



**Ohio Department
of Medicaid**

Behavioral Health Office Hours

6/4/2026

Access, Inclusion, and Reasonable Accommodation

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](mailto: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.

Agenda

MCE Presentations on Provider Portals and Medical Necessity

- Buckeye
- CareSource
- Humana
- Molina
- United

2026 BEHAVIORAL HEALTH BILLING POLICY UPDATES FOR PROVIDERS



buckeye
health plan.

Your Guide to Better Health™

MEDICAID • MEDICARE • MARKETPLACE



Prior Authorization

Prior Authorizations are required on some services and will be submitted directly to the health plan.

To determine if a service needs prior authorization use our **Prior Authorization Prescreen Tool** (buckeyehealthplan.com/providers/prior-authorization/preauth-check.html)

If a service requires prior authorization, please note:

- Standard prior authorization requests should be submitted for medical necessity review at least five (5) business days before the scheduled service delivery date or as soon as the need for service is identified.
- Authorization requests should be submitted via our secure web portal and should include all necessary clinical information.
- Per CMS expectations all Standard authorizations will be determined within 7 days

To submit a Prior Authorization for approval:

- Login to the **Secure Provider Portal** (buckeyehealthplan.com/providers.html) or **Availity** (apps.availity.com/availity/web/public.elegant.login).
 - Access the member's record.
 - Select the New Authorization option. The Authorization screen will appear with the member's data pre-populated.
 - **Complete the Authorization Form.**
- Fax Authorization request to 866-535-6974

Buckeye Secure Provider Portal

Take care of business on YOUR schedule. The Provider Portal is yours to use 24 hours a day, seven days a week to accomplish several tasks.

- Easily check member eligibility
- **COMING SOON!** View Benefits Usage
- View and submit claims
- View and submit service authorizations
- Communicate with us through secure messaging
- Maintain multiple providers on one account
- Control website access for your office
- View historical member health records
- Submit assessments to provide better member care
- And much more



Access the Secure Provider Portal from
the **Provider Home Page**
(buckeyehealthplan.com/providers.html)

Buckeye Secure Provider Portal Eligibility

Step 1: How to Check Member Eligibility in the Secure Provider Portal

1. Log in to the Buckeye Secure Provider Portal.
2. Once on the landing page, locate the Quick Actions section (highlighted on the screen).
3. In the Quick Actions fields, enter:
Member ID or Last Name
Member Date of Birth
4. Select “Eligibility Check” (or the appropriate action type) from the dropdown.
5. Click Submit to view the member’s eligibility details.

The Quick Actions section on the landing page provides the fastest way to access eligibility—no additional navigation is needed.

Admin Settings
Add and manage user access and information.

[Add User](#) [Edit User Access](#) [Add a TIN](#)

Quick Actions
Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

1

Member ID or Last Name *

Member Date of Birth MM/DD/YYYY

Select Action Type *

[SUBMIT](#)

Authorization Overview

[Inpatient Authorizations](#) [View All](#)

[Outpatient Authorizations](#) [View All](#)

Useful Links

[Reports](#) [Provider Analytics - Coming Soon](#) [Buckeye Community Connect](#)

Buckeye Secure Provider Portal Eligibility

Step 2: Review the Eligibility Overview Page

After selecting the eligibility check, you will be directed to the member's Eligibility Overview page (shown on this slide).

At the top of the page, you will see a confirmation message indicating the member's current eligibility status (e.g., "This patient is eligible as of today").

Within the Overview section, you can review key member details, including:

Member demographic information

Eligibility effective dates

PCP (Primary Care Provider) information

Use the left-hand navigation menu to access additional details such as Cost Sharing, Benefits Usage, Authorizations, and Claims.

The screenshot displays the Buckeye Secure Provider Portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, PCP Referrals, Authorizations, Claims, Messaging, and Help. Below this, there are dropdown menus for 'Viewing Authorizations For' (set to 'TIN') and 'Plan Type', with a 'GO' button and a 'Create Authorization' button. The main content area features a left-hand navigation menu with options like Overview, Cost Sharing, Benefits Usage, Assessments, Health Record, ADT, Care Plan, Authorizations, Pharmacy PDL, Care Management Referrals, PCP Referrals, Coordination of Benefits, Claims, Benefit Documents, Document Resource Center, Notes, and Special Needs. The 'Overview' section is highlighted with a red box and a green circle containing the number '2'. A green banner at the top of the Overview section displays a thumbs-up icon and the text 'This patient is eligible as of today'. Below this, there are sections for 'Patient Information' and 'PCP Information'. The Patient Information section includes fields for Name, Gender, Birthdate, Age, Member #, and Address. The PCP Information section includes fields for Name, Address, and Practice Type. There are also links for 'Print Eligibility Overview', 'View PCP History', and 'Care Gaps'. At the bottom, there is an 'Eligibility History' section with a table header: Start Date, End Date, Product Name, and Product Description.

Buckeye Secure Provider Portal Benefits Usage

Step 3: Review Benefits Usage Information

From the Eligibility Overview page, select “Benefits Usage” from the left-hand navigation menu (highlighted on this slide).

The Benefits Usage page will display a summary of the member’s benefit utilization under their current plan.

