Contra Costa County Health Services Department **Behavioral Health Services Division** **Mental Health Plan**	POLICY NO. 706-MH
POLICY: **UTILIZATION REVIEW: SPECIALTY MENTAL HEALTH SERVICE AUTHORIZATION PROCESS**	Effective as of: July 1, 2022 Next Review Date: July 31, 2025 Policy Expires On: July 31, 2026
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POLICY: UTILIZATION REVIEW: SPECIALTY MENTAL HEALTH SERVICE AUTHORIZATION PROCESS

I. PURPOSE:

The purpose of this policy is to establish and outline the Service Authorization process (also known as Level 1 Review) for Contra Costa Behavioral Health Services-Mental Health Plan (CCBHS-MHP) County Owned and Operated Clinics and community-based organizations (CBOs) and to ensure that CCBHS-MHP complies with current State and Federal regulations.

II. REFERENCES:

- 22 CFR
- 42 CFR, part 438.3(h)
- 9 CCR, Chapter 11, §1830.205
- California Department of Health Care Services (DHCS), MHSUDS Information Notice No: 16-051
- DHCS, MHSUDS Information Notice No: 17-004E
- DHCS, MHSUDS Information Notice No: 18-053
- DHCS, Behavioral Health Information Notice 22-013
- DHCS, Behavioral Health Information Notice 22-016
- DHCS, Behavioral Health Information Notice 22-019
- Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services
- Policy 509-MH, Criteria for Beneficiary Access to Specialty Mental Health Services, Medical Necessity and Other Coverage Requirements (CalAIM Initiative)
- Policy 510-MH, Guidelines for Urgent Mental Health Conditions
- Policy 709-MH, Utilization Management/Utilization Review: Mental Health Documentation Standards
- Policy 713-MH, Utilization Review: Mental Health Documentation Standard Compliance and Compliance Monitoring (Level II and Centralized Review)
- Policy 815, Notice of Adverse Benefit Determination
- Policy 831-MH, Scope of Practice Guidelines

III. POLICY:

It is the policy of CCBHS-MHP that all service providers shall obtain Service Authorizations for specialty mental health services (SMHS). Designated Service Authorization Committees shall convene regularly in order to review and authorize services for beneficiaries at Adult and Child/Adolescent County Owned and Operated Clinics and at CBOs based on acuity, medical and service necessity guidelines and eligibility criteria.

IV. AUTHORITY/RESPONSIBILITY:

Mental Health Program Chiefs
Utilization Review (UR) Program Manager
UR Coordinators
UR Mental Health Clinical Specialists
Behavioral Health Service Providers
UR Clerical Staff

V. PROCEDURE:

A. In order to obtain Service Authorization for SMHS, service providers shall complete and submit for review all required clinical documentation that meets medical and service necessity.

B. Requirements Applicable to Authorization of all SMHS.

1. CCBHS-MHP shall establish and implement written policies and procedures to address the authorization of SMHS. Authorization procedures and utilization management criteria shall:

   a. Be based on SMHS access criteria, including access criteria for beneficiaries under age 21 pursuant to the EPSDT mandate.

   b. Be consistent with current evidence-based clinical practice guidelines, principles, and processes.

   c. Be 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.

d. Be evaluated, and updated if necessary, at least annually.

e. Be disclosed to the CCBHS-MHP beneficiaries and network providers.

2. CCBHS-MHP shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested 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.

3. A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for CCBHS-MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision. If CCBHS-MHP modifies or denies an authorization request, CCBHS-MHP shall notify the beneficiary in writing of the adverse benefit determination. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.

4. CCBHS-MHP shall notify the requesting provider in writing and give the beneficiary written notice of any decision by CCBHS-MHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.

5. CCBHS-MHP shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

C. **Timelines for Outpatient Service Authorization.**

1. Initial Service Authorization for outpatient services shall be obtained within sixty (60) days of the date the beneficiary was admitted to the program.

    a. Required documents for initial authorization must be completed, signed and submitted for review before the initial sixty (60)-day service authorization period expires.

2. Annual reauthorizations shall be obtained prior to the expiration of the authorization period listed on the Service Authorization Form or the BHS Service Authorization Form.

    a. The clinical assessment must be conducted and completed within the last month of the authorization.

    b. For Medication Services Only beneficiaries, the psychiatric assessment must be conducted every two (2) years within the last month of the authorization.

