alameda county behavioral health MENTAL HEALTH & SUBSTANCE USE SERVICES	By: _____ Karyn Tribble, PsyD, LCSW Behavioral Health Director
POLICY TITLE **Authorization of Specialty Mental Health Services**	**Policy No: 200-2** **Date of Original Approval**: 06/25/2020 **Date(s) of Revision(s):**

PURPOSE

This policy describes how Alameda County Mental Health Plan (MHP) authorizes Specialty Mental Health Services (SMHS).

AUTHORITY

- CMS Medicaid and CHIP Managed Care Final Rule (Final Rule)
- Title 42, Code of Federal Regulations (CFR), Part 438. Managed Care Regulations
- Title 9, California Code of Regulations (CCR). Rehabilitative and Developmental Services
- Alameda County's Mental Health Plan (MHP) Contract #17-94572 with the State Department of Health Care Services (DHCS)
- MHSUDS Information Notice No.: 19-026 Authorization of Specialty Mental Health Services

SCOPE

All Alameda County Mental Health Plan (MHP) county-operated programs, in addition to entities, individuals and programs providing mental health service review and authorization under the Alameda County MHP.

POLICY

Medical necessity, appropriateness, and efficiency of services provided to eligible Alameda County Medi-Cal beneficiaries and Health Plan recipients are evaluated both prospectively and retrospectively. Prospective evaluation occurs through prior or concurrent authorization procedures. Retrospective evaluation occurs through retrospective authorization procedures.

Authorization decisions will be made based on Medi-Cal medical necessity criteria and consistent with current clinical practice guidelines, principles, and processes. All covered SMHS services deemed to be medically necessary must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The Alameda County MHP does not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary. In addition, the Alameda County MHP follows the authorization timeliness requirements for standard and expedited authorization requests.

Decisions to deny or authorize a service request in an amount, duration, or scope that is less then requested are made by health care professionals who have appropriate clinical expertise in addressing the beneficiary's behavioral health needs. Only a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS request by a beneficiary or a provider, may deny, or modify a request for authorization of SMHS for a beneficiary for reasons related to medical necessity. All psychiatric inpatient hospital service payment denials are made by a physician – except denials are made by a psychologist for beneficiaries admitted by a psychologist and who received services under the psychologist's scope of practice. Applicable provider notification and beneficiary notices of adverse benefit determination (NOABD) are completed within timeliness requirements.

This policy is developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice. These guidelines are evaluated, and updated if necessary, at least annually.

Authorization Mechanisms

For SMHS, three authorization mechanisms are utilized:

- Point of Authorization (POA)
- MHP Centralized Committee
- Provider On-Site Committee

The following sections detail the specific authorization mechanism(s) utilized for SMHS, inclusive of the types of authorization requirements.

MHP Concurrent Review & Authorization

The following SMHS require MHP concurrent review and authorization:

- Psychiatric Inpatient Hospital
- Psychiatric Health Facility (PHF)
- Crisis Residential Treatment (CRT)
- Adult Residential Treatment (ART)

Psychiatric Inpatient Hospital and PHF services are considered emergency services and therefore prior authorization is not required. Concurrent review and authorization is conducted through a POA.

Concurrent review and authorization of CRT and ART, are conducted through a POA and MHP centralized committees.

For SMHS services that require MHP concurrent review and authorization, the Alameda County MHP will:

- Conduct concurrent review of treatment authorization following the first day of admission to a facility through discharge in the absence of an MHP referral;

- Communicate its decision to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries to the beneficiary's treating provider within 24 hours of the decision;
- Not discontinue care until the beneficiary's treating provider has been notified of the MHP's decision and care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.

Prior Authorization or MHP Referral

The following outpatient services require prior authorization or MHP referral:

- Day Treatment Intensive (DTI)
- Day Rehabilitation (DR)
- Intensive Home-Based Services (IHBS)
- Therapeutic Behavioral Services (TBS)
- Therapeutic Foster Care (TFC)

Prior authorization or MHP referral for day treatment services, more specifically DTI and DR, are conducted through a POA and MHP centralized committees.

Prior authorization or MHP referral for IHBS, TBS, and TFC are conducted through a MHP centralized committee.

