

# Community Behavioral Health Services Utilization Management Policy Statement (for Ohio Only)

**Policy Number:** CSBH100OH.A  
**Effective Date:** 07/01/2026

[Instructions for Use](#)

<b>Table of Contents</b>	<b>Page</b>
<a href="#">Application</a> .....	1
<a href="#">Coverage Rationale</a> .....	1
<a href="#">Definitions</a> .....	2
<a href="#">Policy</a> .....	2
<a href="#">Table A-1: New Services Subject to Utilization Management</a>	5
<a href="#">Conditions of Coverage</a> .....	6
<a href="#">Medical Records Documentation Used for Reviews</a> .....	6
<a href="#">Applicable Codes</a> .....	6
<a href="#">U.S. Food and Drug Administration (FDA)</a> .....	7
<a href="#">References</a> .....	7
<a href="#">Policy History/Revision Information</a> .....	8
<a href="#">Instructions for Use</a> .....	8

<b>Related Policies</b>
None

## Application

<b>COMMUNITY BEHAVIORAL HEALTH SERVICES UTILIZATION MANAGEMENT POLICY STATEMENT Ohio Medicaid</b>	
<b>Policy Name &amp; Number</b>	<b>Date Effective</b>
<b>CSBH100OH.A</b>	<b>7/1/2026</b>

This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

## Coverage Rationale

### Community Behavioral Health Services Ohio Medicaid

**A. Subject**

New Utilization Management for Community Behavioral Health Services

**B. Background**

To promote the delivery of clinically appropriate and medically necessary Medicaid-funded substance use disorder and community behavioral health 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 (see Table A-1). 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.

## Definitions

### C. Definitions

- Community Behavioral Health rehabilitative services – services that fall under this description include:
  - a. Therapeutic Behavioral Service, individual (H2019) & unit-based group (H2019 HQ)
  - b. Community Psychiatric Support Treatment, individual (H0036) & group (H0036 HQ)
  - c. Psychosocial Rehabilitation Service (H2017)

## Policy

### D. Policy

1. The Next Generation Medicaid and Next Generation MyCare Ohio plans can opt to apply service thresholds to designated community behavioral health services, but no more stringent than what ODM has included in Table A-1. When a Next Generation Medicaid or Next Generation MyCare Ohio plan decides to implement 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 conditions apply:
  - a. The service authorization forms for Substance Use Disorder (SUD) and Community Behavioral Health Centers (CBHC) (to be updated for July 1, 2026) available on ODM's website must be accepted as a valid authorization request
  - b. **Service Authorization Process**
    1. **Submission**
      - a. Providers must submit prior authorization requests using the Ohio Department of Medicaid (ODM) required Substance Use Disorder (SUD) and Community Behavioral Health Center (CBHC) authorization request forms, as applicable.
      - b. Authorization requests must be submitted through the Optum Provider Express Portal or other designated submission channels outlined in the Care Provider Manual. Requests must include all required clinical documentation, including the most recent assessment and individualized treatment plan, and be submitted with sufficient time to allow for a determination prior to rendering services requiring authorization.
    2. **Review and Approval**
      - a. Authorization requests will be reviewed in accordance with applicable Ohio Administrative Code (including OAC 5160-1-01 and 5160-26-03.1), ODM guidelines, and the UnitedHealthcare Community Plan (the Plan) provider agreement. Medical necessity determinations will be based on Ohio Administrative Code 5160-1-01 through clinical documentation submitted, the individualized treatment plan, and established criteria, including the American Society of Addiction Medicine (ASAM) Criteria, when applicable. Determinations will be made within ODM-required timeframes for standard and expedited requests. Approved authorizations will specify the number of units and duration of services, with a minimum authorization period of ninety (90) days for applicable behavioral health rehabilitation services, unless a shorter duration is requested by the provider.
      - b. All prior authorization determinations will comply with applicable state and federal timeliness requirements, including those set forth in OAC Chapter 5160-26 and 42 CFR 438.210, and will not exceed maximum allowable timeframes for standard and expedited requests
    3. **Denial**
      - a. If an authorization request does not meet medical necessity criteria or is incomplete, UnitedHealthcare Community Plan may deny the request or request additional information. Providers will be notified of the determination in accordance with Ohio Department of Medicaid (ODM) requirements and applicable provisions of the Ohio Administrative Code (OAC), including OAC

Chapter 5160-26 governing utilization management and prior authorization requirements. Denial notices will include the specific reason for the determination, applicable regulatory references, and instructions for next steps, including information regarding the provider's and member's appeal rights.

