

COMMUNITY BEHAVIORAL HEALTH SERVICES UTILIZATION MANAGEMENT POLICY STATEMENT Ohio MyCare	
	Date Effective
Molina Healthcare of Ohio	10/01/2026
Policy Type	
REIMBURSEMENT	

A. Subject

Molina Healthcare of Ohio aligned with Ohio Department of Medicaid’s new Utilization Management for Community Behavioral Health and SUD Services policy for Molina Medicaid and MyCare members.

B. Background

To promote the delivery of clinically appropriate and medically necessary Medicaid-funded substance use disorder 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.

C. Definitions

- Substance Use Disorder
 - SUD Ambulatory Withdrawal Management (H0012), per diem
 - SUD Ambulatory Withdrawal Management (H0014), hourly
 - SUD Intensive Outpatient Program (H0015)
 - SUD Partial Hospitalization (H0015 TG)
 - SUD Residential Clinically Managed (H0010)
 - SUD Residential Medically Managed (H0011)
 - SUD Residential Treatment (H2034)
 - SUD Residential Treatment (H2036)

D. Policy

1. Molina Medicaid and MyCare Ohio plans will apply service thresholds to designated community behavioral health services, but no more stringent than ODM.

2. 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 form for Substance Use Disorder (SUD) (to be updated for July 1, 2026) available on ODM's website will be accepted as a valid authorization request, but specific use of a form is not required by Molina.
 - b. Submit a prior authorization per Molina's standard process via the Availity portal.
 - Include medical records demonstrating the medical necessity for additional services. Recommended documentation:
 - Member's care plan
 - Care Plan 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.
 - If the submitted supporting documentation does not demonstrate that additional services were clinically appropriate based on the member's condition/ diagnosis or does not demonstrate that regulatory requirements were met, the request will be denied. Standard written notification including appeal procedures will be sent per regulatory requirements.
3. Molina 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.
4. Recipient Level Utilization Verification

Upon request by a provider, Molina will provide recipient's utilization to date if a service authorization is required.

 - a. Providers may contact Molina at <<*insert telephone number*>> where a designated Molina representative will provide utilization information based on *claims received to date and may not reflect accurate real-time utilization.* ******(see Molina Addendum below)
 - b. Providers are responsible for keeping track of service delivery for each recipient to ensure services rendered do not exceed the authorized threshold.
 - i. 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.
 - ii. 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: SUD Services – New Prior Authorization Requirements

Service Name	Service Code	Service Threshold at which authorization is required	Turn around time by MCE/MCOP	Effective Date
SUD Ambulatory Withdrawal Management	H0012 H0014	After 7 th consecutive day of H0012 per diem or H0014/H0014AT hourly based claims	48 hours	10/01/2026
SUD Intensive Outpatient Program	H0015	After 30 units per calendar year	7 days	10/01/2026
SUD Residential Clinically Managed -WM	H0010	After 7 th consecutive day	48 hours	10/01/2026
SUD Residential Medically Managed -WM	H0011	After 7 th consecutive day	48 hours	10/01/2026

Table A-2: SUD Services – Prior Authorization Requirements

(No changes to prior authorization requirements for service codes listed in Table A-2 below)

Service Name	Service Code	Service Threshold at which authorization is required	Turn around time by MCE/MCOP
SUD Residential Treatment (level 3.1)	H2034	After 30 days and/or 3 or more stays per calendar year	48 hours
SUD Residential Treatment (level 3.3)	H2036 HI	After 30 days and/or 3 or more stays per calendar year	48 hours
SUD Residential Treatment (level 3.5)	H2036	After 30 days and/or 3 or more stays per calendar year	48 hours
SUD Residential Treatment (level 3.7)	H2036 TG	After 30 days and/or 3 or more stays per calendar year	48 hours

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. Behavioral Health 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

F. References

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 .

Molina Specific Addendum:

Billing Guidance:

** For the most accurate utilization information providers should submit bill with ONE DATE per SERVICE LINE

Approval History	
07/01/2026	New Policy