County of Sacramento Department of Health and Human Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Access and QM
	Policy Number	02-04 and 02-02
	Effective Date	5/19/08
	Revision Date	09/01/2021
Title: **Authorization Requests**	Functional Area: **Services/Authorization**	
Approved By: *Signed version available upon request* Melissa Jacobs, LCSW Human Services Division Manager Kelli Weaver, LCSW Human Services Division Manager Alexandra Rechs, LMFT Program Manager, Quality Management		

Background/Context:
The Mental Health Plan (MHP) links clients to service providers when a referral is received by the Access Team. The Access Team also provides an authorization for payment for services requiring prior authorization identified in the California Department of Health Care Services MHSUDS Information Notice (IN) 19-026 provided within the MHP. These authorizations are subject to standardized time frames for the treatment needed.

Purpose:
The purpose of this policy and procedure is to document a revision in the policy and clarify process for initial prior authorization for payment, and the process and time frames requiring a re-authorization.

Details:
Outpatient Service

The initial assessment for outpatient services will begin with the Access Team or another designated entry point (e.g. Guest House, Intensive Placement Team) upon receipt of a service request. The MHP will then assign the beneficiary to a County operated or contracted provider for ongoing services. All payment authorizations for outpatient services requiring prior authorization, except Electro Convulsive Therapy (ECT) are provided by the Access Team via an electronic Managed Care Authorization form within Avatar.

Initial Payment Authorizations:
Per MHSUDS IN 19-026 MHPs may no longer require prior authorization for the following services/service activities:

- Crisis Intervention;
- Crisis Stabilization;
- Mental Health Services;
- Targeted Case Management;
- Intensive Care Coordination; and,
- Medication Support

Although the MHP may not require prior authorization for these services, the MHP retains the ability to review beneficiaries' Assessments and Client Plans prior to service delivery. The MHP may review the documentation to assure medical necessity is met and services are appropriate for the level of functional impairment prior to payment. In addition, Mental Health Services – Rehabilitation, Targeted Case Management, and Intensive Care Coordination must be included on the beneficiary's Client Plan prior to service delivery. Payment for services is dependent on the beneficiary continuing to meet MediCal Necessity and Target Population and having an active client plan that addresses the beneficiary's symptoms and functional impairment and is appropriate to the level of need (QM 01-07 Determination for Medical Necessity and Target Population and QM 10-27 Client Plan)

Prior authorization or MHP referral is required for the following services for all Contracted and County Operated Providers consistent with their contract:

Treatment	**Authorization Period**[1]
Intensive Home-Based Services (IHBS)[2]	Determined by the CFT
Therapeutic Foster Care (TFC)[2]	6 months
Day rehabilitation services[2]	6 months
Day treatment intensive services[2]	3 months
Therapeutic Behavioral Services (TBS)	1 month
Second Opinion Request	2 months
Psychological testing	4 months
Out of County (OOC)	6 months
Enrolled Network Provider (ENP)	6 months
Electro-convulsive Therapy (ECT)	Per event

1. Out-of-County

   Access Team clinicians authorize services to providers based on medical necessity, services requested, and the funding eligibility criteria. PP-BHS-MH-Access-02-05-Out-of-County

   a. Clients' ages 0-21, with Out of County Medi-Cal - The Access team must obtain approval from the county of responsibility for

initial and reauthorization of clients served in Sacramento who meetthe criteria identified in SB785.

b. Clients' ages 0-21, with Sacramento County Medi-Cal, receiving services in another county - The Access Team provides service authorization to the requesting county to provide mental health treatment to a Sacramento County MediCal beneficiary who meets criteria identified in SB785.

