



**Ohio Department
of Medicaid**

Behavioral Health Office Hours

Answering your Questions ahead of 7/1 Go Live

Week 7

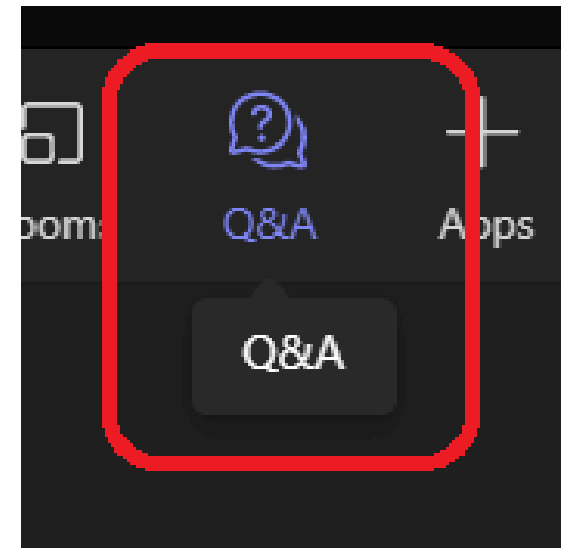
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Housekeeping

- 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. Please submit as a new comment, not as a response to another question.
- 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:** Off for Juneteenth
- Week 7:** Recap before 7/1 Go live
- Week 8:** OFF for July 4th
- Week 9:** Post Implementation Q/A
- Week 10:** “Real-Time” Office Hours

Agenda

- Follow Up from Plan Presentations
- Q/A questions from inbox
- Request Form Scenarios

7/1 Go Live

When does each Plan go live?

July 1

BH and SUD

- Buckeye
- CareSource
- Humana
- UHC/Optum***

July 1

BH Only

- Molina

October 1

BH and SUD

- Amerihealth
- Anthem (SUD)
- Molina (SUD)

January 1, 2027

- Anthem (BH)
- Aetna (SUD)

***For withdrawal management services, UHC/Optum will only be implementing UM for ASAM 3.7 Medically Monitored Inpatient Withdrawal Management (H0011). UHC/Optum will not require prior authorizations for ASAM 2 Withdrawal Management (H0012 and H0014) or ASAM 3.2 Withdrawal Management (H0010).

Go Live cont'd

Will services dated prior to 7/1/2026 be considered as part of this utilization management initiative under any circumstance?

- No!

Does the utilization management initiative also apply to hospitals or professional medical groups?

- Currently, this initiative applies only to services provided by provider types 84 (Community Mental Health Agency) and 95 (SUD Treatment Agency/Organization).

What is the go-live date for members enrolled in Fee-for-Service or “Straight” Medicaid?

- We have not scheduled a go-live date for FFS at this time. There are plans to implement utilization management for this population in the future and more information will be shared with the provider community at that time, with proper notice.

What if a Managed Care Plan has announced or implemented different utilization management requirements than those announced by ODM?

- Any thresholds or requirements previously established by the Managed Care Plans related to the service codes included in this initiative are no longer valid for dates of service July 1 and after.

If a Managed Care Plan doesn't go live until 10/1, when do I need to start tracking utilization for their members?

- On 7/1. This means that you may need to be prepared to submit an authorization at the end of September to continue providing services after 9/30.

Utilization Management Thresholds

What are the new thresholds?

Service Name	Service Code	Threshold at which Authorization is Required
Community Behavioral Health Rehabilitative Services		
Therapeutic Behavioral Services - Individual	H2019	200 units (50 hours) combined TBS or PSR per calendar year
Therapeutic Behavioral Services - Group	H2019 HQ	120 units (30 hours) per calendar year
TBS Day Treatment - Per Diem	H2020	After 30 units in one calendar year
Community Psychiatric Support Treatment – Individual	H0036	200 units (50 hours) per calendar year
Community Psychiatric Support Treatment – Group	H0036 HQ	120 units (30 hours) per calendar year
Psychosocial Rehabilitation	H2017	200 units (50 hours) combined TBS or PSR per calendar year
SUD Treatment Services		
SUD Ambulatory Withdrawal Management (WM)	H0012 H0014	After 7 th consecutive day
SUD Intensive Outpatient Program	H0015	After 30 units in one calendar year
SUD Residential Clinically Managed – WM	H0010	After 7 th consecutive day
SUD Residential Medically Managed – WM	H0011	After 7 th consecutive day

Applicability and Exemptions

Which populations are excluded from the new utilization management thresholds?

- OhioRISE-enrolled youth and youth in the custody of an Ohio public children's services agency are exempt from utilization management for TBS (H2019/HQ), PSR (H2017), CPST (H0036/HQ), and TBS Day Treatment Per Diem (H2020).

Will the services a member receives while in PCSA custody count against their benefit threshold when they are no longer in custody?

- No!

How will the Managed Care Plans be able to identify the youth in PCSA custody?

- The plans receive this information via a daily enrollment report. Youth in custody are designated by specific living arrangement codes.

Are crisis services excluded from utilization management?

- Yes, if the KX modifier is used appropriately.

