers should consult Rule 5160-1-31 Prior Authorization, with regard to retro authorizations. In general, requests for retro authorizations should be preserved for exceptional circumstances. For retroactive enrollments, retro authorization can be submitted for a service.

Form Submission FAQ

How do providers submit the authorization requests to each plan?

Plan specific submission processes will be published in each plans CCP that will be made available on ODMs BH UM site. The plans will also be presenting on this topic on 6/4. See Week 4 slides for more detail.

What about the announcements plans made earlier this year in their CCPs regarding UM?

Announcements for UM that went out from MCEs in late 2025, early 2026 (prior to this announcement) are not valid. All plans must adhere to the thresholds announced by ODM for their own implementation.

How do I request an external medical review?

The processes for submitting external medical reviews and/or appeals are unchanged. [Permedion](#) | [Gainwell](#)

Can I request more than one service on the same PA form?

Yes, but you must include supporting documentation and clinical justification for all services requested

When will the new PA forms be available?

Before 7/1. We will post the updated Forms on the ODM BH UM website

If an MCE approves an authorization and then the client moves to a new MCE, will we have to get a new authorization or will the new plan honor the initial one if we are still within the approved timeframe?

Per their provider agreements, MCEs must coordinate authorizations when members transition between plans.

Universal Authorization Forms

ODM has two universal authorization forms that the MCEs must accept for prior authorization requests, which have been updated for this initiative

- The Community Behavioral Health Rehabilitative Services Authorization Request
- The Substance Use Disorder Authorization Request

MCEs may continue using their plan specific authorization forms; however, they must continue to accept the updated universal authorization forms

Community BH Rehabilitative Services Authorization Request Form

Community BH Rehabilitative Services Authorization Request Form

Key Updates

- New cover sheet and instructions with UM threshold information and guidance on completing the form
- Added procedure codes for services subject to this UM initiative, including:
 - H2020 (TBS Day Treatment Per Diem)
 - H2019 (TBS Individual and Group)
 - H2017 (PSR)
 - H0036 (CPST Individual and Group)
- Added clarification of authorization requirement for TBS Hourly and Day Treatment Per Diem and H0015 SUD IOP and PHP **when provided on the same day.**
- Added additional column that allows providers to select reason for authorization (ex. Service Threshold Met, Same Day Services)
- Reflects authorization requirement for group services rendered for more than 1 hour (4 units) combined on the same day as IOP, PHP and TBS Hourly and Day Treatment Per Diem.
- Establishes standardized medical necessity criteria for TBS, TBS Day Treatment Per Diem, PSR, and CPST

Community BH Rehabilitative Services Form Guidance

Community Rehabilitative Services Request Form Overview

Instructions for Service Requests:

In Section III, complete each column for the applicable service:

1. Select the service(s) and code(s) being requested
2. Identify the reason for the request (see definitions below). Select all that apply.
3. Identify the number of units for the request.
4. Provide the requested start date or dates of service.

Reason for Request:

Day 1 Authorization Required: Authorization is required prior to rendering this service

Service threshold met: Client is already receiving service and is nearing or has met the initial threshold OR member has exhausted previously authorized units.

Exceeds daily limit: Client requires an amount of service that exceeds the daily limit set for that particular service.

Same Day Services (Adults Only):

- An authorization is required for a client to receive same day group service for more than 1 hour (cumulative) on the same day as H2012 TBS Day Tx hourly, H2020 TBS Day Tx per diem, H0015 IOP, H0015TG PHP. Prior authorization is also required to receive reimbursement for IOP/PHP and TBS Day Treatment per diem or hourly, when delivered to one Medicaid member on the same day, whether by a different or the same provider.
- In general, when you add a second group service, that is the service that will require a same day authorization. The documentation on the form should demonstrate the necessity of the new group service in addition to the group service the client is already receiving. A follow up authorization may also be required for additional units of either service.
- When requesting a community BH Rehabilitative group service to be billed on the same day as an SUD service, utilize the Community Behavioral Health Rehabilitative Services Authorization Request. When requesting an SUD group service on the same day as a TBS Day Treatment Per Diem/Hourly, utilize the SUD ASAM LOC Authorization Form.

Community BH Rehabilitative Services Authorization Request Form

Ohio Department of Medicaid

Community Behavioral Health Rehabilitative Services

Authorization Request

Instructions

The following information should be submitted to the MCE as an attachment to this form:

- Include service start date and referral source along with reason for services
- Attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service.
- Provide primary/secondary diagnoses and psychosocial issues/barriers to treatment
- Provide pertinent medical and BH history including suicidal ideation/homicidal ideation risk
- Provide treatment plan with target dates and discharge plan
- For continued stay requests please provide: any new problems identified, an update on the treatment plan including how lack of progress is being addressed in any areas, updated discharge plan, and updated information on psychosocial barriers.