D. **Prior Authorization and Concurrent Review Requirements.**

1. CCBHS-MHP shall notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

2. CCBHS-MHP shall maintain telephone access 24-hours a day, 7-days a week for providers to request expedited authorization of an outpatient service requiring prior authorization.

3. Prior authorization or a CCBHS-MHP referral is required for the following services:

    a. Intensive Home-Based Services.

    b. Day Treatment Intensive.

    c. Day Rehabilitation.

    d. Therapeutic Behavioral Services.

    e. Therapeutic Foster Care.

4. CCBHS-MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that CCBHS-MHP has authorized. CCBHS-MHP must document their determinations of whether a service

requires CCBHS-MHP referral or prior authorization and maintain that documentation in accordance with Title 42 of the CFR, part 438.3(h).

5. No prior authorization shall be required for mental health assessment services, nor for outpatient services other than those services listed above.

6. CCBHS-MHP shall disclose to DHCS, CCBHS-MHP providers, beneficiaries and members of the public, upon request, the utilization management or utilization review policies and procedures that CCBHS-MHP, or any entity that CCBHS-MHP contracts with, uses to authorize, modify, or deny SMHS. CCBHS-MHP may make the criteria or guidelines available through electronic communication means by posting them online.

7. CCBHS-MHP shall ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS.

8. CCBHS-MHP shall provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

9. CCBHS-MHP shall not require prior authorization for the following services/service activities:

    a. Crisis Intervention.

    b. Crisis Stabilization.

    c. Mental Health Services, including initial assessment.

    d. Targeted Case Management.

    e. Intensive Care Coordination.

    f. Peer Support Services.

    g. Medication Support Services.

10. For purposes of prior authorization, referral by CCBHS-MHP to a contracted provider is considered to serve the same function as approving a request for authorization submitted by a provider or beneficiary.

11. The following factors determine which services will be subject to CCBHS-MHP referral or prior authorization requirements:

    a. Service type.

b. Appropriate service usage, cost, and effectiveness of service and service alternatives.

c. Contraindications to service and service alternatives.

d. Potential fraud, waste, and abuse.

e. Patient and medical safety.

f. Other clinically relevant factors.

12. CCBHS-MHP may require providers to request payment authorization for the continuation of services at intervals specified by CCBHS-MHP (e.g., every six months). CCBHS-MHP shall determine these intervals based on the criteria and guidelines provided by DHCS.

E. **Retrospective Authorization Requirements.**

1. CCBHS-MHP shall establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). CCBHS-MHP may conduct retrospective authorization of SMHS under the following limited circumstances:

a. Retroactive Medi-Cal eligibility determinations.

b. Inaccuracies in the Medi-Cal Eligibility Data System.

c. 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.

2. In cases where the review is retrospective, CCBHS-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.

F. **Documents Required for Outpatient Service Authorization.**

1. Providers shall complete the following documentation and submit to the Service Authorization Committee for review and authorization. CCBHS-MHP CBOs may use either the County forms listed or their own forms that have been approved by CCBHS-MHP.

a. One of the following assessment forms:

i) Child (0-20) Clinical Assessment (County providers).

ii) Form MHC-033, Clinical Assessment - Under 21 (CBO providers).

iii) Adult (21 and older) Clinical Assessment (County providers).

iv) Form MHC-100, Clinical Assessment - 21 and over (CBO providers).

v) Another initial assessment that was completed within twelve (12) months of admission.

a) For County providers, this must be scanned into the ccLink Media Tab.

b. For beneficiaries under age 21, either CANS (County providers), if not completed as part of the Initial Assessment for Children, or form MHC-118, Child and Adolescent Needs and Strengths (CANS), or electronically entered equivalent (CBO providers).

c. For beneficiaries age 3-18, either BHS Pediatric Symptom Checklist - PSC35 (County providers) or form MHC-120, Pediatric Symptom Checklist (PSC35) (CBO providers).

a. Either Problem List (County providers) or Form MHC-018, Mental Health Client Problem List (CBO providers).

b. If requesting Medication Support Services:

i) For County Owned and Operated Clinics, the beneficiary's Medication Tab on ccLink must be updated. For CBO providers, a copy of the current form MHC-046, Physician Orders / Medication Record, or equivalent.

i) Completed medication consent forms must have been scanned into the ccLink Media Tab (County providers) or submit form MHC-029, Informed Consent for Psychotropic Medications (CBO providers), including:

a) Consents for each medication prescribed by the Psychiatrist/NP.

b) The signatures of the Psychiatrist/NP and the beneficiary and/or their legal responsible party within the past two (2) years.

ii) For minor beneficiaries who are under legal guardianship, State JV-220 and JV-223 forms must accompany a signed medication consent form.

iii) The Service Authorization Committee will grant full Service Authorization starting on the date when medication consents are considered complete with all required signatures.

