7.2.1 Authorization Standards for Outpatient Specialty Mental Health Services

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References: Sonoma County's Mental Health Plan Contract with Department of Health Care Services, Exhibit A, Attachments 2, 6 and 12; California Code of Regulations (CCR); Title 9, Chapter 11; Title 42, Code of Federal Regulations (CFR) Sections 438.10, 438.210 (a)(3)(ii), 438.210 (a)(4)(ii), 438.210(b)(3), 438.210(c), 438.210(e), 438.330(a)(1), 438.330(b)(3), and 438.608(a)(1); DMH Information Notice 02-06 and 08-38 DMH Letter 03-03; 04-01, and 05-03 MHSUD Information Notice 18-011, 19-026, 22-016 and 21-073

Policy Owner: Sonoma County Behavioral Health Division, QAPI Mental Health Plan, QA Manager

Director Signature: Signature on File

I. Policy Statement

The Sonoma County Department of Health Services – Behavioral Health Division (DHS-BHD) maintains utilization management mechanisms to ensure that delivered services are medically necessary, appropriate, timely, cost-effective and culturally competent. Consistent applications of review criteria standards for initial and continuing service authorizations are met through prior and retrospective review. DHS-BHD utilization management is also employed to detect underutilization and overutilization, as well as to detect and prevent fraud, waste, and abuse.

II. Scope

This policy applies to all DHS-BHD staff and contractors who are involved with authorization and utilization review of outpatient mental health services for Sonoma County clients.

III. Definitions

A. Adoption Assistance Program (AAP): An entitlement program to provide financial and medical coverage to facilitate the adoption of children who otherwise would remain in long-term foster care.

B. Kinship Guardianship Assistance Payment Program (KinGap): A permanency option for children in long-term placement with relatives, which provides a monthly payment to the relative guardian.

C. Non-minor dependents: Foster youth between the ages of 18 and 21 who satisfies criteria to remain in foster care beyond their 18th birthday.

D. Youth: Includes individuals under the age of 18 and non-minor dependents.

IV. Policy

A. DHS-BHD is committed to ensuring Medi-Cal beneficiaries have appropriate access to Specialty Mental Health Services (SMHS). DHS-BHD maintains a policy of authorization of organizational providers' requests for SMHS as a condition of reimbursement for individuals who receive SMHS from DHS-BHD (i.e. clients).

B. Authorization and utilization management of services provided by the DHS-BHD adhere to the following principles:

1. Are based on SMHS access criteria, including access criteria for beneficiaries under age 21 pursuant to the EPSDT mandate;

2. Are consistent with current evidence-based clinical practice guidelines, principles, and processes;

3. Are developed with involvement from organizational providers and licensed mental health professionals acting within their scope of practice;

4. Are evaluated and updated if necessary, at least annually and are disclosed to the DHS-BHD's clients and organizational providers.

C. DHS-BHD 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. (See: V.C.1.e.)

D. Compensation provided to individuals or entities that conduct utilization management activities will not be structured as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

V. Procedures

A. Communication Requirements - DHS-BHD shall do to the following:

1. Notify the Department of Health Care Services (DHCS) and organizational providers in writing of all services that require prior authorization and

ensure that all organizational providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

2. Maintain telephone access 24-hours a day, 7-days a week for organizational providers to make admission notifications and request authorization to request expedited authorization of outpatient services requiring prior authorization.

3. Disclose to DHCS, organizational providers, Medi-Cal beneficiaries and members of the public, upon request, the utilization review policies and procedures that DHS-BHD or its' organizational providers use to authorize, modify, or deny SMHS. These policies and procedures shall be available electronically and in hard copy upon request.

4. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,

5. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization

B. SMHS Authorization and Review Requirements

1. Through policy and utilization review, DHS-BHD shall ensure consistent application of review criteria for authorization decisions and shall consult with requesting providers when appropriate.

2. Authorization and reimbursement of services shall be granted based on the criteria of Medical Necessity.

3. All authorized medically necessary SMHS shall be sufficient in amount, duration, and scope to achieve the purpose for which the services are rendered.

4. Authorization decisions to approve, deny, modify, or defer the requested services shall be made by a licensed healthcare professional who has the appropriate clinical expertise in treatment of the client's illness.

5. DHS-BHD shall 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.

6. Reasons for payment authorization denials, service modifications, denials or deferrals (beyond the timeframe) shall be clearly communicated to beneficiary and provider (if applicable), using a Notice of Adverse Benefit Determination form.

