SANTA CRUZ COUNTY
Behavioral Health Services

POLICIES AND PROCEDURE MANUAL

Subject: Prior Authorization for Outpatient SMHS	**Policy Number: 3425**
Date Effective: 8/01/19	**Pages: 8**
Replaces: N/A	**Responsible for Updating:** Quality Improvement Director, Adult Behavioral Health Director, Children's Behavioral Health Director
Approval: _____ Behavioral Health Director	July 31, 2019 Date

PURPOSE: To establish requirements for prior authorization of outpatient Specialty Mental Health Services (SMHS) that are complaint with the Parity Rule.

POLICY: Santa Cruz County Mental Health Plan (MHP) approves SMHS based on Medical Necessity Criteria determination (see **Policy 2103- Access Assessments**). In addition to determination of Medical Necessity Criteria, some services require prior authorization.

BACKGROUND: Santa Cruz County Behavioral Health Services (SCCBHS), a Mental Health Plan (MHP), is required to operate a utilization management (UM) program that ensures Medi-Cal beneficiaries have appropriate access to SMHS. The UM program must evaluate medical necessity, appropriateness, and efficiency of services provided to beneficiaries prospectively, such as through prior or concurrent authorization procedures, or retrospectively, such as through retrospective authorization procedures.

SCCBHS is responsible for certifying that claims for all covered SMHS meet federal and state requirements, including medical necessity. SMHS are provided to beneficiaries based on medical necessity in accordance with an individualized client plan, approved and authorized according to state requirements. As specified in MHSUDS IN 17-040, certain services and service activities, such as assessment, plan development and crisis intervention, are reimbursable prior to the client plan being approved while other services (e.g. mental health services other than assessment and plan development, and non-emergency medication support) require an approved client plan. This policy focuses on UM practices for specific Specialty Mental Health Outpatient Services.

SCOPE: Policy pertains to all Santa Cruz County Behavioral Health and Santa Cruz County Behavioral Health Contractor staff who refer and/or authorize a Medi-Cal beneficiary for the outpatient level of care services listed within this policy based on medical necessity. This

policy was developed in collaboration with MHP stakeholders and shall be reviewed and evaluated at least annually. This policy, and/or the content within the policy, will be available to both MHP beneficiaries and network providers.

DEFINITIONS:

1. **Care Coordinator:** Santa Cruz County or Santa Cruz County Contractor staff who provides primary mental health services to the beneficiary.

2. **County IHBS Coordinator:** Santa Cruz County management staff who oversees IHBS program and authorizes IHBS services.

3. **County TBS Coordinator:** Santa Cruz County management staff who oversees TBS program and authorizes TBS services.

4. **County TFC Coordinator:** Santa Cruz County management staff who oversees TFC program and authorizes TFC services.

5. **Day Rehabilitation (DR)**: A structured program providing evaluation, rehabilitation and therapy to improve, maintain or restore personal independence and functioning consistent with requirements for learning and development. See **Policy 2323 – Day Treatment Programs** and **Policy 3331 – Mental Health Service Definitions Adult & Children** for further details.

6. **Day Treatment Intensive (DTI)**: A service providing an organized and structured multi-disciplinary treatment program as an alternative to hospitalization, to avoid placement in a more restrictive setting, or to maintain the Individual in a community setting. See **Policy 2323 – Day Treatment Programs** and **Policy 3331 – Mental Health Service Definitions Adult & Children** for further details.

7. **Intensive Home-Based Services (IHBS):** Supplemental specialty mental health service providing strength-based interventions designed to help the child/youth build skills necessary for successful functioning and/or improve the family's ability to help the child/youth successfully function in the home and community. See **Policy 2434 – Intensive Care Coordination & Intensive Home-Based Services** for further details.

8. **Therapeutic Behavioral Services (TBS):** Supplemental specialty mental health service providing intensive, one-to-one, individualized, short-term, home/community-based interventions addressing target behaviors that jeopardize a current living situation and/or severely impact functioning and ability to live safely in the community. See **Policy 2461 – Therapeutic Behavioral Services** for further details.

9. **Therapeutic Foster Care (TFC):** A short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. TFC is intended for children/youth who require intensive and frequent mental health support in a family environment and is available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit to children/youth, under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria.