For SMHS services that require prior authorization or MHP Referral, the Alameda County MHP will:

- Review and make a decision regarding a provider's request as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination;
- Specify the amount, scope, and duration of treatment that the MHP has authorized;
- Communicate its decision to modify or deny a provider request to the beneficiary, in writing, of the adverse benefit determination;
- Communicate its decision to terminate, reduce, or suspend a previously authorized service to the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

No Prior Authorization

Prior authorization cannot be required for the following outpatient services:

- Crisis Intervention
- Crisis Stabilization
- Mental Health Services
- Targeted Case Management

- Intensive Care Coordination
- Medication Support Services

For Fee-for-Service (FFS) Network Outpatient Providers (e.g. therapists), an MHP referral and MHP concurrent review and authorization is conducted through a POA and MHP centralized committee.

For Organizational Outpatient Providers, inclusive of county and county-contracted, concurrent review and authorization is conducted through a provider on-site committee. Providers are delegated by the MHP the authority to independently assess, authorize, and render treatment as clinically necessary and indicated. The MHP retains the oversight and monitoring functions, inclusive of chart audits to determine whether or not documentation meets Medi-Cal reimbursement criteria.

Retrospective Review & Authorization
Retrospective review and authorization of SMHS may occur under the following limited 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 hospital services).

In cases where the review is retrospective, the Alameda County 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.

Summary Table of SMHS and Authorization Mechanism & Type

The below table provides an overview of Alameda County SMHS and Authorization Mechanisms and Types Utilized:

SMHS TYPE	AUTHORIZATION MECHANISM	AUTHORIZATION TYPE
Psychiatric inpatient hospital and psychiatric health facility services	Point of Authorization (POA)	MHP Concurrent
Crisis residential treatment (CRT) and adult residential treatment (ART)	POA/MHP Centralized Committee	MHP Referral/ MHP Concurrent
Day Treatment Intensive	POA/MHP Centralized Committee	Prior/MHP Referral
Day Rehabilitation	POA	Prior/MHP Referral

Intensive Home-Based Services (IHBS)	MHP Centralized Committee	Prior/MHP Referral
Therapeutic Behavioral Services (TBS)	MHP Centralized Committee	Prior/MHP Referral
Therapeutic Foster Care (TFC)	MHP Centralized Committee	Prior/MHP Referral
Fee-for-Service Network Outpatient SMHS	POA/ MHP Centralized Committee	MHP Referral/ MHP Concurrent
Organizational Outpatient SMHS	Provider On-Site Committee	Provider Concurrent

PROCEDURE

I. Authorization of Psychiatric Inpatient Hospital and Psychiatric Health Facility (PHF) Services:
   A. The ACBH Utilization Management Program (UM) is the designated POA.
   B. Prior Authorizations are not required and are not provided.
   C. Concurrent review and authorization is completed by UM licensed clinical staff upon notification of the admission of an Alameda County MHP beneficiary. Notification to UM shall be within 24 hours of admission or upon knowledge that an admission is an Alameda County MHP beneficiary.
   D. Concurrent review methodology and frequency shall be determined based upon beneficiary clinical status and operational ability of both ACBH UM and the admitting facility.
   E. Concurrent review shall be conducted through and until beneficiary discharge.
   F. Administrative tasks associated with payment authorization shall be completed post-discharge and via the applicable reimbursement claim form and billing mechanism/system.

II. Authorization of Crisis Residential Treatment (CRT) and Adult Residential Treatment (ART) Services:
   A. A Centralized Committee either through the ACBH Adult and Older Adult System of Care (AOSOC) or the Child and Young Adult System of Care (CYASOC) and ACBH UM collaboratively conduct concurrent review and authorization.
   B. Referrals to CRT and ART may occur via the MHP, MHP contractors, and external organizations.
   C. Concurrent review and authorization is completed by licensed clinical ACBH staff upon notification of admission of an Alameda County MHP beneficiary.
   D. Concurrent review frequency shall be determined based upon beneficiary clinical status and number of authorized days.
   E. Authorization decisions shall be entered in Alameda County data/billing systems to ensure appropriate reimbursement claims.