Is a member's service utilization toward the threshold based on the agency/provider?

- No, the count is based on the member and will follow them across providers and Managed Care Plans. The Managed Care Plans will be required to communicate member utilization as part of a member's transition from one plan to another.

Does the new utilization management also apply to members enrolled in MyCare?

- Yes!

When the thresholds reset on January 1, 2027, will the limits double since they will be for a full year?

- No, the limits were determined based on a full year of utilization, but ODM made the decision not to prorate the thresholds for the remainder of 2026.

Threshold and Utilization Questions

How are the TBS, PSR and CPST thresholds combined?

- Individual TBS (H2019) and PSR (H2017) are limited to a combined 200 units before authorization is required. Individual CPST (H0036) is not combined with either service, so 200 units may be billed prior to requiring authorization.

Are the units for TBS group (H2019 HQ), CPST group (H0036 HQ), and TBS Day Treatment Per Diem (H2020) combined in any way?

- No!

Do these thresholds also include daily or weekly caps for TBS, PSR or CPST?

- Apart from restrictions on same day group services, no.

Threshold and Utilization Questions, cont'd

What if a member doesn't attend a TBS Day Treatment session long enough to reach the per diem minimum?

- You should submit the claim with a TBS Day Treatment Hourly (H2012) code based on the duration of the member's actual participation. This session would not count against their 30 units allowed prior to the authorization requirement but may mean that you do not use all of the approved units before they expire if the service is currently under an active authorization. You should document any extenuating circumstances related to "leftover" units in the next authorization request should the member require continuing services.

What if a member with approval to participate in SUD PHP or IOP fails to reach the weekly service duration required for that LOC due to situations beyond their or our control?

- For any days on which the member participated for less than the per diem minimum, your agency should submit a claim for SUD Group Counseling H0005 for the actual duration of their participation on that day, which will not count against the member's approved units. Per rule, failure to meet the 20 hour weekly minimum for SUD PHP for four consecutive weeks will automatically result in conversion to IOP. Any extenuating circumstances which lead to failure to use all of the approved units should be documented and explained in the next authorization request, if needed.

If a member leaves withdrawal management after 5 days, where does their utilization stand if they return to withdrawal management later in the same calendar year?

- The member's utilization for withdrawal management resets by episode, so they will not need authorization for continued stay until after the 7th consecutive day of withdrawal management services.

Benefit Verification

How will I know how many units my client has used since July 1 (or for the year, after 1/1/2027)?

- Each Managed Care Plan has developed a method for benefit verification. We will be uploading an *MCE Implementation Summary* document to the ODM BH website before 7/1, which will include detailed information and instructions by Plan.

What if the information provided by the Managed Care Plan is not up to date and the member has used more units than we expected?

- The benefit verification information provided by each Managed Care Plan is only as up to date as the claims that have been submitted. If you receive a denial for a member who you believed had available units remaining, depending on the Plan, you should submit a retroactive authorization or engage in the claim denial dispute process to receive reimbursement from that Plan. A denial will also serve as a signal to you that you need to submit an authorization request form to continue services. Timely claims submission will have a meaningful impact on this effort. We're encouraging all providers to submit their claims in a timely manner for the benefit of the entire provider community.

What if another agency submits older claims after we have already verified a member's units and started billing for services?

- You should submit a retroactive authorization or engage in the claim denial dispute process with the member's Managed Care Plan as outlined in the Plan's Provider Manual and also submit an authorization request to continue services.

Members often don't know which other providers they are working with or what services are being billed. How can we get this information, so that we don't duplicate services?

- As part of the benefit verification process, the Managed Care Plans will be able to tell you which services the member has received to date this year. Per HIPAA and ORC, the Managed Care Plans are permitted to share agency and provider details related to the Community BH Rehabilitative Services without signed member consent. This should ease some collaboration and care coordination processes.

Where can I find the new authorization forms and other related resources?

<https://medicaid.ohio.gov/resources-for-providers/bh>

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For Providers:

- **Behavioral Health Information for Providers:** The Ohio Department of Medicaid (ODM) works with a variety of behavioral health providers to offer a wide range of treatment and supportive services. Visit this page for an overview of these services and information related to:
 - Enrolling as an Ohio Medicaid provider.
 - Managed care resources.
 - Behavioral health programs available through ODM.
- **Manuals, Rates, and Resources:** Documentation surrounding ODM processes, as well as important billing information is found here. Visit this page for information related to:
 - Behavioral Health Provider Manual.
 - Billing resources.
 - Behavioral Health Coding Workbook and code packages.
 - Utilization Management.
- **Training Opportunities:** Training resources for behavioral health providers both specific to the state of Ohio and from other national and state organizations. Visit this page for information related to:
 - Next Generation of Ohio Medicaid Managed Care.
 - Training resources from national, state, and academic organizations.
- **Behavioral Health Bulletins:** ODM regularly releases newsletters to keep Medicaid providers and members informed of program and policy changes, new services or supports, and more. Visit this page to see new and past BH Bulletins.

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Form Submission and Denials

When will the new authorization forms be available online?