2. Intensive Home Based Services (IHBS)

   The MHP delegates authority to the Provider for the authorization of Intensive Home Based Services (IHBS) via the Child and Family Team (CFT) process.

   i. The Provider would complete the ICC_IHBS Screening Tool reflecting the CFT Decision Date and CFT Outcome approving IHBS services.
      1. Providers must follow QM's documentation standards in regards to ensuring that prior to billing, all planned mental health interventions are included in the Client Plan based on an Assessment.
   ii. The CFT would determine the amount, scope and duration of IHBS. IHBS can be authorized immediately, that same day, solely based on the youth and family's voice and choice.
   iii. IHBS may be authorized for the length of time specified by the youth and shall be reviewed and reauthorized within the CFT process at least every 6 months.

3. Day Treatment Intensive (DTI) or Day Rehabilitation (DR).
   a. Initial service requests (SR)
      i. For clients placed in DTI or DR programs, the SRs are submitted to the Access Team through the Interagency Placement Committee (IPC).
      ii. Interagency Placement Committee (IPC) will determine the appropriate level of service: DTI or DR. The name of the residential program providing DTI or DR will appear on the SR, along with the date the client was placed.
      iii. Providers are also required to submit a Service Authorization Requests (SAR), using the DHCS SB785 SAR template, to Sacramento County Access Team within 5 days of client admission into a provider's program, when applicable.
      iv. Access will authorize the client to the provider and program identified on the SR.

<u>Re-authorizations:</u>

For those services requiring re-authorization, the provider shall, within 30 days prior to the expiration of the authorization, review the client's need for continued services

to ensure continued medical necessity. If continuation of services is appropriate, the provider is required to request re-authorization of services from the Access Team prior to the expiration of the current authorization period.

When multiple Children's System of Care providers are serving a client, a CFT is required prior to completion of the reauthorization to ensure coordination of care. Signatures are required on the Client Plan according to current Quality Management Policies and Procedures.

A SAR is required to re-authorize any mental health service provided by an out of county provider to a MediCal beneficiary who meets the criteria identified in SB785.

Only the following services will require re-authorization by the Access Team:

Treatment	**Re-Authorization Period**[1]
Intensive Home-Based Services (IHBS)[2]	6 months
Therapeutic Foster Care (TFC)[2]	6 months
Day rehabilitation services[2]	6 months
Day treatment intensive services[2]	3 months
Therapeutic Behavioral Services (TBS)	2 months
Second Opinion Request	2 months
Psychological testing	4 months
Out-of-County (OOC)	6 months
Enrolled Network Provider	6 months
Electro-convulsive Therapy (ECT)	Per event

The provider's licensed clinical supervisor or licensed designee shall attest on the re-authorization request continued medical necessity. The Provider shall ensure that the appropriate clinical forms, including a current client plan as required by Quality Management for chart documentation and reimbursement, are completed and in the Client Record. The Access Team will utilize the same authorization duration applied for initial authorizations when determining a re-authorization. *Exception*: TBS re-authorizations are 2 months in length.

The MHP will review and make a decision regarding a provider's request for prior authorization and reauthorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the receipt of the information reasonably necessary and requested by the MHP to make a determination. For cases where the standard timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice

as expeditiously as the beneficiary's health condition requires, but no later than 72 hours after receipt of the request for services. The MHP may extend the timeframe for making an authorization decision for up to 14 additional calendar days if the following conditions are met:

1. The beneficiary, caregiver, or provider requests an extension; or,
2. The MHP justifies and documents a need for additional information and how the extension is in the beneficiary's interest.

The Access Team will provide a Notice of Action (NOABD) for any denial, reduction, modification, or termination of services per the State requirements for issuing of a NOABD.

In circumstances where the Point of Authorization to the MHP has processed a beneficiary's request for services and is unable to find an appropriate provider within the network of contracted service providers, the beneficiary is able to seek services with an out of network provider. For payment of services, the out of network provider must be eligible to provide Medi-Cal reimbursable specialty mental health services.

Authorization and Concurrent Review for Psychiatric Inpatient Hospital, Psychiatric Health Facility Services

Prior authorizations may not be required for an emergency admission for psychiatric inpatient hospital services or to a psychiatric health facility, whether the admission is voluntary or involuntary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize food, shelter, or clothing.