B. **Crisis Residential Services.**

1. CCBHS-MHP must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). CCBHS-MHP may not require prior authorization.

2. If CCBHS-MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as CCBHS-MHP specifies the parameters (e.g., number of days authorized) of the authorization. CCBHS-MHP must then reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on the beneficiary's continued need for services.

3. In the absence of a CCBHS-MHP referral, CCBHS-MHP shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. CCBHS-MHP may elect to authorize multiple days, based on the beneficiary's mental health condition, for as long as the services are medically necessary.

4. The referral from CCBHS-MHP will serve as the initial authorization for a period of three (3) calendar days from the date of admission.

5. CCBHS-MHP will authorize a maximum of thirty (30) days of crisis residential services.

   a. CCBHS-MHP may extend the authorization beyond thirty (30) days based on the beneficiary's mental health condition for as long as the services are medically necessary.

i) Must complete a Justification for Continued Authorization form.

b. Length of stay: Crisis residential treatment may not continue past the expiration of the third treatment plan (length is typically ninety [90] days).

6. CBO service providers must submit the completed required documentation to the Service Authorization Committee for continued service authorization prior to the end of the third (3rd) calendar day of the initial authorization. The following documentation is required for service authorization:

a. Form MHC-100, Clinical Assessment - 21 and over. Must be signed by a psychiatrist if the beneficiary is discharged with psychotropic medication.

b. A completed Form MHC-029, Informed Consent for Psychotropic Medications, for each drug prescribed by the Psychiatrist/NP. Must be signed by the Psychiatrist/NP and by the beneficiary and/or their legal responsible party within the past two (2) years to be valid.

c. Form MHC-018, Mental Health Client Problem List.

d. Admission Agreement.

G. **Service Authorization Committee.**

1. Service Authorization Committee meetings shall be held for each of the Adult and Child/Adolescent County Owned and Operated Clinics and CBOs at least one (1) time per month.

2. All Service Authorization requests shall be approved or denied by CCBHS-MHP licensed mental health professionals.

3. The Service Authorization Committee shall be comprised of the following:

a. UR Program Supervisor.

b. Program Manager/Supervisor.

c. UR Coordinators.

d. Mental Health Clinical Specialists/Team Leads.

e. UR Mental Health Clinical Specialists.

f. UR Clerk.

4. Service Authorization Committee responsibilities.

   a. The Program Manager/Supervisor, UR Coordinator, UR Mental Health Clinical Specialist, and clinic Mental Health Clinical Specialists/Team Leads shall be responsible for review and authorization of services.

   b. The UR Clerk shall coordinate the Authorization Meetings and be responsible for verifying eligibility, collecting and organizing documentation to be reviewed. The UR Clerk shall utilize reports to determine cases requiring review for service authorization and provide notification via the ccLink Flag Notification System or email. The UR Clerk shall also be responsible for entering Service Authorizations into the billing system.

      i) Report SCR4412: Outpatient Utilization Control prints on a weekly basis and is distributed to all County Owned and Operated Clinic and CBO service providers. This report details the cases where the Service Authorization has expired or is expiring. These cases require submission/presentation of UR documentation for continued service authorization.

5. Committee members shall use the Service Authorization Committee Worksheet to ensure that all required documents are present and completed, that medical and service necessity criteria have been met, and that the beneficiary is receiving services at the appropriate level of care.

6. The Committee members shall ensure that the assigned diagnosis, and, if applicable, the formulated treatment plan is consistent with the clinical presentation, symptoms/behaviors and functional impairments as identified within the assessment.

   a. Feedback regarding documentation submitted and any authorization decisions will be documented on Service Authorization Committee Worksheet.

   b. A copy of the worksheet will be provided to the requesting program.