- The new forms should be up by end of day on 6/26/26. In the meantime, consult the 5/28 and 6/11 presentations for form content.

Will all the Managed Care Plans be required to accept the new forms?

- Yes!

Do we have to use the Managed Care Plan portals to submit the forms?

- Some of the Plans may also accept submission by fax, mail or email. Please consult the forthcoming *MCE Implementation Summary* document on the ODM BH website for information and instructions by Plan.

Which members of our staff can fill out and sign the authorization forms?

- Most Managed Care Plans don't require an actual signature in their portal. If a signature is included, either electronically or on the PA form as an upload, the Managed Care Plan will assume that the signer can attest to the clinical content included in the request. Specific requirements for the submission may vary by Plan and can be found in that Plan's Provider Manual.

Can I use a single form to request more than one service?

- The Community BH Rehab. Services Request Form may be used to request multiple services, though medical necessity documentation must be provided for each service requested. The SUD Services Request Form may be used to request withdrawal management or a same day group service along with an LOC of 2 or 3, but cannot otherwise be used to request multiple services at the same time.

What do I do if I receive a denial for my authorization request?

- The process for appeals, peer-to-peer, and external medical reviews is unchanged. The details for engaging in these processes can be found in the Managed Care Plan Provider Manuals, as well as the denial notification communication itself.

Request Form Questions

How soon can I submit the request form for additional units?

- This will be somewhat dependent on the service you are requesting and there is no hard and fast rule. Instead, we recommend that you submit early enough that you do not run out of units and disrupt member services, but not so early that the documentation you are providing will not be an accurate representation of the member's clinical status when they do reach the threshold. Remember that standard requests are turned around within 7 calendar days and expedited requests within 2 calendar days. Use clinical judgement.

Which services are authorized for 90 days?

- Individual and group TBS and CPST and individual PSR will be approved for 90 days at a time. When completing the authorization request, you should request the number of units you anticipate needing during that 90-day period based on the service schedule outlined in the member's treatment plan. Number of units requested and approved will be unique to each request and member based on their treatment plan and clinical needs.

Will there be an expiration date for the rest of the services in this initiative or will we just get an allotted number of units to use?

- Your request will be approved for a specific number of units to be used by a specific end date based on the information you outlined in your request and what the clinical documentation supports. If the member needs services beyond the approved end date, a new authorization request form will need to be submitted, even if you haven't exhausted all the approved units.

Request Form Questions, cont'd

When a Managed Care Plan authorizes a service for a member, to which providers will that authorization apply?

- Any providers qualified to provide the approved service employed by the billing agency which submitted the authorization will be allowed to submit claims under the authorization.

Will more than one agency be approved to provide similar services to a member at the same time?

- Yes, this is technically possible, but the Managed Care Plans will want to see that each agency is addressing a unique clinical need and are not duplicating each other. Both agencies will be responsible for clearly demonstrating the medical necessity of the service they are providing. Before the threshold is reached, claims from both agencies will draw down from the same unit allotment therefore collaboration and coordination will be vital for claim submission and reimbursement. Once the threshold is reached and the agencies are approved for ongoing services, the approved units will be unique to each agency.

Same Day Group Services

Adult Same Day Group Services Restrictions

Which group services can be billed on the same day as TBS Day Treatment (H2012/H2020), SUD PHP (H0015 TG), and SUD IOP (H0015)?

- Agencies may provide up to one additional hour total of group services on the same day as H2012, H2020, H0015TG or H0015 so long as they are separate and distinct and outlined clearly in the member's treatment plan. This includes:
 - 90853 (Group Psychotherapy)
 - H0036 HQ (Group CPST)
 - H2019 HQ (Group TBS)
 - H0005 (SUD Group Counseling)
 - H0038 HQ (Group Peer Support)

Any additional same day group services beyond one hour on the same day will require authorization.

Can a member receive TBS day treatment (H2012 or H2020) on the same day as SUD IOP or PHP?

- Not without prior authorization, regardless of whether it is the same or different billing organizational provider.

What if a member is currently receiving TBS Day Treatment and is then referred for SUD IOP to occur on the same day but hasn't used any units toward the threshold yet?

- In this scenario, the member would need authorization prior to starting SUD IOP as a same day group service regardless of the member's current utilization. This would also be true in the reverse scenario: If a member is currently receiving SUD IOP and has been referred to receive TBS Day Treatment on the same day, an authorization must be submitted prior to the first day of TBS Day Treatment.

Billing and Misc.

What about everything else?

We want to acknowledge that we cannot detail every possible scenario and that many of you have submitted questions unique to your agency's situation (i.e. pre- or post-payment review status, staffing, certification, population served, etc.) and/or questions related to claims and denials issues. For these types of concerns, we encourage you to continue contacting the ODM BH Policy mailbox at bhpolicy@medicaid.ohio.gov.

Our presentation on 7/9 will include answers to questions submitted to the online questionnaire with a particular focus on post-implementation issues. We be holding open office hours on 7/16 during which participants can unmute to ask more specific questions. Our hope is to answer questions in real time and engage with some of these unique situations, though NO billing guidance will be provided.

THANK YOU

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