What information is available:

- **Services used to date** – Shows how many covered services the member has already utilized
- **Remaining benefits** – Indicates how many services are still available within the benefit limit
- **Annual or service limits** – Reflects any caps on services based on the member’s plan
- **Disclaimers and notes** – Provides important reminders regarding claims processing and prior authorization requirements

The screenshot shows the provider portal interface. At the top, there are navigation tabs for Eligibility, Patients, PCP Referrals, Authorizations, Claims, Messaging, and Help. Below these are dropdown menus for 'Viewing Authorizations For: TIN' and 'Plan Type', followed by a 'GO' button and a 'Create Authorization' button. The left-hand navigation menu includes: Overview, Cost Sharing, **Benefits Usage** (highlighted with a red box and a green circle with the number 3), Assessments, Health Record, ADT, Care Plan, Authorizations, Pharmacy PDL, Care Management Referrals, PCP Referrals, Coordination of Benefits, Claims, Benefit Documents, Document Resource Center, Notes, and Special Needs. The main content area is titled 'Benefits Usage' and contains the following text: 'Under your plan, you are limited to a certain number of services each year.' Below this is a 'Disclaimers' section with three bullet points: 'Click here to review the prior authorization or call the number listed on the ID card.', 'The counter limit displayed on the page is based on claims processing. If Ambetter has not received a claim for a date of service, it will not be included in the counts above.', and 'Prior authorization is based on medical necessity and is not a guarantee of benefits.' At the bottom, there is a table with the following structure:

Benefit	Total Used to Date	Total Remaining

Buckeye Secure Provider Portal Benefits Usage

Important reminders for providers:

- Always verify eligibility and benefits at the time of service
- Benefit usage is based on processed claims, so recent services may not yet be reflected
- Prior authorization is based on medical necessity and is not a guarantee of payment
- Providers can contact Provider Services at 1-866-296-8731 to obtain Benefit Usage Data

Why this matters:

The Benefits Usage section helps providers understand how much of a member's benefit has been utilized and what remains available—supporting accurate treatment planning and billing.

Availity Essentials

- Buckeye has chosen **Availity Essentials** (availability.com/providers/) as its new, secure provider portal. Starting January 20, 2025, providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials.
- Our current **Secure Provider Portal** (buckeyehealthplan.com/providers.html) is still available for other functions that providers use today.
- For providers new to Availity Essentials, getting their Essentials account is the first step toward working with Buckeye on Availity.
 - The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
 - Administrators can **Register and Get Started with Availity Essentials** (availability.com/documents/learning/LP_AP_GetStarted/index.html#/).
 - Providers needing additional assistance with registration can call Availity Client Services at
 - **1-800-AVAILITY (282-4548)**, Monday through Friday, 8 a.m. – 8 p.m. ET.
 - For general questions, providers can reach out to their health plan Provider Engagement representative.

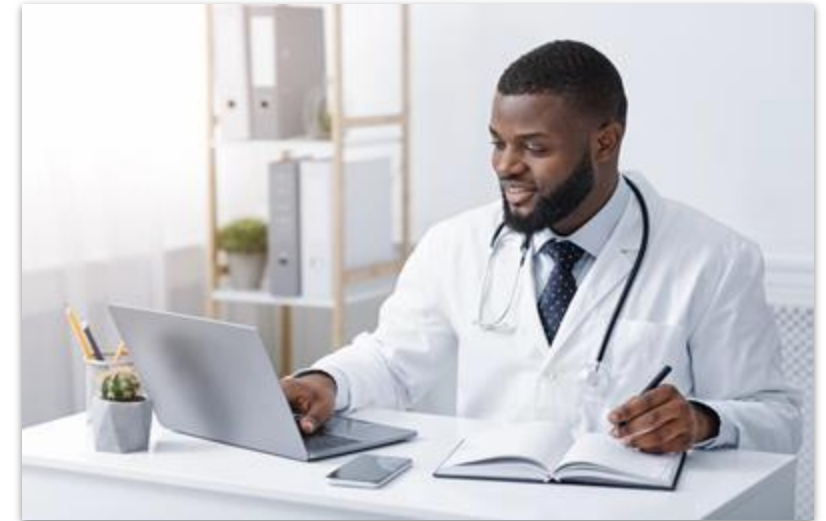
Medical Necessity Review

■ Requests will be reviewed using:

- Ohio Medicaid coverage rules (e.g., OAC 5160-27 series)
Medical Necessity Criteria (MNC) for BH rehabilitative services
- Treatment-plan alignment, progress indicators, and clinical justification

■ Documentation typically required:

- Updated treatment plan with measurable goals
- Rationale for service intensity (e.g., functional impairment, safety risk, acute phase of treatment)
- Evidence of progress or need for continued intensive intervention



Steps for Denial Resolution

- **Review Denial Notices**
 - Providers should carefully review denial notices to identify missing documentation or unmet criteria promptly.
- **Submit Corrected Appeals**
 - Appeals must include corrected or additional information showing compliance with medical necessity and coverage requirements.
- **Timely Submission**
 - Submitting appeals within designated time frames is critical to ensure consideration and resolution of claims.
- **Provider Support**
 - Buckeye offers resources and guidance to help providers navigate the appeals process and prevent future denials.

 buckeye
health plan.
4349 Easton Way
Suite 120
Columbus, OH 43219

Dear <<Provider Name>>,

Buckeye Health Plan has reviewed the clinical information provided for the above-named member. The service authorization request did not meet the medical necessary criteria referenced below. Therefore, the request has been [MANDATORY User Notes 03 "ENTER APPLICABLE ACTION: service denied; service suspended, reduced or Terminated; Denial, in whole or part, of payment for a non-covered service"].

Based on the clinical notes provided, Buckeye Health Plan is unable to approve the request for [MANDATORY User Notes 04 "ENTER THE SERVICE REQUESTED"] received on [MANDATORY User Notes 05 "ENTER THE DATE THE REQUEST WAS RECEIVED"]. [MANDATORY User Notes 06 "ENTER DENIAL RATIONALE AND DATE THE SERVICE IS DENIED BEGINNING (IF APPLICABLE TO THE REQUEST TYPE)"]. [MANDATORY User Notes 07 "ENTER THE RULE/CRITERIA USED TO COMPLETE THE REVIEW"].

If you don't agree with this decision, you can ask for a peer-to-peer review or ask for a formal provider service authorization appeal by taking the following steps.

1. You can ask for a Peer-to-Peer Review

The treating provider can request a Peer-to-Peer Review with the physician reviewer within five (5) business days of the date on this letter. The actual peer-to-peer discussion may take place after this period. Please note we recognize business days as Monday through Friday 8-5 p.m. The MCO medical professional conducting the peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines. To make the request: Please call our Peer to Peer Coordinator at 866-246-4356 ext. 24084 or you may also send a secure email to: Buckeye_peer_to_peer_notification@CENTENE.COM. You will receive an automatic response with a form to be completed to request the Peer to Peer conversation.