4. Appeals

- a. Providers and/or members may appeal adverse determinations, including denials, reductions, or terminations of services, in accordance with ODM requirements and OAC 5160-26-08.3 through 5160-26-08.4, which establish managed care entity appeal and grievance processes. Appeals must be submitted within required timeframes as outlined in the provider manual and applicable regulations. Expedited appeals are available when delay could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, consistent with OAC 5160-26-08.4. Appeal determinations will be conducted by qualified clinical personnel who were not involved in the original decision and will adhere to ODM-mandated turnaround time requirements. As part of the appeal or reconsideration process, providers may request a peer-to-peer clinical review to discuss the medical necessity determination with a qualified clinical reviewer, consistent with the requirements of OAC Chapter 5160-26. Peer-to-peer review does not replace the formal appeal process and does not extend applicable appeal filing deadlines.
- b. Members are entitled to continuation of benefits during the appeal process when the appeal is filed timely, consistent with OAC 5160-26-08.4. The Plan will provide member notices that meet all ODM content and timing requirements, including clear explanation of rights and continuation options.
- c. The Plan must ensure 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 the Plan not having properly configured its system to enforce the limit. Additionally, the Plan will not deny services retrospectively for failure to obtain prior authorization during initial implementation if provider notification and system configuration were not fully operational. Providers will be given advance notice consistent with ODM requirements prior to enforcement of new authorization requirements.
- d.
  1. Outpatient Care Engagement (OCE) and Utilization Management (UM) Approach
    - a. The Plan utilizes a two-pronged utilization management approach that combines the Outpatient Care Engagement (OCE) program with Ohio Department of Medicaid (ODM) targeted prior authorization threshold requirements. This approach is designed to promote clinically appropriate, medically necessary care while minimizing administrative burden for providers and supporting care coordination.
    - b. The Outpatient Care Engagement (OCE) program is a proactive, data-driven utilization management approach that monitors utilization of community behavioral health rehabilitation services, including but not limited to Therapeutic Behavioral Services (TBS), Community Psychiatric Support Treatment (CPST), Psychosocial Rehabilitation (PSR), Peer Support Services, and Day Treatment services. These services do not require prior authorization at initiation. Instead, the Plan monitors utilization against ODM-established thresholds using claims and utilization management data and may proactively engage providers as members approach or exceed applicable thresholds.
    - c. When utilization trends indicate that a threshold is being approached or exceeded, the Plan may engage the treating provider to support care planning, ensure alignment with medical necessity, and facilitate coordination of services. Prior authorization requirements are applied only after established thresholds are exceeded, in accordance with ODM guidance and applicable utilization management standards.
  2. Utilization Management (UM) and Prior Authorization
    - a. In accordance with Ohio Department of Medicaid (ODM) requirements, prior authorization is required only after established service thresholds are exceeded. Authorization requirements apply to designated community behavioral health and substance use disorder services, including SUD Intensive Outpatient Program (IOP), withdrawal management, residential SUD services, and community behavioral health rehabilitation services once utilization exceeds ODM-defined limits. Authorization requests are subject to medical necessity review and must be supported by appropriate clinical documentation, consistent with OAC 5160-26-03.1, OAC Chapter 5160-27, and applicable ODM guidance.
  3. Provider Responsibilities
    - a. Providers are responsible for delivering clinically appropriate and medically necessary services in accordance with applicable regulations and documenting services in the individualized treatment plan, consistent with OAC 5160-1-01 and OAC Chapter 5160-27. Providers are expected to monitor member utilization, utilize available provider tools (including the provider portal) to review utilization levels, and coordinate care when members are receiving services from multiple providers, in

alignment with managed care requirements set forth in OAC 5160-26-03.1 and applicable provider agreements.

4. Substance use disorder (SUD) services subject to utilization management
  - a. For substance use disorder (SUD) services subject to utilization management, including SUD Intensive Outpatient Program (IOP), withdrawal management, and residential SUD services, providers are required to submit a prior authorization request using ODM-required forms once the applicable service threshold has been reached or exceeded.
  - b. For community behavioral health rehabilitation services monitored through the Outpatient Care Engagement (OCE) program, including Therapeutic Behavioral Services (TBS), Community Psychiatric Support Treatment (CPST), Psychosocial Rehabilitation (PSR), Peer Support, and Day Treatment services, the Plan monitors utilization against ODM-established thresholds and may proactively engage providers when a member is approaching or has exceeded a threshold. Prior authorization is required when ODM-established service thresholds are reached or exceeded. The Plan may conduct proactive outreach as providers approach applicable thresholds; however, the requirement to obtain prior authorization is not contingent upon Plan notification.
  - c. Providers remain responsible for submitting a prior authorization request when additional services are required beyond applicable thresholds and for cooperating with utilization management processes, including responding to Plan outreach and providing necessary clinical documentation to support medical necessity determinations, in accordance with OAC 5160-26-03.1, OAC 5160-1-01, and OAC Chapter 5160-27. Providers must submit continued stay requests with updated clinical documentation when ongoing services require authorization.