Requests for Substance Use Disorder (SUD) Residential Treatment, SUD Intensive Outpatient, SUD Partial Hospitalization and Withdrawal Management should be submitted using the ODM 10276 "Substance Use Disorder Services Prior Authorization Request" form.

If H2012 or H2020 is to be provided on the same day as H0015 or H0015TG or more than one hour of H0005, providers must ensure ODM SUD Authorization Request Form has been submitted and approved in addition to this request.

Community BH Rehabilitative Services Authorization Request Form

Section I: Member Information	
Managed Care Plan:	Date of Request:
Member Name:	Date of Birth:
Member ID Number:	Member Phone:
Requested Authorization Decision Type <input type="checkbox"/> Standard <input type="checkbox"/> Expedited	
Section II: Provider Information	
Organizational Billing Provider/Agency Name:	Service Location Address:
Organizational Billing Provider/Agency NPI:	Provider / Agency Tax ID:
Contact Name:	Phone Number:
Email Address:	Fax Number:
Practitioner's Name and Credentials:	Practitioner NPI:
Network Status with Managed Care Plan, if applicable <input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating	

Accurate org. billing provider (not rendering) information is essential for processing.

Community BH Rehabilitative Services Authorization Request Form

Section III: Service(s) Requested			
Description	Reason For Request	Units/Visits Requested	Requested Start Date or Dates of Service
Alcohol and Drug Assessment <input type="checkbox"/> H0001	<input type="checkbox"/> Service threshold met		
Assertive Community Treatment <input type="checkbox"/> H0040	<input type="checkbox"/> Initial or reauthorization		
Psychological / Neuropsychological Testing <input type="checkbox"/> 96130 <input type="checkbox"/> 96131 <input type="checkbox"/> 96136 <input type="checkbox"/> 96137 <input type="checkbox"/> 96132 <input type="checkbox"/> 96133 <input type="checkbox"/> 96112 <input type="checkbox"/> 96113 <input type="checkbox"/> 96116 <input type="checkbox"/> 96121	<input type="checkbox"/> Service threshold met		
SBIRT Services <input type="checkbox"/> G0396 <input type="checkbox"/> G0397	<input type="checkbox"/> Service threshold met		
Psychiatric Diagnostic Evaluation <input type="checkbox"/> 90791 <input type="checkbox"/> 90792	<input type="checkbox"/> Service threshold met		
Peer Support <input type="checkbox"/> H0038 <input type="checkbox"/> H0038 HQ	<input type="checkbox"/> Exceeds daily limit <input type="checkbox"/> Same day services		
*TBS Individual <input type="checkbox"/> H2019	<input type="checkbox"/> Service threshold met		
*TBS Group <input type="checkbox"/> H2019 HQ	<input type="checkbox"/> Service threshold met <input type="checkbox"/> Same day services		
*CPST Individual <input type="checkbox"/> H0036	<input type="checkbox"/> Service threshold met		
*CPST Group <input type="checkbox"/> H0036 HQ	<input type="checkbox"/> Service threshold met <input type="checkbox"/> Same day services		
*PSR <input type="checkbox"/> H2017	<input type="checkbox"/> Service threshold met		
Group Psychotherapy <input type="checkbox"/> 90853	<input type="checkbox"/> Same day services		
*TBS Day Treatment (Hourly) <input type="checkbox"/> H2012	<input type="checkbox"/> Same day services		
*TBS Day Treatment (Per Diem) <input type="checkbox"/> H2020	<input type="checkbox"/> Service threshold met <input type="checkbox"/> Same day services		
OhioRISE Only Services	Service Code	Units/Visits Requested	Requested Start Date or Dates of Service
**Behavioral Health Respite	<input type="checkbox"/> S5150 <input type="checkbox"/> S5151		
**Intensive Home-Based Treatment	<input type="checkbox"/> H2033 <input type="checkbox"/> H2015		
Primary Diagnosis (ICD 10):			

*For services marked with *, providers are required to complete Section IV: Medical Necessity Criteria

**Services marked with ** may require additional assessment results to be provided (e.g. ANSA, CANS, [including CIP-IHBT version], Achenback)