The MHP will authorize payment for out-of-network services when a beneficiary of the MHP, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services, upon notification of the hospital. Hospitals must request authorization for continued stay services for the beneficiary, after the date of admission.

Per MHSUDS IN 19-026, the MHP will conduct a concurrent review and authorization process for all psychiatric inpatient hospital services and psychiatric health facility services. The MHP will conduct concurrent review of treatment authorizations following the first day of admission and each day their after to determine on going medical necessity and/or continued stay criteria.

For Medi-Cal reimbursement of psychiatric inpatient hospital services, the beneficiary must meet medical necessity criteria set for the in Title 9 of the CCR, section 1820.205. The beneficiary must meet the following medical necessity criteria for admission to a hospital for psychiatric inpatient services: [3]

1. Have an included diagnosis;
2. Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and,
3. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to one of the following:
    a. Has symptoms or behaviors due to a mental disorder that (one of the following);
        i. Represent a current danger to self or others, or significant property destruction.
        ii. Prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter.
        iii. Present a severe risk to the beneficiary's physical health.
        iv. Represent a recent, significant deterioration in ability to function.
    b. Require admission for one of the following:
        i. Further psychiatric evaluation.
        ii. Medication treatment.
        iii. Other treatment that can be reasonably provided only if the beneficiary is hospitalized.

The medical necessity criteria are applicable regardless of the legal status (voluntary or involuntary) of the beneficiary.

Continued stay services in a hospital shall be reimbursed when a beneficiary experiences one of the following: [4]

1. Continued presence of indications that meet the medical necessity criteria;
2. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization;
3. Presence of new indications that meet medical necessity criteria; and,
4. Need of continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital.

The MHP will maintain responsibility to ensure that services furnished to beneficiaries are medically necessary and are compliant with all requirements necessary for Medi-Cal reimbursement. [5] The MHP will review documentation sufficient to determine that medical necessity criteria are met for acute days and administrative day criteria are met for administrative days.

The MHP may reimburse for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services, but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. In order to conduct concurrent review

and provide authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

The MHP may waive the requirement of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.

Retrospective Authorizations

The MHP may conduct retroactive authorization of SMHS under the following circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System:
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or
- Beneficiary's failure to identify payer (e.g., for inpatient psychiatric services)

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements."

Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services

The MHP utilizes referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). The MHP may not require prior authorization. If the MHP refers a beneficiary to a CRTS or ARTS facility, the referral may serve as the initial

authorization as long as the MHP specifies the number of days authorized. The MHP must then reauthorize medically necessary CRTS and ARTS as appropriate, based on the beneficiary's continued need for services.

As with the authorization of psychiatric inpatient and PHF services, decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating provider within 24 hours of the decision and care shall not be discontinued until the beneficiary's treating provider has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.

General Authorization Requirements

Authorization procedures and utilization management criteria will adhere to the following principles:

- Be based on Specialty Mental Health Services (SMHS) medical necessity criteria and consistent with current clinical guidelines, principles, and processes;
- Be developed with involvement from County and contracted providers including staff acting within their scope of practice;
- Be evaluated, and updated if necessary, at least annually; and,
- Be disclosed to the MHP's beneficiaries and providers.

Related Policies:

MH-Access 02-02 Access Team Services
MH-Access 02-03 Urgent Service Requests
MH-Access 02-05 Out of County Service Requests for Medi-Cal
QM 02-01 Notice of Adverse Benefit Determination
QM 01-07 Determination for Medical Necessity and Target Population
QM 10-27 Client Plan

Distribution:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Mental Health Contract Providers

Contact Information:

Access Program	Quality Management Unit
AccessInfo@saccounty.net	QMInformation@saccounty.net

[1] All authorizations for treatment programs will be date to date. (e.g. 11/7/16 through 5/6/16 = 6 month authorization)
[2] Services identified in IN 19-026 for prior authorization by MHP.
[3] CCR, Title 9, § 1820.205 (a)
[4] CCR, Title 9, § 1820.205 (b)
[5] W&I, § 14705 (a)(3)