2. Recipient Level Utilization Verification - Upon request by a CBHC provider, the Next Generation Medicaid and MyCare Ohio plan must provide recipient's utilization to date if a service authorization is required.

- a. Upon request by a Community Behavioral Health Center (CBHC) provider, the Plan will provide recipient-specific utilization-to-date information based on claims received and processed, in support of utilization management and care coordination activities conducted under OAC 5160-26-03.1. Providers may access member-level utilization information through the UnitedHealthcare Optum Provider Express Portal, which serves as the primary self-service tool for verifying eligibility, claims activity, and service utilization.

In accordance with Ohio Department of Medicaid (ODM) requirements, the Plan maintains provider-accessible self-service options for verifying member utilization. In addition to the Provider Express Portal, providers may obtain utilization information through designated provider support channels, separate from the general customer service line, as outlined in the Care Provider Manual.

Utilization information provided by the Plan is based on claims received and processed at the time of the inquiry and may not reflect complete or real-time utilization. The Plan does not provide information regarding other servicing providers or Tax Identification Numbers (TINs) associated with claims.

The Plan may also proactively monitor utilization through the Outpatient Care Engagement (OCE) program and may notify or engage providers when a member is approaching or has exceeded established thresholds to support care planning and coordination. These activities are conducted consistent with utilization management authority under OAC 5160-26-03.1, medical necessity standards defined in OAC 5160-1-01, and behavioral health service requirements set forth in OAC Chapter 5160-27.

- c. Provider Access to Utilization Information
  - i. In compliance with Ohio Department of Medicaid (ODM) requirements, the Plan provides provider-facing resources for recipient-level utilization verification that extend beyond a general customer service telephone number.
  - ii. Providers have access to a self-service portal through the Provider Express Secure Portal, which offers 24/7 access to member, provider, and claims information, including utilization tracking and prior authorization submission functionality. The portal may be accessed at:

<https://www.providerexpress.com/api/auth/ssone-healthcare>

- iii. Additional guidance is available through the Provider Express Portal Quick Reference Guide:

- iv. Providers may also utilize real-time Live Chat support available through Provider Express for assistance with benefits, claims, service unit counts, prior authorizations, appeals, and technical support at:

<https://www.providerexpress.com/chat-support?open=true>

- v. In addition to the self-service portal, the Plan provides a designated, state-specific provider support contact for Ohio providers. Providers may submit inquiries for recipient-level utilization verification and support via email at:

[ohbs.centralregion@optum.com](mailto:ohbs.centralregion@optum.com)

- vi. These resources serve as the primary and preferred methods for accessing utilization information and obtaining provider support, in alignment with ODM requirements for accessible, provider-facing communication channels.

- d. Note that the Plan must disclaim that this information is based on claims received to date and may not reflect accurate real-time utilization. If the Plan implements an authorization requirement for a BH service, a designated and reliable point of contact for the provider to access this information must be made available. The 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.

## Table A-1: New Services Subject to Utilization Management

### 1. Table A-1: New Services Subject to Utilization Management

Service Name	Service Code	Service Threshold at which authorization is required	Expected turnaround time by the MCE/MCOP
*Therapeutic Behavioral Service - Individual	H2019	200 units (50hrs) combined TBS or PSR per calendar year	7 days
*Therapeutic Behavioral Service - Group	H2019 HQ	120 units (30hrs) per calendar year	7 days
*Therapeutic Behavioral Service Day Treatment – per diem	H2020	After 30 units per calendar year	7 days
*Community Psychiatric Support Treatment – Individual	H0036	200 units (50hrs) per calendar year	7 days
*Community Psychiatric Support Treatment – Group	H0036 HQ	120 units (30hrs) per calendar year	7 days
*Psychosocial Rehabilitation Service	H2017	200 units (50hrs) combined TBS or PSR per calendar year	7 days
SUD Ambulatory Withdrawal Management	H0012 H0014	After 7 <sup>th</sup> consecutive day of H0012 per diem or H0014/H0014AT hourly based claims	48 hours
SUD Intensive Outpatient Program	H0015	After 30 units per calendar year	7 days

SUD Residential Clinically Managed -WM	H0010	After 7 <sup>th</sup> consecutive day	48 hours
SUD Residential Medically Managed -WM	H0011	After 7 <sup>th</sup> consecutive day	48 hours

Table Note: Services identified with an asterisk (\*) are managed through the Outpatient Care Engagement (OCE) program and are monitored against ODM-established thresholds. These services do not require prior authorization at initiation; however, the Plan will proactively engage providers as utilization approaches or exceeds thresholds, at which point prior authorization may be required for continued services.