2. You can ask for a Provider Service Authorization Appeal

The appeal shall be between the health care provider requesting the service in question and a clinical peer designated by the MCO. A Service Authorization Appeal can be submitted within 60 calendar days of the date on this letter. Appeal Requests can be sent in writing to: Appeals and Grievance Department Buckeye Health Plan 4349 Easton Way,

1-866-246-4358 (TTY: 711)
BHP- Medicaid 12102024

BuckeyeHealthPlan.com

Buckeye Key Information Highlights

Buckeye's **Provider Home Page**

(buckeyehealthplan.com/providers.html) provides links to key resources, provider updates, communications, and trainings.

Provider Resources are located via the left hand side of the **Provider Home Page**.

- **Provider Manuals** buckeyehealthplan.com/providers/resources/forms-resources.html
- **Provider Bulletin** buckeyehealthplan.com/providers/provider-communications/provider-update-newsletter.html
- **Provider Training and Education** buckeyehealthplan.com/providers/training-and-education.html
- **Buckeye Pre-Auth Check tool** buckeyehealthplan.com/providers/prior-authorization/preauth-check.html

Provider Services Support:

Medicaid

Monday - Friday 7 a.m. to 8 p.m.
[866-296-8731](tel:866-296-8731)

WellCare by Buckeye Health Plan / Next Generation MyCare Program

Monday-Friday 8 a.m. to 8 p.m. EST
[833-998-4892](tel:833-998-4892)

Buckeye Contract Coordination:

Ohiocontracting@centene.com

Contract Negotiators:

OHNegotiators@centene.com

Contact Us



Our helpful Provider Services representatives are available to take your call at **866-296-8731** Monday through Friday from 7 a.m. to 8 p.m.



Send a secure message on our portal:

1. **Log in to the portal** (buckeyehealthplan.com/providers.html)
2. Select “Message” from the top banner.
3. Complete your message. Allow 3 to 5 business days for a reply.



BEHAVIORAL HEALTH SERVICE THRESHOLDS FOR UTILIZATION MANAGEMENT

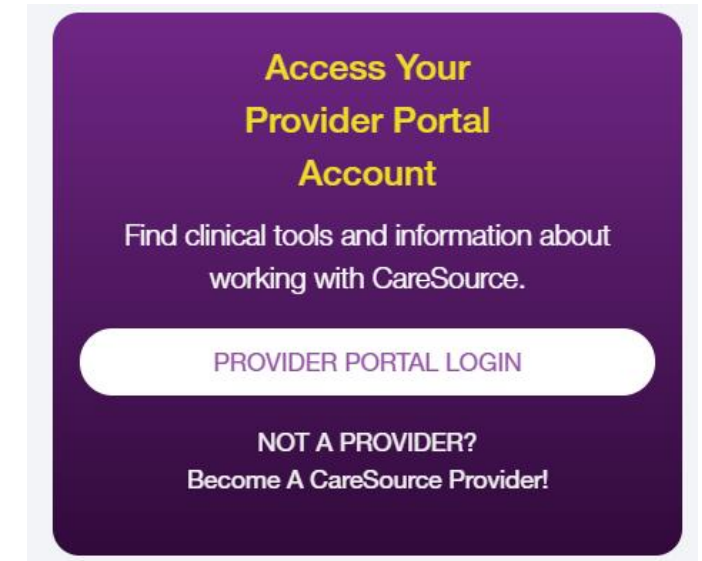
Julie Carlson, LMHC, LMSW, CADC, Senior Director, Utilization Management – Behavioral Health

June 4, 2026

CareSource Provider Portal

A user-friendly platform giving you access to essential information and tools whenever you need. Our portal offers you the ability to:

- ✓ Verify member eligibility and access member service utilization
- ✓ Submit prior authorization requests
- ✓ Connect with Member's assigned Case Manager via contact information
- ✓ Submit claims, check the status of a claim, correct and resubmit claims with ease
- ✓ File a claim dispute or appeal if you disagree with an adverse claim determination
- ✓ Explore comprehensive training resources
- ✓ And much more to streamline your workflow and enhance your productivity

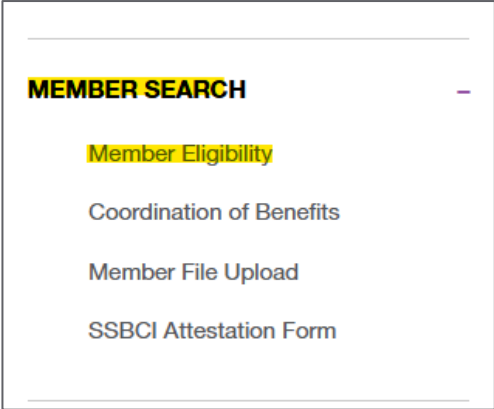


To access multiple provider portal user trainings, log in to the portal and navigate to Users >Provider Training > Using the Provider Portal.

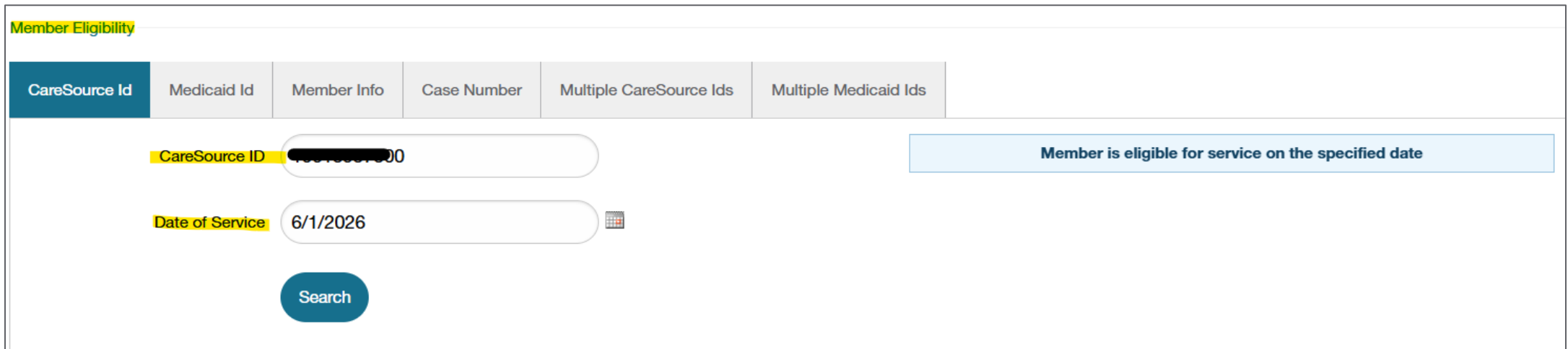


CareSource Provider Portal

To view utilization in the portal, log in and navigate to *Member Search* on the left-hand menu. Click *Member Eligibility*:



Enter Search Criteria (CS ID, Medicaid ID, Member Info, etc). Click *Search*:

A screenshot of the "Member Eligibility" search form. At the top, there is a tab labeled "Member Eligibility". Below the tab is a navigation bar with six tabs: "CareSource Id", "Medicaid Id", "Member Info", "Case Number", "Multiple CareSource Ids", and "Multiple Medicaid Ids". The "CareSource Id" tab is selected. The form contains two input fields: "CareSource ID" with the value "4887888780" and "Date of Service" with the value "6/1/2026". A "Search" button is located below the input fields. A blue notification box on the right side of the form displays the message: "Member is eligible for service on the specified date".

CareSource Provider Portal

Scroll down to and expand the section titled *Member Covered Benefits Summary*:

Member Information	+
Subscriber Information	+
Member Covered Benefits Summary	+

New soft limits will be captured in this section (will be available following 7/1/2026 go live)

Prior Authorization Required after remaining used:

Behavioral Health Service - Outpatient Mentalhealth	1/1 Units Remaining	Behavioral Health Services/OP/PA Y	48/48 Units Remaining
Disposable Canister For Pump	3/3 Units Remaining	DME Diabetic Supplies Outpatient Limits	4/4 Units Remaining
Durable Medical Equipment - PA Required	4/4 Units Remaining	DURABLE MEDICAL EQUIPMENT UV THERAPY/OFFICE/PROF	1/1 Units Remaining
DURABLE MEDICAL EQUIPMENT UV THERAPY/OUTPATIENT/PROF	1/1 Units Remaining	Enteral Nutrition Formula - Children	72/72 Units Remaining
Home Health Care	4/4 Units Remaining	Injections - Outpatient Service	12/12 Units Remaining
Laboratory Services	30/30 Units Remaining	MAMMOGRAPHY-DIAGNOSTIC/OP/FAC	1/1 Units Remaining
Maternity Cesarean Delivery/IP/PROF/FAC	6/6 Days w/o Prior Auth Remaining	Maternity Vaginal Delivery/IP/FAC	4/4 Days w/o Prior Auth Remaining
OBSERVATION ROOM/OTPT/FAC/3 DAY MAX	72/72 Units Remaining	Orthopedic Footwear, Ladies Shoes, Oxford	2/2 Units Remaining
Patient Lift Bathroom Or Toi	1/1 Units Remaining	Qualitative (Presumptive) Services	30/30 Units Remaining
QUALITATIVE(PRESUMPTIVE) SERVICES/OP/FAC	30/30 Units Remaining	QUANTITATIVE(CONFIRMATORY) SERVICES/OP/FAC/PROF	12/12 Days Remaining
Radiology Chiropractic Services - 1	2/2 Units Remaining	Radiology Services - Interpretations, Facility Outpatient Only	2/2 Units Remaining
TENS 2 OR 4 LEAD MOD NU NR/OP/FAC	1/1 Units Remaining	TENS 2 OR 4 LEAD MOD NU NR/OP/FAC/PA N	1/1 Units Remaining



Authorization Form Submission

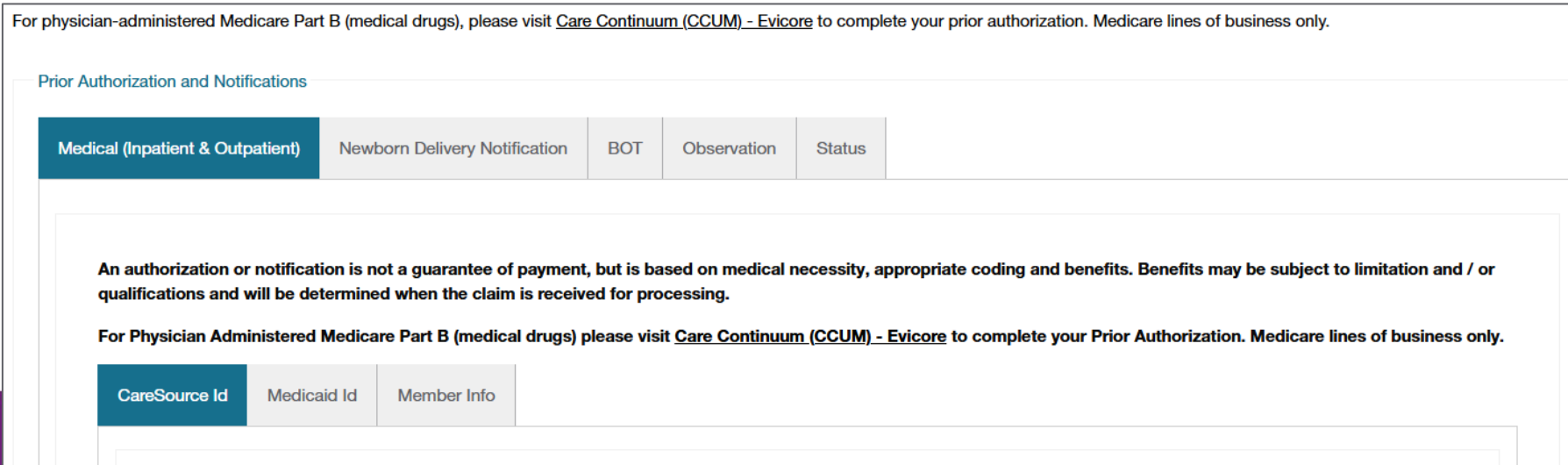
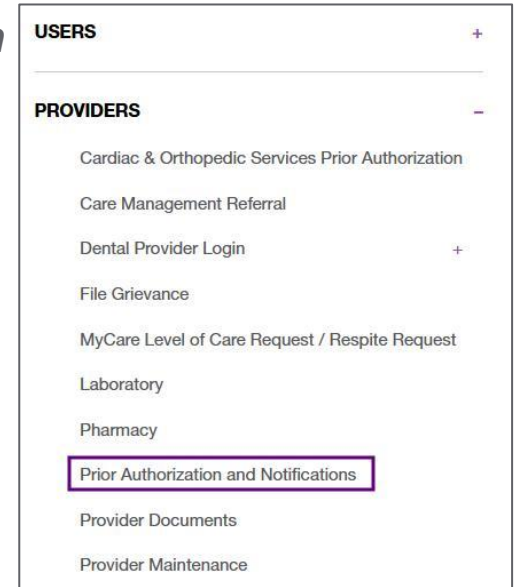
Method	Contact Info
<u>Provider Portal (Preferred)</u>	If you need assistance with submitting your prior authorization or have questions regarding submissions via the Provider Portal, please email CiteAutoAssistance@caresource.com and a representative will be in contact. This email is only for assistance and questions regarding prior authorizations within the Provider Portal.
Phone	1-800-488-0134
Fax	1-888-752-0012
Mail	CareSource P.O. Box 1307 Dayton, OH 45401-13



CareSource Provider Portal – Authorization Submission

To submit an Auth request in the portal, log in and navigate to *Prior Authorization and Notifications* on the left-hand navigation panel, located under *Providers tab*:

Scroll to the bottom of the page after clicking the link.
Input Member information, verifying member/eligibility
and proceed with Auth request.



Suggested Clinical to Submit with Prior Authorization Requests

Non-SUD Requests

- Comprehensive clinical assessment (≤ 12 months)
- Functional impairment documentation (tools optional, such as the WHODAS 2.0, OHIO Scales)
- Treatment plan with goals, interventions, barriers
- Recent progress notes (≈ 30 days)



Suggested Clinical to Submit with Prior Authorization Requests

IOP Requests

- Submit updated ASAM Dimensions (must be at least updated within the last 14 days)
- Treatment plan with goals, interventions, barriers
- Recent progress notes (\approx 30 days)
- Discharge plan



Prior Authorization Requests

Acute Detox - Typical initial request: up to 3 days

Intensive Outpatient Program (IOP) - Typical initial request: up to 6 units

TBS (Per Diem) - Typical initial request: up to 30 units for 90 days

TBS (15-minute units) - Typical initial request: up to 90 units for 90 days

CPST – Individual - Typical initial request: up to 200 units for 90 days

CPST – Group - Typical initial request: up to 90 units for 90 days

PSR (PCR) - Typical initial request: up to 90 units for 90 days

These are guidance ranges, not limits.

Providers should request what is clinically appropriate for the member, even if outside these ranges.

Requests above or below these ranges may be appropriate based on clinical need.

All requests are reviewed based on:

- Medical necessity (OAC 5160-1-01)
- Individualized treatment planning



Medical Necessity

All requests are reviewed based on:

- Ohio Medicaid requirements (OAC 5160-1-01)
- Clinical appropriateness (type, frequency, duration, setting)
- Member-specific needs and expected outcomes
- Individualized treatment planning
- Lowest cost-effective level of care

*Provider order alone does not guarantee approval or payment



Appeals Process

Peer-to-Peer Process

CareSource provides the opportunity to discuss UM medical necessity denials or decrease in level of care with CareSource's Medical Director/Behavioral Health Medical Director or designee within five business days of notification. This peer-to-peer review is independent of the appeal process and does not impact the appeal timeframe.

To initiate the peer-to-peer process, please call CareSource's UM team at 1-833-230-2168.

Clinical Appeals

After receiving a letter from CareSource denying coverage, you may can submit a pre-service clinical appeal or post-service clinical dispute.

- **Pre-Service Appeal:** denial of an authorization for a service prior to being completed. You have 60 days from the date of the authorization denial to submit a pre-service appeal.
- **Post-Service Clinical Dispute:** denial of an authorization for a completed service. You have 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely submission, whichever is later.



How to Submit Appeals

The most efficient way to submit appeals is through our Provider Portal.

Other options include submittal of a Standard Appeal Form or an Expedited Appeal Form.

Include the following required documentation:

- Progress notes including symptoms and their duration, physical exam findings, conservative treatment that the member has completed, preliminary procedures already completed and the reason service is being requested.
- Any documentation of specialists' reports or evaluations, any pertinent previous diagnostic reports and therapy notes.
- If the service has already been provided, a copy of the original remittance advice and/or the denied appeal/dispute.



How to Submit Appeals

Online: CareSource.com > Providers > Provider Portal Login > [Ohio](#)

Fax: 937-531-2398

Phone: 1-833-230-2101

Phone for Expedited Appeals: 1-800-488-0134

Mail:

CareSource
Attn: Grievance & Appeals Department
P.O. Box 2008 Dayton, OH 45401



Presented by:

Julie Carlson, LMHC, LMSW, CADC, Senior Director, Utilization Management – Behavioral Health

BEHAVIORAL HEALTH SERVICE THRESHOLDS FOR UTILIZATION MANAGEMENT

June 4, 2026

CARESOURCE.COM      

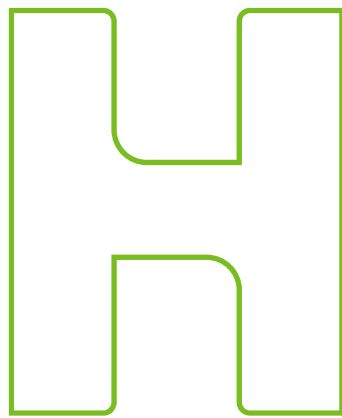
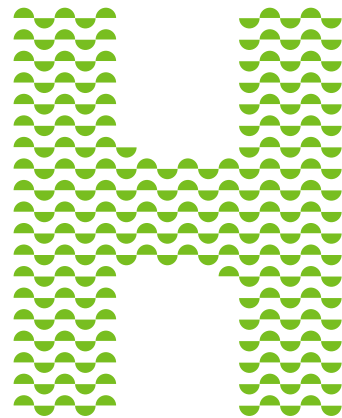


Humana

Healthy Horizons®
in Ohio

Behavioral Health Billing Policy Updates

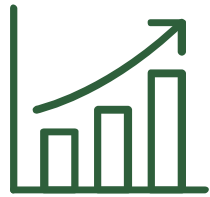
New Authorization Guidelines: Effective July 1, 2026



Humana Healthy Horizons in Ohio is a Medicaid Product of Humana Health Plan of Ohio, Inc.



Policy Overview and Purpose



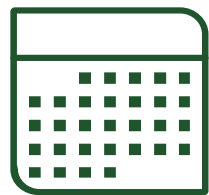
New Utilization Management Framework

- Introduces UM thresholds for select outpatient behavioral health services.
- Triggers medical necessity review at key points in treatment.



Care Delivery Impact

- Ensures continued access to behavioral health services.
- Strengthens appropriate, coordinated care.



Go-Live and Transition

- Go-Live: July 1, 2026.
- Ensures continued access to behavioral health services.



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

Clinical Thresholds



Key Exclusions: Crisis services (KX modifier), BH Nursing per OAC 5160-27-11 , OhioRISE enrollees and Children in Public Child Welfare custody (Mental Health services only).

Service	Code(s)	Authorization Threshold	UM Turnaround
Therapeutic Behavioral Service - Individual	H2019	200 units/50 hrs. combined TBS+PSR/yr, per member	7 days - Standard
Therapeutic Behavioral Service - Group	H2019 HQ	120 units/30 hrs. per yr, per member	7 days - Standard
Therapeutic Behavioral Service - MH Day Treatment (per diem)	H2020	After 30 units per yr, per member	7 days - Standard
Community Psychiatric Support Treatment - Individual	H0036	200 units/50 hrs. per yr, per member	7 days - Standard
Community Psychiatric Support Treatment - Group	H0036 HQ	120 units/30 hrs. per yr, per member	7 days - Standard
Psychosocial Rehabilitation Service	H2017	200 units/50 hrs. combined TBS+PSR/yr, per member	7 days - Standard
SUD Intensive Outpatient Program (IOP)	H0015	After 30 units per yr, per member	7 days - Standard
SUD Ambulatory Withdrawal Management	H0010 H0011 H0012 H0014	After 7th consecutive day	48 hours - Expedited

Authorization Form Submission



The full list of treatment services that require Prior Authorization (PA) can be found here: [Prior Authorization Resources | Ohio Medicaid for Providers | Humana](#)

Use the ODM Authorization Form

Complete the updated ODM MH/SUD Prior Authorization form; available on ODM's [Behavioral Health Manual, Rates, and Resources](#) page under Utilization Management.

Submit via Availity

Log in to [Availity](#). Navigate to Auth & Referrals → Authorization Requests. Attach documentation of evidence of Medical Necessity, including a completed ODM MH/SUD Prior Authorization form.

Preferred PA Submission Timelines

Submit at any time, but only once medical necessity requirements are met.

Expedited: Submit approx. 2 business days before reaching clinical threshold or current before auth is exhausted.

Standard: Submit approx. 7 business days before reaching clinical threshold or current before auth is exhausted.

PA Decision Timelines

Standard turnaround: 7 days for MH services and SUD IOP.

Expedited turnaround: 48-hours for Ambulatory Withdrawal Management.



Member Utilization and Provider Support

Humana Member Utilization Level Verification Inquiries

Individual member behavioral health benefit service utilization level verification inquiries can be attained by calling Humana's call center Monday - Friday 7 am - 8 pm Eastern Time at 877-856-5707 and select the dedicated prompt for immediate connection to Humana's call center team supporting behavioral health benefit service utilization level verification inquiries.

Please Note:

- Weekend/holiday inquiries will be handled on the next business day
- Utilization level information is based on claims received to date and may not reflect real-time utilization

Provider Support:

Jane Ellis

Manager, Consumer Service Operations

OHMedicaidProviderRelations@humana.com

John Nisky, PCC-S

Director, Behavioral Health Strategy

jnisky@humana.com

Stacy-Ann Samuels, RN, MBA

Associate Director, Provider Engagement

ssamuels7@humana.com

Medical Necessity Criteria


When authorization is required, Humana Healthy Horizons in Ohio leverages state & national regulations and standards like the Ohio Administrative Code and Milliman Care Guidelines (MCG) Health clinical guidelines.

[Home](#) / [Medicaid](#) / [Ohio Medicaid](#) / Clinical Coverage Policies

Behavioral and physical health clinical coverage policies adopted by Humana Healthy Horizons in Ohio

Clinical coverage policies are resources for physicians and other Humana-contracted healthcare professionals providing care to our members enrolled in Humana Healthy Horizons® in Ohio. Humana Healthy Horizons in Ohio has adopted the following behavioral and physical health clinical coverage policies.



When filing electronic Medicaid claims, please use Payer ID 61103 for your patients with coverage through Humana Healthy Horizons in Ohio. Please do not use Humana's traditional Payer ID for fee-for-service claims (61101) when submitting Humana Healthy Horizons in Ohio Medicaid claims. [Learn more about filing electronic claims](#) .



Helpful Links and Resources

- [Review our clinical coverage policies](#)
- [Network Notification](#)

Clinical criteria published on [ODM's website](#) via Plan Authorization Lists (PAL) and individual UM policy pages prior to 7/1/2026

Appeals Process for Authorization Denials

Denial Issued	Provider or member receives written notice of denial with specific clinical rationale and appeal rights.
Request an Appeal	Submit a written appeal within 60 calendar days of the denial notice. Appeals may be submitted via Availity , fax, or mail.
Clinical Review	A licensed clinician not involved in the original decision conducts an independent clinical review of all submitted documentation.
Decision Issued	Standard appeal decision: within 30 days. Expedited appeal (if urgent): within 72 hours. Written notice provided with outcome and rationale.
External Review	If appeal is denied, providers and members have the right to request an independent external review through the State of Ohio.