PROCEDURES:

1. **Intensive Home-Based Services (IHBS):**
   a. Request for service:
      i. Beneficiaries not currently receiving Santa Cruz County SMHS and/or their parent/guardian may request SMHS, including IHBS, through the Children's Behavioral Health Access process (See **Policy 2103 – Access Assessments**).
      ii. Beneficiaries currently receiving Santa Cruz County SMHS and/or their parent/guardian may request IHBS by discussing their needs with their Care Coordinator.
      iii. A Care Coordinator who is interested in IHBS services for a beneficiary shall discuss the option with their supervisor. The supervisor will review TBS criteria and medical necessity, in consultation with the County IHBS Coordinator as needed. If the service is appropriate the Care Coordinator will discuss the service availability with the beneficiary, parent/guardian, and the Child Family Team.
   b. Eligibility review:
      i. All requests for IHBS services are submitted in writing by the Care Coordinator to their supervisor using the **IHBS/TBS/TFC Referral and Authorization form** and the **IHBS Checklist**.
         1. The supervisor verifies IHBS eligibility criteria.
            a. If the beneficiary does not meet eligibility criteria for IHBS the supervisor, or Care Coordinator under the direction of the supervisor, will provide the beneficiary with a NOABD – Denial letter (See **Policy 3223: Notice of Adverse Benefit Determination**).
            b. If the beneficiary meets eligibility criteria, the supervisor submits the request to the County IHBS Coordinator or designee (a licensed or waived representative of the MHP).
   c. Determination:
      i. The County IHBS Coordinator or designee will review verification of IHBS eligibility criteria and clinically significant information sufficient to make a determination. Further information may be requested as is reasonably necessary to make a determination.
         1. When services are approved, the County IHBS Coordinator, or designee, will provide to the beneficiary and provider written authorization detailing the amount, scope and duration that has been authorized. The written authorization will be maintained in the client record.
         2. When services are denied, the County IHBS Coordinator, or designee, will provide the beneficiary with a NOABD – Denial letter (See **Policy 3223: Notice of Adverse Benefit Determination**).
   d. Re-authorization
      i. Request to continue IHBS must be submitted to the County IHBS Coordinator no later than three (3) weeks before the original authorization is set to expire.
2. IHBS will be authorized for a duration of six (6) months or less and must be re-authorized by the County IHBS Coordinator if services are to continue longer. **Therapeutic Behavioral Services (TBS):**
   a. Request for service:
      i. Beneficiaries not currently receiving Santa Cruz County SMHS and/or their parent/guardian may request SMHS, including TBS, through the Children's Behavioral Health Access Process (See **Policy 2103 – Access Assessments**).

ii. Beneficiaries currently receiving Santa Cruz County SMHS and/or their parent/guardian may request TBS by discussing their needs with their Care Coordinator.
iii. A Care Coordinator who is interested in TBS services for a beneficiary shall discuss the option with their supervisor. The supervisor will review TBS criteria and medical necessity, in consultation with the County IHBS Coordinator as needed. If the service is appropriate, the Care Coordinator will discuss the service availability with the beneficiary, parent/guardian, and the Child Family Team.
iv. A TBS provider from outside the MHP may request authorization of services by contacting the County TBS Coordinator. The MHP will authorize all eligible providers according to SMHS requirements and contract agreements.

b. Eligibility review:
   i. All requests for TBS are submitted in writing by the Care Coordinator to their supervisor using the **IHBS/TBS/TFC Referral and Authorization form** and the **TBS Checklist**.
      1. The supervisor verifies TBS class membership.
         a. If the beneficiary does not meet TBS class membership criteria the supervisor, or Care Coordinator under the direction of the supervisor, will provide the beneficiary with a NOABD – Denial letter (See **Policy 3223: Notice of Adverse Benefit Determination**).
         b. If the beneficiary meets TBS class membership criteria, the supervisor submits the request to the County TBS Coordinator or designee (a licensed or waived representative of the MHP).
         c. If class membership is unclear, supervisor may request County TBS Coordinator to authorize service for 30-day while eligibility is being determined.

c. Determination:
   i. The County TBS Coordinator or designee will review verification of TBS class membership criteria and clinically significant information sufficient to make a determination. Further information may be requested as is reasonably necessary to make a determination.
      1. When services are approved, the County TBS Coordinator, or designee, will provide to the beneficiary and provider a written authorization detailing the amount, scope and duration that has been authorized. The written authorization will be maintained in the client record.
         a. TBS Treatment Plans identifying specific frequency, scope and duration must be authorized by the Care Coordinator.
         b. Amount of service will be approved for up to 20-hours per week as determined necessary by the Care Coordinator and TBS Provider, and as identified in the client Treatment Plan.
         c. A specific request must be made to the County TBS Coordinator for services greater than 20-hours per week.
      2. When services are denied, the County TBS Coordinator, or designee, will provide the beneficiary with a NOABD – Denial letter (See **Policy 3223: Notice of Adverse Benefit Determination**).

d. Re-authorization
   i. The County TBS Coordinator will authorize initial services for 30-days. The Care Coordinator and TBS provider will assess continued need for TBS services in the first 30-days.

ii. The Care Coordinator will authorize services for up to 90-days by approving the initial TBS Treatment Plan. (See **Policy 2461 – Therapeutic Behavioral Services** for further details).
iii. The Care Coordinator will evaluate, and may re-authorize, continued services at least every 90-days by approving the TBS Treatment Plan.
iv. The County TBS Coordinator will review services every 90-days for continued class membership and medical necessity, and as appropriate will give permission to continue services.
v. Services may be modified or terminated at each 90-day re-authorization (or when clinically indicated). When services are modified or terminated, without request of the beneficiary, the County TBS Coordinator, their designee, or the Care Coordinator will, in a timely manner, provide the beneficiary with the appropriate NOABD letter (See **Policy 3223: Notice of Adverse Benefit Determination**).
vi. TBS can be authorized by the Care Coordinator, in 90-day increments, for a duration of 12-months or less by approval of the TBS Treatment Plan.
vii. If services are to continue past 12-months, a re-authorization request must be submitted to and approved by the County TBS Coordinator. Request to continue TBS services must be submitted to the County TBS Coordinator no later than three (3) weeks before the original authorization is set to expire.

See **Policy 2461 – Therapeutic Behavioral Services** for full TBS criteria, terms, and procedures.

3. **Therapeutic Foster Care (TFC):**
   a. Request for service:
      i. The MHP shall review TFC service requests from various placement entities.
   b. Determination:
      i. All requests for TFC services are submitted in writing to the County TFC Coordinator using **the IHBS/TBS/TFC Referral and Authorization form** and the **TFC Checklist**.
      ii. The County TFC Coordinator or designee (a licensed or waived representative of the MHP), verifies TFC eligibility and reviews clinically significant information sufficient to make a determination. Further information may be requested as is reasonably necessary to make a determination.
         1. When services are approved, the County TFC Coordinator, or designee, will provide to the beneficiary and provider a written authorization detailing the amount, scope and duration that has been authorized. The written authorization will be maintained in the client record.
         2. When services are denied, the County TFC Coordinator, or designee, will provide the beneficiary with a NOABD – Denial letter (See **Policy 3223: Notice of Adverse Benefit Determination**).
   c. Re-authorization
      i. Request to continue TFC must be submitted to the County TFC Coordinator no later than 3-weeks before the original authorization is set to expire.
      ii. TFC will be authorized for a duration of 6 months or less and must be re-authorized by the County TFC Coordinator if services are to continue longer.

4. **Day Treatment Intensive (DTI) and Day Rehabilitation (DR)**
   a. Request for service:

i. Beneficiaries not currently receiving Santa Cruz County SMHS may request SMHS, including DTI or DR through Santa Cruz County Adult Access Team (See **Policy 2103 – Access Assessments**).
ii. Beneficiaries currently receiving Santa Cruz County SMHS may request DTI or DR by discussing their needs with their Care Coordinator or psychiatric provider if they do not have a Care Coordinator.
iii. A Care Coordinator who is interested in DTI or DR services for a beneficiary shall discuss the option with their supervisor to obtain approval and then discuss the service availability with the beneficiary.
iv. A DTI or DR provider from outside the MHP may request authorization of services by contacting the Santa Cruz County Adult Access Team. The MHP will authorize all eligible providers according to SMHS requirements and contract agreements.

