

Substance Use Disorder Intensive Outpatient Program

Humana

Medicaid Medical Coverage Policy

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Disclaimer

The Clinical Coverage Policies are reviewed by the Humana Medicaid Coverage Policy Adoption (MCPA) Forum. Policies in this document may be modified by a member's coverage document. Clinical policy is not intended to preempt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another. Clinical technology is constantly evolving, and we reserve the right to review and update this policy periodically. References to CPT® codes or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee of claims payment. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise, without permission from Humana.

Scope

This policy applies to all physical and behavioral health prior authorization requests received by Humana Healthy Horizons in Ohio.

Policy

Humana Healthy Horizons in Ohio uses established criteria guidelines to make medical necessity decisions and follows the below procedure. Decisions are made on a case-by-case basis, utilizing the information provided about the member's health status and an assessment of the local delivery system. Emergent services do not require a referral or preauthorization.

The Plan covers all benefits and services required in Ohio Administrative Code (OAC) chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.

When the plan receives a request for a primary code that requires prior authorization and the primary code is denied for lack of medical necessity, any related secondary codes submitted on the authorization request will be denied based on lack of medical necessity. When a primary code is approved, related secondary codes requiring prior authorization will be reviewed individually for medically necessity determinations.

Please see [Ohio Medicaid Prior Authorization and Notification List](#) for a list of CPT and HCPCS codes that require prior authorization.

Humana Healthy Horizons in Ohio will review requested non-MCO covered codes and services as required for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for medical necessity to ensure children and adolescents receive appropriate and preventative, dental, mental health, developmental and specialty services.

Humana Healthy Horizons in Ohio does not cover services, items or devices that have not been approved by the Food and Drug Administration (FDA). Other factors affecting reimbursement supersede this policy. These factors include but are not limited to Federal and/or State statutes and regulations, the State Plan, the MCE Manual, physician or other provider contracts, the beneficiaries' benefit coverage documents, and/or other reimbursement, medical or drug policies.

Providers may submit authorization request(s) through the provider portal. A provider may request an urgent prior authorization in situations where the provider considers a delay in providing services, supplies or prescription drugs requiring prior authorization to be detrimental to the health of the member. The absence of authorization and/or notification prior to the date of a service could result in financial penalties for the practice and reduced benefits for the member, based on the healthcare provider's contract and the member's Certificate of Coverage. Services or medications provided without preauthorization may be subject to retrospective medical necessity review. We recommend individual practitioners making specific requests for services or medications verify benefits and preauthorization requirements with Humana prior to providing services.

Medical necessity documentation and rationale must be submitted with the prior authorization request. Providers may access physical and behavioral clinical coverage policies and medical necessity criteria at the below links.

Physical Health:

<https://provider.humana.com/medicaid/ohio-medicaid/clinical-coverage-policies>

Behavioral Health:

<https://provider.humana.com/medicaid/ohio-medicaid/clinical-coverage-policies>

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, 7AM to 8PM EST.

Providers may request a copy of the medical necessity criteria by calling provider services at 877-856-5707 (TTY:711), Monday-Friday, 7AM to 8PM EST or emailing the request to OHMCDUM@humana.com.

Procedures

1. The Plan uses the following hierarchy of guidelines to review for medical necessity:
 - 1.1 Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
 - 1.2 Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines).
 - 1.3 Humana Healthy Horizons™ in Ohio clinical policies
 - 1.4 In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes;
 - 1.4.1 Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
 - 1.4.2 Professional standards for safety and effectiveness recognized in the US for diagnosis, care, or treatment;
 - 1.4.3 Medical association publications;
 - 1.4.4 Government-funded or independent entities that assess and report on clinical care; Decision and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
 - 1.4.5 Published expert opinions;
 - 1.4.6 Opinion of health professionals in the area of specialty involved;
 - 1.4.7 Opinion of attending provider;
 - 1.5 Dental: DentaQuest coverage guidelines and policies
[Dental Coverage - Humana Healthy Horizons in Ohio | Humana](#)
 - 1.6 Vision: EyeMed coverage guidelines and policies
[Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana](#)

Description

Per Ohio rule 5160-27-09⁷ substance use disorder treatment services shall be defined by and shall be provided according to the American society of Addiction Medicine (ASAM) also known as the ASAM

treatment criteria for addictive, substance related and co-occurring conditions for admission, continued stay, discharge, or referral to each level of care (LOC).

Medicaid will reimburse for the services provided under the following ASAM levels of care when medically necessary:

LOC 1: outpatient services. LOC 1 services are designed to treat the recipient's level of clinical severity and function. These services may be delivered in a variety of settings. Addiction, mental health, or general health care treatment personnel provide professionally directed screening, evaluation, treatment and ongoing recovery and disease management services. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols. Service provision is limited to less than nine hours per week for adults and less than six hours per week for adolescents.