[Learn about Availity](#)

Payment Integrity Operating Model

Datamining	Medical Records
<p>CCRO Query Development Team develops general overpayment audits on adjudicated claims that are supported by Medicare, Medicaid, or Humana policies and regulations. In addition to internal systems and process errors.</p>	<p>The Medical Record New Concepts team helps identify savings opportunities by researching and validating requests for clinical review to determine viability for new audit or audit expansion.</p>
<p>Opportunities Include, but not limited to:</p> <ul style="list-style-type: none"> • COB payment accuracy • Duplicate billing, excessive units • Incorrect coding e.g., inaccurate code selection • Prior authorization • Pricing updates • Upcoding • Unbundling of services 	<p>Opportunities Include, but not limited to:</p> <p><u>Coding Integrity (certified coders)</u> perform comprehensive coding reviews to identify:</p> <ul style="list-style-type: none"> • Coding not supported • Unit Errors • Upcoding • Services not rendered <p><u>Clinical/Medical necessity (Licensed Clinical Reviewers)</u> conduct clinical and medical necessity reviews to evaluate:</p> <ul style="list-style-type: none"> • Behavioral health services <ul style="list-style-type: none"> • Level of care • Duration • Intensity of services • Hospital billing accuracy • Skilled nursing services • Experimental/Investigational

Payment Integrity Operating Model (cont.)

FRAUD ANALYTICS	SPECIAL INVESTIGATIONS UNIT
<p>The Fraud, Research, Analytics & Concepts Team, (FRAC) primary focus is to identify potential fraud, waste, and abuse (FWA) in the areas of pharmacy, medical and dental.</p>	<p>SIU is responsible for the prevention, detection and investigation of insurance fraud, waste and abuse (FWA) for all of Humana's lines of business.</p>
<p>Opportunities Include, but not limited to:</p> <ul style="list-style-type: none">• Identify Outlier/anomalous behavior by provider compared to their own billing history and peers• Impossible days – Providers billing for more services than possible during operating hours• Cookie cutter style billing – Providers continuously billing the same CPT and DX code at a high rate• New non-par providers – Identify potential phantom providers billing for services not rendered• Off label prescribing – Identifying providers prescribing prescriptions drugs for conditions other than intended use	<p>Indicators of Potential FWA:</p> <ul style="list-style-type: none">• Billing for Services Not Provided or Rendered: Charging for services/procedures that were never performed• Unbundling: Separately billing for components that should be billed as a single charge• Medically Unnecessary Services: Providing/ billing for services that aren't medically necessary• Kickbacks and Bribes: Accepting or offering incentives for patient referrals or ordering specific tests• Falsifying Diagnoses or Alteration(s) of Claims

Ensuring Continuity of Care for our Members



Care Management Services

Members engaged with Humana's [Complex Care Management Services](#) team will receive additional support throughout the medical necessity review and prior authorization process. Providers can contact Humana Healthy Horizons to refer members needing care management assistance:

Call: 877-856-5702

Email:

- Complex care management: OHMCDCareManagement@humana.com
- Chronic condition management behavioral health: OHMCDCareManagement_BH@humana.com
- HumanaBeginnings prenatal: OHMCDCareManagement@humana.com
- SDOH needs and short-term member coordination/scheduling support: OHMCDSDOH@humana.com

Member care plans and Health Risk Assessments (HRAs) are viewable, with member consent, via [Availity Essentials](#).



90-Day Minimum Authorization

For BH Rehabilitation services, Humana will issue authorizations for a minimum duration of 90 days, preventing frequent re-authorization burden on providers.



Collaborative Transition Support

Humana will partner with ODM and BH provider associations throughout implementation to provide education, tools, and direct support to minimize disruption.

Questions? We're here to help.



Provider Relations Email:

OHMedicaidProviderRelations@humana.com



Provider Services Phone Number:

[877-856-5707](tel:877-856-5707)

Jane Ellis
Manager, Consumer Service Operations
OHMedicaidProviderRelations@humana.com

John Nisky, PCC-S
Director, Behavioral Health Strategy
JNisky@humana.com

Stacy-Ann Samuels
Associate Director, Provider Engagement
Ssamuels7@humana.com

Humana

Healthy Horizons®
in Ohio

Provider Update

Community Behavioral Health and SUD Services

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)

Prior Authorization Request

Health Care Professionals

Need a Prior Authorization?

[Code LookUp Tool](#)

[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.

- ❑ When services are approved, Molina will authorize for a duration of 90 days.

- ✓ Authorization is valid until the service limit is exhausted or the authorized period expires.

Continuation of Services: Expedited: Submission must be received at least 2 days prior
Standard requests must be received at least 7 days prior



Thresholds & Billing

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

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.

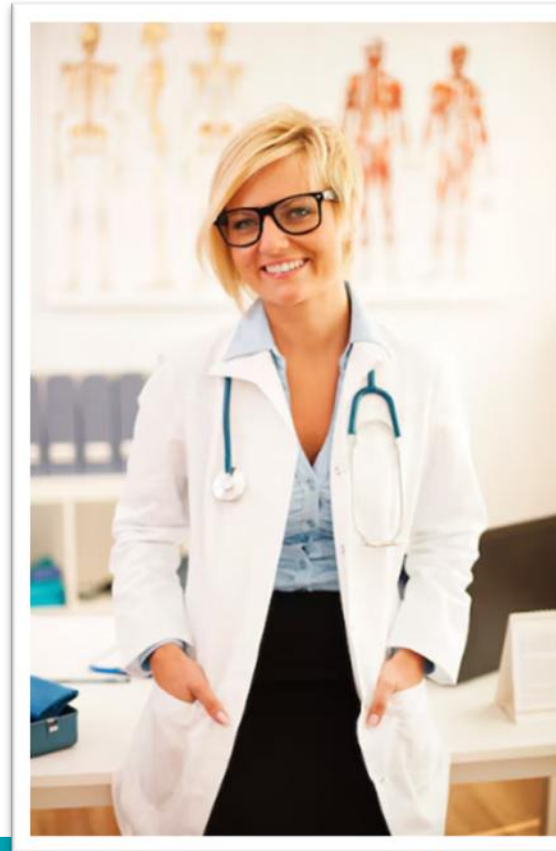
Contact Molina

** 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”



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](#)

Optum



UnitedHealthcare
Community Plan

Outpatient Care Engagement

OH C&S

Optum with UnitedHealthcare Community
Plan Ohio



What is Outpatient Care Engagement?