7. Service Authorizations shall be documented on one of the following:
   a. The Service Authorization Form, form MHC-036, for beneficiaries seen at CBOs who do not have an open admission at a County Owned and Operated clinic.
   b. The BHS Service Authorization Form in ccLink for beneficiaries seen at County Owned and Operated Clinics and/or CBOs who have an open admission to the County.
8. Service Authorizations may be approved for up to 12 months.
   a. If using an initial assessment from another provider, the assessment is valid for 12 months from the date it was completed. Full authorization may or may not be granted depending upon the completion date of the assessment.
   b. The type of service and length of authorization must be noted.
   c. The Service Authorization must document whether any Adverse Authorization Decision were made and if a Notice of Adverse Benefit Determination (NOABD) was issued.
   d. A Service Authorization Committee member must initial and date the authorization given.

B. **Service Authorization Request (SAR).**

1. For beneficiaries who are not a Presumptive Transfer, who have out-of-county Medi-Cal and are receiving services from CBOs and/or County Owned and Operated Clinics, a SAR must be obtained from the home county prior to the authorization of continued services.
2. Prior to the submission of the SAR request, the service provider must establish that medical and service necessity criteria are met (completion of an assessment/treatment plan for targeted case management services or a problem list) and that services are appropriate for the level of care.
3. Providers shall complete and submit the following documentation to the home county for review and authorization per timeframes listed above.
   a. A Service Authorization Request (State Form SB765 / MH5125), which must include the following:
      i) The specific program/organization that will be provider of SMHS.

ii) The proposed SMHS that will meet service necessity to achieve treatment goals, frequency of services, total time requested, start date and end date of the authorization.

iii) If approved by the home county, the home county authorizing agent will affix their signature to submitted SAR.

b. The maximum duration for a SAR is one (1) year.

c. An approved SAR from the home county must be submitted to the Service Authorization Committee for continued authorization of services.

i) The approved SAR for County Owned and Operated Clinics must be scanned into ccLink.

4. For beneficiaries who have Contra Costa County Medi-Cal, who reside outside of Contra Costa County and who receive services from a host county provider, the host county provider must submit a SAR to the Contra Costa authorizing agent for continued authorization of services.

5. Host county providers shall complete and submit the following documentation to the home county for review and authorization.

a. A Service Authorization Request (State Form SB765 / MH5125), which must include the following:

i) The specific program or organization that will be provider of SMHS.

ii) The proposed SMHS that will meet service necessity to achieve treatment goals, frequency of services, total time requested, start date and end date of the authorization.

b. A copy of the clinical assessment.

c. A copy of the clinical treatment plan.

C. **Expedited Authorization.**

1. CCBHS-MHP must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from CCBHS-MHP's receipt of the information reasonably necessary and requested by CCBHS-MHP to make the determination. For cases in which

a provider indicates, or CCBHS-MHP determines, that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, CCBHS-MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

2. CCBHS-MHP may extend the timeframe for making an authorization decision for up to fourteen (14) additional calendar days, if the following conditions are met:

   a. The beneficiary, or the provider, requests an extension; or,

   b. CCBHS-MHP justifies (to the State upon request), and documents, a need for additional information and how the extension is in the beneficiary's interest.

D. **Denial and Modification of Requested Services Authorization.**

1. 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 twenty-four (24) hours of the decision and care shall not be discontinued until the beneficiary's treating provider has been notified of CCBHS-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. If CCBHS-MHP denies or modifies the request for authorization, CCBHS-MHP must notify the beneficiary, in writing, of the adverse benefit determination. In cases where CCBHS-MHP determines that care should be terminated (no longer authorized) or reduced, CCBHS-MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

2. If CCBHS-MHP denies or modifies the request for authorization, CCBHS-MHP must notify the beneficiary, in writing, of the adverse benefit determination. In cases where CCBHS-MHP terminates, reduces, or suspends a previously authorized service, CCBHS-MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services. Written notification will be sent in accordance with Policy 815.

3. In cases where CCBHS-MHP determines that care should be terminated (no longer authorized) or reduced, CCBHS-MHP must notify the

beneficiary in writing of the adverse benefit determination prior to discontinuing services. Written notification will be sent in accordance to Policy 815.

E. **Use of Electronic Signatures by CBOs.**

1. CBO providers who use an electronic health record may use electronic signatures instead of wet signatures provided that they have submitted certification to CCBHS-MHP that their electronic health record system meets the minimum DHCS standards.