LOC 2: intensive outpatient/partial hospitalization including LOC 2 withdrawal management (WM). LOC 2 services are capable of meeting the complex needs of people with addiction and co-occurring conditions. They can be rendered during the day, before or after work or school, in the evening, and/or on weekends.

LOC 3: residential services/inpatient services including LOC 3 WM. These services are co-occurring capable, co-occurring enhanced and complexity capable in nature and provided by addiction treatment, mental health and general medical personnel in a twenty four hour treatment setting. Services are provided in Ohio department of mental health and addiction services certified permanent facilities which are staffed twenty four hours a day. The following services are included in the residential treatment service and will not be reimbursed separately:

- (a) Ongoing assessments and diagnostic evaluations
- (b) Crisis intervention
- (c) Individual, group, family psychotherapy and counseling
- (d) Case management
- (e) Substance use disorder peer recovery services
- (f) Urine drug screens
- (g) Medical services

Coverage Determination

Conditions of Coverage

The service authorization request forms will be accepted for Substance Use Disorder (SUD) and Community Behavioral Health Centers (CBHC) available on the Ohio Department of Medicaid (ODM) website.

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:

- Expedited: Submission must be received at least 2 days prior
- Standard: Submission must be received at least 7 days prior

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 selecting the dedicated prompt for immediate connection to the team supporting behavioral health benefit service utilization level verification inquiries. Please note that utilization information is based on claims received to date and may not reflect real-time utilization.

Prior Authorization Requirements

Service Name	Service Code	Service Threshold (at which authorization is required)	ASAM LOC
SUD Intensive Outpatient Program	H0015	After 30 units per calendar year, per member	2.1

Refer to [ASAM Criteria](#) and [ODM Medicaid Behavioral Health State Plan Services: Provider Requirements and Reimbursement Manual](#).

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
No code(s) identified		
CPT® Category III Code(s)	Description	Comments
No code(s) identified		
HCPCS Code(s)	Description	Comments
H0015	SUD Partial Hospitalization	See ODM Medicaid Behavioral Health State Plan Services: Provider Requirements and Reimbursement Manual for duration and service description

References

1. American Society of Addiction Medicine. <https://asam.org>.
2. MCG Health. <https://humana.access.mcg.com/index>.
3. Ohio Administrative Code Chapter 5160 Ohio Department of Medicaid. [Chapter 5160 - Ohio Administrative Code | Ohio Laws](#).
4. Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. [Rule 5160-1-01 - Ohio Administrative Code | Ohio Laws](#).
5. Ohio Administrative Code Chapter 5160-1-31 Prior authorization. [Rule 5160-1-31 - Ohio Administrative Code | Ohio Laws](#).
6. Ohio Administrative Code 5160-26-01 Managed care: definitions. [Rule 5160-26-01 - Ohio Administrative Code | Ohio Laws](#).
7. Ohio Administrative Code 5160-27-09 Substance use disorder treatment services. [Rule 5160-27-09 - Ohio Administrative Code | Ohio Laws](#).
8. Ohio Department of Medicaid. ODM Medicaid Behavioral Health State Plan Services: Provider Requirements and Reimbursement Manual. Version 1.28.1. <https://medicaid.ohio.gov/resources-for-providers/bh/manuals>. Published March 24, 2026.

Definitions

1. Adverse Benefit Determination – As defined in OAC rule 5160-26-01, is a managed care entity’s (MCEs):
 - 1) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
 - 2) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCE;
 - 3) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code;
 - 4) Failure to act within the resolution timeframes specified in rule 5160-26-08.4 of the Administrative Code;
 - 5) Denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable; or
 - 6) Denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” as defined in 42 C.F.R. 447.45(b) (October 1, 2021) is not an adverse benefit determination).
2. American Society of Addiction Medicine (ASAM) – a professional medical society representing over

7,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addiction and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.

3. MCG – are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
4. Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:
 - A. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
 - B. Medical necessity for individuals not covered by EPSDT is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person 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.
 - C. Conditions of medical necessity for a procedure, item, or service are met all the following apply:
 - 1) It meets generally accepted standards of medical practice;
 - 2) It is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
 - 3) It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
 - 4) It is the lowest cost alternative that effectively addresses and treats the medical problem;
 - 5) It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
 - 6) It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.
 - D. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment.
 - E. The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within the Ohio Department of Medicaid (ODM) coverage policies or rules.

Change Summary

05/15/2026 State Request: New Policy Development. Version 000

05/21/2026 State Request: Added email address for recipient level utilization verification. Version 000

05/28/2026 Removed language not applicable to this service. Removed language excluding children and youth from service authorization requirements. Revised H0015 description and added comment referring to ODM BH manual. Version 000

06/02/2026 New Policy. Version 000

06/05/2026 State Request: Added provider call center telephone number and removed email address for recipient level utilization verification. Version 000