



REIMBURSEMENT POLICY STATEMENT

Ohio MyCare

Policy Name & Number	Date Effective
Community Behavioral Health Services Utilization Management-MyCare OH FIDE-PY-1816	07/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Community Behavioral Health Services Utilization Management

B. Background

To promote the delivery of clinically appropriate and medically necessary Medicaid-funded substance use disorder (SUD) and community behavioral health (BH) services, the Ohio Department of Medicaid (ODM) has determined new service thresholds upon which an authorization requesting to exceed these limits can be required from the provider. This measure is to ensure that Medicaid-funded services are supported by an individualized assessment that accurately summarizes the clinical presentation and presenting treatment needs. This also ensures the requested services are appropriately captured in the treatment plan to illustrate how the service will support progress toward the individualized treatment goals.

C. Definitions

- **Community Behavioral Health Rehabilitative Services** – Services under this description include
 - Therapeutic Behavioral Service, Individual (H2019) and Group (H2019 HQ)
 - Therapeutic Behavioral Service Day Treatment, Per Diem (H2020)
 - Community Psychiatric Support Treatment, Individual (H0036) and Group (H0036 HQ)
 - Psychosocial Rehabilitation Service (H2017)
- **Non-Network or Non-Participating Provider** – Any provider, group of providers or entity eligible as providers according to Ohio Administrative Code (OAC) 5160-1-17 but without a CareSource provider contract to provide covered services to members.

D. Policy

- I. CareSource can opt to apply service thresholds to designated community behavioral health services no more stringently than what is included in the table in D.III. When CareSource implements service authorizations for a community behavioral health service that does not reflect current authorization requirements found in OAC Chapter 5160-27 or the applicable Provider Agreement, the following applies:
 - A. The service authorization forms for SUD and Community Behavioral Health Centers (CBHC), to be updated for July 1, 2026, available on ODM's website will be accepted as a valid authorization request.
 - B. For CareSource Ohio MyCare, providers submit authorization requests and track authorization status through the secure CareSource Provider Portal (providerportal.caresource.com).
 1. Providers may also reference the CareSource public provider pages for Ohio for current prior authorization requirements, forms, and submission instructions (CareSource.com > Ohio > Medicaid/MyCare, as applicable > Providers > Provider Resources > Prior Authorization).
 2. Determinations (approval, partial approval, or denial) are communicated through plan-issued written determination notices and reflected in the Provider Portal authorization status view.

3. For appeals, providers should follow the CareSource Ohio provider appeals guidance (CareSource.com > Ohio > Medicaid/MyCare, as applicable > Providers > Provider Resources > provider Disputes and Appeals), including required submission methods and timeframes.
 - C. CareSource ensures accurate system configuration to enforce the limits before implementing authorization for a service. Retroactive recoupments are prohibited if a service was paid in error due to CareSource not having properly configured its system to enforce the limit.
- II. Recipient Level Utilization Verification
- Upon request by a CBHC provider, CareSource will provide a member’s utilization to date if a service authorization is required. Member utilization will be available within the CareSource Provider Portal by navigating to www.caresource.com – Providers/Provider Portal Login. This information is based on claims received to date and may **not** reflect accurate real-time utilization.
- A. A designated and reliable point of contact for the provider to access this information will be made available.
 - B. The CBHC providers are responsible for keeping track of service delivery for each member to ensure services rendered do not exceed the authorized threshold. If the member is simultaneously receiving the same service from more than 1 provider, the providers will need to coordinate care to prevent service duplication and reduce risk of prematurely exhausting authorized hours.
 - C. It is recommended that providers routinely check in with members to inquire whether the member is receiving CBHC services elsewhere.
- III. Providers should refer to CareSource’s Procedure Code Lookup Tool, any published network notifications at www.caresource.com and the annual *Prior Authorization List* in the Provider Portal. These resources will provide the most current information on any service limits required prior to medical necessity review. The following services and associated limits apply per member per calendar year (CY) or per member per day before a review of medical necessity is required:

Service Code	Service Name	Service Threshold for Required PA	Expected Turnaround Time
H0010	Clinically Managed Withdrawal Management ASAM 3.2 WM	after 7 th consecutive day	48 hours
H0011	Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	after 7 th consecutive day	48 hours
H0012 H0014	Withdrawal Management ASAM 2 WM (Per Diem/Hourly)	after 7 th consecutive day	48 hours
H0015	SUD Intensive Outpatient Program	30 units per CY	7 days
H0036	Community Psychiatric Supportive Treatment (CPST)- Ind	200 units (50 hours) per CY	7 days
H0036 HQ	Community Psychiatric Supportive Treatment (CPST)- Group	120 units (30 hours) per CY	7 days



H2017 H2019	Psychosocial Rehabilitation Services (PSR) Therapeutic Behavioral Services (TBS)- Ind	200 units (50 hours) combined TBS and/or PSR per CY	7 days
H2019 HQ	Therapeutic Behavioral Service (TBS)- Group	120 units (30 hours) per CY	7 days
H2020	Therapeutic Behavioral Service Day Treatment, Per Diem	30 units per CY	7 days

E. Conditions of Coverage

- I. Providers must follow OAC 5160-1-31 regarding submission requirements for authorization forms.
- II. Providers must adhere to the following authorization request submission timelines to ensure a determination is made prior to the expiration or exhaustion of the current authorization:
 - A. Expedited: Submission must be received at least 2 days prior.
 - B. Standard: Submission must be received at least 7 days prior.
- III. Services rendered with the KX crisis modifier are excluded from service thresholds.
- IV. Behavioral health nursing services rendered in accordance with OAC 5160-27-11 are excluded from service thresholds.
- V. Due to the chronic nature of severe and persistent mental illness and the vulnerability of many requiring reliable access to support, the following applies to BH rehabilitation services:
 - A. The coverage period for approved service is a minimum of 90 days unless a shorter duration is requested by the provider.
 - B. The PA is valid until the approved service limit is exhausted or when the authorization period has expired.
 - C. Children and youth in custody of a public child welfare agency or enrolled in the OhioRISE plan are excluded from PA requirements for BH rehabilitation services.

F. Related Policies/Rules

Behavioral Health Service Record Documentation Standards
Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	05/20/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	07/01/2026	
Date Archived		

H. References

1. Community Behavioral Health Agency Services, OHIO ADMIN. CODE 5160-27-01 to 14 (2024).
2. Coverage and Authorization of Services, 42 C.F.R. § 438.210 (2024).
3. Managed Care: Definitions, OHIO ADMIN. CODE 5160-26-01 (2022).
4. Medicaid and CHIP Payment and Access Commission. Advising Congress on Medicaid and CHIP Policy. MACPAC; 2024. Accessed May 4, 2026.
www.macpac.gov
5. *Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual*. Ohio Dept of Medicaid. Accessed May 12, 2026.
www.medicaid.ohio.gov
6. Practice Guidelines, 42 C.F.R. § 438.236 (2024).
7. Prior Authorization, OHIO ADMIN. CODE 5160-1-31 (2024).
8. Requirements and Procedures for Behavioral Health Services, OHIO ADMIN. CODE 5122-29-01 to 31 (2023).
9. Sufficiency of Amount, Scope and Duration, 42 C.F.R. §§ 440.230 (2024).

Ohio Department of Medicaid approved May 28, 2026.