Community BH Rehabilitative Services Authorization Request Form

<p>Section IV: Medical Necessity Criteria (For TBS, PSR, TBS Day Treatment, and CPST only)</p> <p>Select the check box next to the service(s) you are requesting for the member. All corresponding clinical criteria for that service must be met for member to qualify for prior authorization.</p>
<p><input type="checkbox"/> Therapeutic Behavioral Services (TBS)</p> <p><input type="checkbox"/> Member demonstrates one or both of the following (select all that apply):</p> <ul style="list-style-type: none">(a) <input type="checkbox"/> Onset or worsening of symptoms associated with mental health condition(b) <input type="checkbox"/> Persistent mental health symptoms that impair functioning in daily life <p><input type="checkbox"/> Member would benefit from services that promote acquisition of coping skills or other evidence-based techniques to reduce or alleviate symptoms of mental illness.</p> <p><input type="checkbox"/> Treatment plan clearly describes measurable goals related to symptom management AND (select all that apply):</p> <ul style="list-style-type: none">a) <input type="checkbox"/> Describes how <u>INDIVIDUAL</u> TBS services will be used to reduce or alleviate mental health symptoms.b) <input type="checkbox"/> Describes how <u>GROUP</u> TBS services will be used to reduce or alleviate mental health symptoms.
<p><input type="checkbox"/> Psychosocial Rehabilitative Services (PSR)</p> <p><input type="checkbox"/> Member experiences functional limitations in at least one of the following life domains (select all that apply):</p> <ul style="list-style-type: none">(a) <input type="checkbox"/> Independent living (managing budget, housing stability, nutrition, self-care)(b) <input type="checkbox"/> Social Skills(c) <input type="checkbox"/> Community integration (participation in family, community, or workplace) <p><input type="checkbox"/> Member would benefit from services that promote acquisition of skills and prevent or decrease regression in the performance of tasks in major life domains.</p> <p><input type="checkbox"/> Treatment plan clearly describes measurable goals related to functional limitations and how PSR services will be used to restore skills.</p>

Community BH Rehabilitative Services Authorization Request Form

<input type="checkbox"/> Therapeutic Behavioral Services Day Treatment Hourly / Per Diem
<input type="checkbox"/> Member demonstrates acute onset or worsening of symptoms associated with mental health condition that significantly disrupt daily functioning.
<input type="checkbox"/> Member would benefit from services that promote acquisition of coping skills or other evidence-based techniques to reduce or alleviate symptoms of mental illness.
<input type="checkbox"/> Member requires a highly structured environment to support skills acquisition and facilitation.
<input type="checkbox"/> Treatment plan clearly describes measurable goals related to symptom management and how day treatment services will be used to stabilize functioning.
<input type="checkbox"/> Treatment plan includes measurable discharge criteria and plan for transitioning member to a lower level of care.
<input type="checkbox"/> Request includes an individualized sample schedule demonstrating the duration, frequency, and intensity of day treatment program.
<input type="checkbox"/> Community Psychiatric Supportive Treatment (CPST)
<input type="checkbox"/> Member has mental health condition(s) requiring ongoing management by multiple providers AND would benefit from a coordinated plan of care that includes collaboration among care providers and natural supports.
<input type="checkbox"/> Member is at risk of treatment non-adherence due to mental health condition(s)
<input type="checkbox"/> Member would benefit from services that promote acquisition of coping skills or other evidence-based techniques to reduce or alleviate symptoms of mental illness.
<input type="checkbox"/> Member needs assistance with linkages to community supports and services.
<input type="checkbox"/> Clinical documentation clearly demonstrates member's difficulty following treatment plans without support.
<input type="checkbox"/> One or both of the following is true (select all that apply):
a) <input type="checkbox"/> Treatment plan clearly describes how <u>INDIVIDUAL</u> CPST services will be used to assist member in achieving goals in ISP.
b) <input type="checkbox"/> Treatment plan clearly describes how <u>GROUP</u> CPST services will be used to assist member in achieving goals in ISP.

Community BH Rehabilitative Services Authorization Request Form

Required Supporting Information
<p>Describe any recent circumstances such as hospitalizations, life transitions, health-related social needs, multi-system involvement, and/or scores from clinical symptoms rating scales, etc. that support member's need for the requested service(s). Attach an additional document if more space is needed.</p>

Signature of Staff Completing the Form	
Name (print):	
Signature/Credential:	Date:

Next week: MCEs-Individual Presentations

- MCEs going live 7/1 will give an overview of plan-specific instructions for submitting authorizations
- Walking through approved CCPs
- Anticipating approx. 10-min presentation per plan

THANK YOU

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