III. Authorization of Day Treatment Intensive (DTI) and Day Rehabilitation (DR) Services:
   A. ACBH UM is designated to conduct initial and continuation authorizations for adult DTI and DR services and continuation authorizations for children and non-minor dependent DTI and DR services.
   B. A Centralized Committee through the ACBH Child and Young Adult System of Care (CYASOC) is designated to conduct the initial authorizations for children and non-minor dependent DTI and DR services.
   C. DTI and DR services receive prior authorization.
   D. DTI services are reviewed and authorized every three (3) months.
   E. DR services are reviewed and authorized every six (6) months.

IV. Authorization of Intensive Home-Based Services (IHBS), Therapeutic Behavioral Services (TBS), and Therapeutic Foster Care (TFC):
   A. A Centralized Committee through the ACBH Child and Young Adult System of Care (CYASOC) is designated to conduct prior authorization for these services.

V. Authorization of Fee-for-Service (FFS) Network Outpatient SMHS:
   A. A Centralized Committee through ACBH ACCESS is designated to conduct the initial MHP Referral and authorization.
   B. Continuation authorizations are conducted by ACBH UM.
   C. Authorization duration is in six (6) month intervals.

VI. Authorization of Organizational Outpatient SMHS:
   A. Review and authorization is delegated by ACBH to Provider On-Site Committees
   B. ACBH Quality Assurance (QA) conducts oversight and monitoring, inclusive of chart audits to determine if documentation meets Medi-Cal reimbursement criteria.

NON-COMPLIANCE

I. Non-compliance is defined as the Mental Health Plan (MHP) county and county-operated programs, entities, individuals not acting in accordance with the above policies and procedures.
II. Providers may report non-compliance through the ACBH Provider Problem and Resolution and Appeal process.
III. Beneficiaries may report non-compliance through the ACBH Consumer Grievance and Appeal process
IV. Staff shall not face retribution for filing a notice of non-compliance.
V. Staff can notify their immediate supervisor about non-compliance, and the immediate supervisor can complete a Non-Compliance Notification Form to send to ACBH. Alternatively, staff can notify the appropriate ACBH staff directly.
VI. Staff should report the non-compliance to ACBH as soon as possible.
VII. Communication that contains protected health information or otherwise confidential information should be sent through secure methods such as email with secure encryption.

CONTACT

ACBH Office	Current as of	Email
Utilization Management Program (UM)	4/28/20	um@acgov.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff
- ACBH County and Contract Providers (i.e. Network Providers)
- ACBH Beneficiaries
- Public

ISSUANCE AND REVISION HISTORY

Original Authors: Karen Capece, LCSW, Division Director, Utilization Management Program
Original Date of Approval: xx/xx/xxxx by Karyn Tribble, PsyD, LCSW, Behavioral Health Director
Date of Revision: N/A

Revise Author	Reason for Revise	Date of Approval by (Name)
N/A		

DEFINITIONS

Term	Definition
Adult Residential Treatment (ART) Services	Adult Residential Treatment Services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services (e.g. assessment, plan development, therapy, rehabilitation, collateral) that support beneficiaries in their efforts to restore, improve, and /or preserve interpersonal and independent living skills and to access community support systems that support recovery and enhance resiliency. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.
Centralized Committee	Licensed or "waivered/registered" clinical staff who have the appropriate clinical expertise in addressing the beneficiary's behavioral health needs, and conduct review and authorization of SMHS off-site.
Concurrent Review and Authorization	Review of services to determine that admission and continued stay medical necessity criteria is met while a beneficiary receives these services.

Crisis Residential Treatment (CRT) Services	Crisis Residential Treatment Services are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical completions requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services (e.g. assessment, plan development, therapy, rehabilitation, collateral, crisis intervention) are available all seven days. The timing, frequency, and duration of the various types of services provided to each beneficiary receiving Crisis Residential Treatment services will depend on the acuity and individual needs of each beneficiary. For example, a beneficiary newly admitted to a crisis residential treatment program would be more likely to receive crisis intervention or psychotherapy then the development of community support systems, which would be more appropriate as the beneficiary prepares for discharge from the program.
Day Rehabilitation (DR)	Day rehabilitation means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
Day Treatment Intensive (DTI)	Day Treatment Intensive means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, to avoid placement in a more restrictive setting, or to maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours a day and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
Intensive Home-Based Services (IHBS)	IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning. Interventions are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community. IHBS can be effective in preventing a child from being removed from home and/or being admitted to an inpatient hospital or residential treatment setting.
Mental Health Plan (MHP)	An entity which enters into an agreement with the Department of Health Care Services (DHCS) to contract, arrange and/or provide psychiatric inpatient hospital services for beneficiaries. A MHP may be a county, counties acting jointly or another governmental or nongovernmental entity.