b. Eligibility Review:
   i. All requests for DTI or DR services are submitted in writing to the team supervisor using the **DTI/DR Referral and Authorization form.**
      1. The supervisor verifies DRI or DR eligibility criteria.
         a. If the beneficiary does not meet eligibility criteria for DRI or DR services the supervisor, or Care Coordinator under the direction of the supervisor, will provide the beneficiary with a NOABD – Denial letter (See **Policy 3223: Notice of Adverse Benefit Determination**).
         b. If the beneficiary meets eligibility criteria, the supervisor submits the request to the team manager or the Managed Care Manager if the request is for a Managed Care provider.

c. Determination:
   i. The authorizing manager will review verification of DTI or DR service eligibility criteria and clinically significant information sufficient to make a determination. Further information may be requested as is reasonably necessary to make a determination.
      1. When services are approved, the authorizing manager, or designee, will provide to the beneficiary and provider a written authorization detailing the amount, scope and duration that has been authorized. The written authorization will be maintained in the client record.
      2. When services are denied, the authorizing manager, or designee, will provide the beneficiary with a NOABD – Denial letter (See **Policy 3223: Notice of Adverse Benefit Determination**).

d. Re-authorization
   i. Request to continue DTR or DR must be submitted to the authorizing manager no later than five (5) county business days before the original authorization is set to expire.
   ii. DTI and DR services will be authorized for a duration of four (4) weeks or less and must be re-authorized by the authorizing manager if services are to continue longer.

5. Determination Timeframe

a. Routine determination:
   i. Routine requests for prior authorization of the services covered in the policy will be made within five (5) county business days of the MHP receipt of the information reasonably necessary and requested by the MHP to make a determination.
   ii. The timeframe may be extended up to 14 additional calendar days if:

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

b. Expedited determination:
For cases where it is indicated that the standard routine timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning, an expedited decision will be made as quickly as the beneficiary's health condition requires, but not more than 72 hours after the request for service.

6. Retrospective Authorization

Retrospective Authorization of services covered in this policy may be conducted under the following circumstances:

- Retroactive Medi-Cal eligibility determination;
- Inaccuracies in the Medi-Cal Eligibility Data System; and/or
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries.

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the beneficiary and provider within 30-days of the receipt of information that is reasonably necessary to make the determination.

7. Services not requiring prior authorization

The following services do not require prior authorization:

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

Mental Health Services, Target Case Management, Intensive Care Coordination, and Medication Support Services do require assessment to determine whether beneficiary meets medical necessity criteria. Therapy, Rehabilitation, *Target Case Management, *Intensive Care Coordination, and *Medication Support Services must be included on the beneficiary's Treatment Plan prior to service delivery and the MHP retains the option to review and approve beneficiaries' Treatment Plans prior to service delivery.

* Per DHCS Information Notice 17-040: The following services may be provided under certain circumstances prior to beneficiary Treatment Plan being approved:

- Targeted Case Management and Intensive Care Coordination for assessment, plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services; and,
- Medication Support Services for assessment, evaluation, or plan development; or *if there is an urgent need, which must be documented.*

8. Monitoring

a. Authorized services will be entered into the Prior Authorization Database by the authorizing manager or their designee.
b. Information maintained will include, but not be limited to, beneficiary name, medical record number, service authorized, amount of service, duration, date authorization expires, and explanation of medical necessity.
c. Each authorizing manager, or their designee, will review the database monthly to audit entries for complete and accurate information and authorization is medically necessary.
d. Current Utilization Review practices will be conducted according to amount, scope, and duration of service as authorized.

PRIOR VERSIONS: N/A

REFERENCES: 42 CFR, Parts 438, 440, 456, and 457 as amended March 30, 2016, as published in the Federal Register (81 Fed. Reg. 18390); Medicaid Mental Health Parity and Addiction Equity Act Compliance Plan October 2, 2017; MHSUDS Information Notice No. 19-026; Policy 2103; Policy 2323; Policy 2434; Policy 2461; Policy 3223; Policy 3331.

FORMS/ATTACHMENTS: DTI/DR Referral and Authorization form, IHBS/TBS/TFC Referral and Authorization form, IHBS Checklist, TBS Checklist, TFC Checklist