- This program engages in utilization management using claims analysis to identify cases for which treatment intensity is higher than average. Members with higher treatment intensity often have more complex clinical needs.
- The purpose of OCE-UM processes is to ensure that covered members are receiving the most effective, efficient, and necessary care to meet the member's individual needs.
- The goal of the OCE-UM program is to facilitate a discussion between Optum and the treating provider for those cases outside the typical range of utilization.
- OCE decreases provider administrative burden by removing the need to track service counts. We will track for the provider, and we call the provider when thresholds are reached and it is time for a medical necessity review.
- When Outpatient Care Engagement identifies a case as having high or frequent utilization, a licensed clinician will call the treating provider to initiate a clinical case discussion. These discussions are designed to be collaborative, with the purpose of ensuring that the member is receiving evidence based and medically necessary treatment.
- In situations where treatment does not appear to meet the Optum Clinical Criteria, Optum staff will schedule a conversation between the treating provider and an Optum licensed peer reviewer.
- Based on member clinical needs and Optum Clinical Criteria, the peer review discussion may result in continued payment of services or in a partial or full denial of further routine outpatient treatment.

Outpatient Management

The Process:

For community-based services, outpatient analytics enable targeted interventions at the case level.



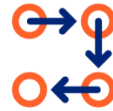
Inputs

Claims Data



Analysis

Outpatient analytics identify cases for targeted intervention



Actions

- Outreach to provider to ensure evidenced based practice
- Clinician to clinician telephonic review
- Ensure care meeting clinical guidelines



Results

- Improved clinical outcomes
- Improved clinical systems

Outreach to Providers



An Ohio dedicated care advocate will conduct all outreaches to providers



For larger provider groups, a dedicated email address can be provided for care advocate outreach



An Optum team member outreach will be made to contact the provider per case two attempts with one week separating each attempt



If no response has occurred after 5 business days from the 2nd call, the case will be referred to the peer review process



If services are deemed to be not medically necessary, either in part or in whole, the provider will be notified both verbally (at the time of the decision), and in writing. The letter will be sent to the Mailing Address loaded in our source of truth provider data system. The member will also be notified in writing of this decision.



Payment of claims will continue while medical necessity review is taking place and until a determination has been made.

Outpatient Review: Key Components

Clinical Status of the Member

- ❑ Diagnosis
- ❑ Symptoms that support the diagnosis
- ❑ Degree of impairment that results from the symptoms
- ❑ Existence of risk issues
- ❑ Environmental Stressor
- ❑ Medical co-morbidity

Appropriateness of Treatment

- ❑ Length of treatment
- ❑ Frequency of sessions
- ❑ Type of therapy/treatment approach
- ❑ Nature of treatment goals
- ❑ Appropriateness of treatment goals for the stage of treatment
- ❑ Special Interventions used to achieve the treatment goals
- ❑ Incorporation of adjunctive treatments into the treatment plan
- ❑ Progress made in treatment
- ❑ Obstacles to progress
- ❑ Projected future course of treatment

Outpatient Care Engagement and other UM issues

- Most services of enhanced UM will go through OCE: TBS individual and group, CPST individual and group, PSR, IOP
- Withdrawal Management (H0010-H0014) will go through the UM team that currently services PHP, SUD Residential, and BH Inpatient, using a more traditional approach of requiring submission of SUD PA form at 7 days of the stay.
 - Submission process: Withdrawal Management follows standard UM pathways: These services are not managed through OCE and instead follow the existing utilization management process used for PHP, SUD Residential, and BH Inpatient services. Providers are required to submit a prior authorization request using the ODM SUD PA form once the 7-day threshold is reached, consistent with established UM workflows.
 - Submission process remains unchanged for providers: Authorization requests are submitted through Provider Express using the appropriate ODM SUD or BH prior authorization forms, which outline medical necessity criteria and required clinical documentation for review and determination. Aside from updated ODM thresholds, forms, and criteria, the overall submission and review process remains consistent with current practice.
- Looking up total units: because UHC will be tracking units for providers, we expect that demand for provider to check total current billed claims in our system will possibly be lower. None the less, we will have adequate staff available on our provider service and chat lines to assist with these inquires to those who desire, and we are working on a self-service portal to look up units that we hope to have live by July 1st.

Outpatient Care Engagement and other UM issues

- Appeals process is consistent across all UM determinations: Regardless of whether a service is managed through OCE or another UM program, the appeals process remains unchanged and is administered in accordance with OAC 5160-26-08.3 and 5160-26-08.4, with all required timelines upheld to regulatory standards.
- Standardized notification and rights: All providers and members receive an adverse determination notice that includes clear instructions on how to file an appeal and request a peer-to-peer review; all appeal and review timeframes meet required state and federal standards, and peer-to-peer discussions do not replace the formal appeal process or extend appeal filing deadlines.
- Compliance and Program Integrity/Audits:
 - Practice Management: Reviews high-level service delivery and documentation for potential improvements and compliance issues
 - Provider Performance: More in-depth review of providers who show outlier billing patterns
 - Provider Network Integrity (PNI): Reviews tips around possible fraud/waste/abuse in conjunction with state MFCU/ODM
 - Additional OCE collaborative/voluntary activates: Reaches out to engage with providers on a voluntary basis for outlier members in a variety of codes. Problem solves collaboratively with providers on engaging members with the most effective service.

THANK YOU

medicaid.ohio.gov