## Conditions of Coverage

### E. Conditions of Coverage

1. Providers must follow OAC 5160-1-31 regarding submission requirements for authorization forms
2. 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
3. Services rendered with the KX crisis modifier are excluded from service thresholds.
4. BH nursing rendered in accordance with OAC 5160-27-11 are excluded
5. Due to the chronic nature of severe and persistent mental illness and the vulnerability of many who require reliable access to support, the following additional requirements apply to behavioral health rehabilitation services:
  - a. The coverage period for an approved service is a minimum of 90 days unless a shorter duration is specifically requested by the provider
  - b. The authorization is valid until the approved service limit is exhausted OR the authorization period has expired
  - c. Children and youth enrolled in the OhioRISE plan or in the custody of an Ohio Public Child Welfare Agency (identified on the 834 report with a living arrangement code of FC, AA, or KG) are excluded from service authorization requirements. TBS Day Tx per diem (H2020) for members enrolled in OhioRISE and/or in Public Children Services Agency (PCSA) custody are excluded from service authorization requirements.

## Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Code/Modifier	Service
H0010	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
H0012	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
H0014	Alcohol and/or drug services; ambulatory detoxification

Code/Modifier	Service
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H0036	Community Psychiatric Support Treatment, individual
H0036 HQ	Community Psychiatric Support Treatment, group
H2017	Psychosocial Rehabilitation Service
H2019	Therapeutic Behavioral Service, individual
H2019 HQ	Therapeutic Behavioral Service, unit-based group
H2020	Therapeutic behavioral services, per diem

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The services described herein are services and, therefore, not subject to regulation by the FDA.

## References

Ohio Administrative Code, Rule 5160-1-01, Medicaid medical necessity: definitions and principles. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-01>. Accessed May 20, 2026.

Ohio Administrative Code, Rule OAC 5160-26-03.1, Managed care: primary care and utilization management. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-26-03.1>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-01 Eligible provider of community behavioral health services. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-01>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-02 Coverage and limitations of behavioral health services. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-02>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-03 Reimbursement for community behavioral health services. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-03>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-04 Mental health assertive community treatment service. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-04>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-06 Therapeutic behavioral group service-hourly and per diem. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-06>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-08 Mental health therapeutic behavioral services and psychosocial rehabilitation. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-08>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-09 Substance use disorder treatment services. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-09>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-10 Substance use disorder targeted case management. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-10>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-11 Behavioral health nursing services. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-11>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-12 Behavioral health crisis intervention provided by unlicensed practitioners. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-12>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-13 Mobile response and stabilization service. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-13>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-27-14 Behavioral health peer support service. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-14>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-26-08.3, Managed care: member rights. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-26-08.3>. Accessed May 20, 2026.

Ohio Administrative Code, Rule 5160-26-08.4, Managed care: appeal and grievance system. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-26-08.4>. Accessed May 20, 2026.

## Policy History/Revision Information

Date	Summary of Changes
05/20/2026	<p><b>Application</b></p> <ul style="list-style-type: none"> <li>Applied statutory requirements</li> </ul> <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>Added coverage rationale</li> </ul> <p><b>Definitions</b></p> <ul style="list-style-type: none"> <li>Added definitions</li> </ul> <p><b>Policy</b></p> <ul style="list-style-type: none"> <li>Added policy</li> </ul> <p><b>Applicable Codes v Table A-1: New Services Subject to Utilization Management</b></p> <ul style="list-style-type: none"> <li>Added section</li> </ul> <p><b>Conditions of Coverage</b></p> <ul style="list-style-type: none"> <li>Updated section</li> </ul> <p><b>Medical Records Documentation Used for Reviews</b></p> <ul style="list-style-type: none"> <li>Added section</li> </ul> <p><b>Applicable Codes</b></p> <ul style="list-style-type: none"> <li>Added codes</li> </ul> <p><b>U.S. Food and Drug Administration (FDA)</b></p> <ul style="list-style-type: none"> <li>Updated Section</li> </ul> <p><b>References</b></p> <ul style="list-style-type: none"> <li>Added references</li> </ul>
05/23/2026	<b>ODM Approved</b>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]) or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this guideline, check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and/or Utilization Review Guidelines that have been approved by the Ohio Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

In the event of any conflict, Ohio Administrative Code, ODM guidance, and applicable federal Medicaid requirements control over this policy and any internal guidelines.