7. Ensure compliance with all requirements necessary for Medi-Cal reimbursement.

8. Relevant clinical information shall be obtained and used for authorization decisions including, but not limited to:

    a. Assessments, progress reports, client plans and other clinical documentation; and,

    b. Consultation with treatment provider(s) as necessary

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

    a. Crisis Intervention

    b. Crisis Stabilization

    c. Mental Health Services: assessment and plan development

    d. Targeted Case Management: for assessment plan development and referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services

    e. Intensive Care Coordination: for assessment plan development and referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services

    f. Peer Support Services

    g. Medication Support Services: for assessment, evaluation, or plan development; or if there is an urgent need, which must be documented

10. DHS-BHD requires prior authorization or referral for the following services:

    a. Intensive Home-Based Services

    b. Day Treatment Intensive

    c. Day Rehabilitation

    d. Therapeutic Behavioral Services

    e. Therapeutic Foster Care

C. DHS-BHD Authorization or Referral Process for Outpatient SMHS

1. Initial authorization for SMHS that require prior authorization:

    a. Initial authorization for these services (See: V.B.10.a.-e.) will be provided by referral and shall specify the amount, scope and duration

of the treatment DHS-BHD has authorized (referral by DHS-BHD serves as authorization).

b. All authorizations will be completed by a Licensed Practitioner of the Healing Arts (LPHA).

c. Prior to the expiration of the initial referral, DHS-BHD requires providers to request authorization for the continuation of services at the following intervals:

   i. At least every 30 days

      (1) Day Treatment Intensive

      (2) Day Rehabilitation

   ii. At least every 90 days

      (1) Therapeutic Behavioral Services

   iii. Every 6 months

      (1) Intensive Home-Based Services

      (2) Therapeutic Foster Care

d. DHS-BHD shall document all authorization determinations.

e. If DHS-BHD denies, terminates, reduces, or suspends an authorization request, notification will be given to the beneficiary, in writing, of the adverse benefit determination prior to services being discontinued. Notification of adverse benefit decisions shall follow established guidelines:

   i. For termination, suspension, or reduction of a previously authorized specialty mental health service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 (Exceptions from advanced notice) and 431.214 (Notice in cases of probable fraud);

   ii. For denial of payment, at the time of any action denying the provider's claim; or,

   iii. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two business days of the decision.

   iv. DHS-BHD organizational providers must also communicate the decision to the affected provider within 24 hours of making the decision.

2. Initial authorization for SMHS for youth who are placed out of county:

    a. For youth with an Aid to Adopt Parents (AAP) Aid Code or Kinship Guardianship Assistance Payment (KinGAP) program Medi-Cal code, regardless of county of origin, DHS-BHD, as the host county provides SMHS in the same manner as those services provided to any other youth Medi-Cal beneficiaries.

    b. As the county of origin for youth with an AAP/KinGap Medi-Cal code placed out of county, DHS-BHD shall evaluate a Service Authorization Request (SAR) from the host county.

    c. Foster youth who have a waiver to presumptive transfer from their county of origin may also have a SAR issued by their host county.

    d. For youth with an AAP/KinGap Medi-Cal code placed in a county other than the county of original jurisdiction, the responsibility for authorization, provision, and payment of SMHS will transfer to the MHP in the foster youth's county of residence.

    e. Upon presumptive transfer, the MHP in the county in which the foster youth resides shall assume responsibility for the authorization and provision of SMHS and the payment for services.

D. Outpatient Authorization Timeframes: DHS-BHD shall review and make authorization determinations regarding provider requests for prior authorization as expeditiously as the beneficiary's mental health condition requires.

    1. Standard Authorization Decision: request for prior authorization will be made 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.

    2. Expedited Authorization Decision: Are made no later than 72 hours from receipt of the request for service from the provider.

        a. Expedited authorization requests are for cases in which a provider indicates, or DHS-BHD determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

    3. Authorization Decision Extension: DHS-BHD may extend the timeframe for making an authorization for up to 14 additional calendar days if:

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

b. DHS-BHD justifies (to DHCS upon request) and documents the need for additional information, including how the extension is in the beneficiary's best interest.

i. Notification of the extension is sent to the beneficiary and a copy to the Quality Assurance Manager.

E. Retrospective Authorization Requirements

1. DHS-BHD's Utilization Management staff or designee conducts retrospective authorization of outpatient SMHS under the following 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

d. Beneficiary's failure to identify payer

2. Designated DHS-BHD staff communicate retrospective authorizations decisions to the individual who received the services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make the determination in a manner consistent with state requirements.

F. Utilization Review: DHS-BHD conducts utilization review and/or auditing activities in accordance with state and federal requirements, and may disallow claims and/or recoup funds, as appropriate, in accordance with DHS-BHD's obligations to DHCS.

VI. Forms

None

VII. Attachments

None