On-Site Committee	Licensed or "waivered/registered" clinical staff who have the appropriate clinical expertise to address a beneficiary's behavioral health needs and to conduct review and authorization of SMHS on-site.
Outpatient Services	Services that meet Medi-Cal medical necessity criteria for SMHS (Title 9, California Code of Regulations, §§1830.205, 1830.210).
Point of Authorization (POA)	The function within the Mental Health Plan (MHP) that is required to receive provider communications 24 hours a day, seven days a week regarding requests for MHP payment authorization of psychiatric inpatient hospital, psychiatric health facility, and psychiatric nursing facility services and authorizes payment for those services. This function may be assigned to a person, an identified staffing unit, a committee, or an organized executive who may delegate the authorization functions.
Prior Authorization	As defined by State law, prior authorization is an approval of a specified service in advance of the provision of that service based upon a determination of medical necessity. Payment is made after post-service prepayment audit, which is a review for medical necessity and program coverage after service was provided. Payment may be withheld or reduced if the service provided was not a covered benefit, deemed medically unnecessary or inappropriate. This contrasts with the State's prior authorization definition, which is the issuance of an MHP payment authorization to a provider before the requested service has been provided (WIC §14133; Title 9, CCR, §1810.234).
Psychiatric Inpatient Hospital Services	Medi-Cal medical necessity criteria for Psychiatric Inpatient Hospital Services are as follows: 1) Covered Medi-Cal DSM diagnosis; 2) Cannot be safely treated at a lower level of care; 3) Requires psychiatric inpatient hospital services, as a result of a mental disorder, due to the below indications: symptoms or behaviors represent a current danger to self or others, or significant property destruction, prevent the beneficiary from providing for or utilizing food, clothing or shelter, present a severe risk to the beneficiary's physical health, represent a recent significant deterioration in ability to function and/or require admission for further psychiatric evaluation, medical treatment, and/or other treatment that can reasonably be provided only if the patient is hospitalized; 4) Continued presence of indications that meet the medical necessity criteria indicated above, serious adverse reaction to medication, procedures or therapies requiring continued hospitalization, presence of new indications that meet medical necessity criteria as previously indicated, and/or need for continued medical evaluation and treatment that can only be provided if the beneficiary remains in the hospital (Title 9, CCR, §§1820.205; 1820.220).
Retrospective Review and Authorization	Post-service review to determine if medical necessity criteria for reimbursement is met.
Specialty Mental Health Services (SMHS)	Beneficiaries with a current moderate-to-severe mental health condition as evidenced by meeting the following Medi-Cal medical necessity criteria for Specialty Mental Health Services: 1) Covered Medi-Cal DSM diagnosis; 2) Significant impairment or a reasonable probability of significant deterioration in an important area of life functioning; or a reasonable probability a beneficiary under the age of 21 will not progress developmentally as individually appropriate; 3) The proposed intervention is to address the

	covered diagnosis and the expectation is that the proposed intervention will significantly diminish the impairment, or prevent significant deterioration in an important area of life functioning; 4) The condition would not be responsive to physical health care based treatment (Title 9, California Code of Regulations, §§1830.205, 1830.210).
Therapeutic Behavioral Services (TBS)	TBS are adjunct, short-term, one-to-one behavior intervention services for eligible full-scope Medi-Cal beneficiaries who receive services from a primary mental health therapist (SMTP). These beneficiaries have serious emotional problems and may be experiencing a stressful transition or life crisis and need additional mental health services. TBS are intended to prevent placement into a group home/DTRTP or a locked facility. TBS is also utilized to facilitate transition from the aforementioned high levels of care to lower-level-of-care options.
Therapeutic Foster Care (TFC)	TFC is 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 available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit to children and youth, under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria.