SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

DATE: January 9, 2020

BHRS POLICY: 20-05

SUBJECT: Utilization Management Program and Authorization of Specialty Mental Health Services: SMHS

AMENDED: Technical Edit July 17, 2020; Amended November 5, 2020

SUPERSEDES: Policy 04-09: Authorization Standards – Managed Care

AUTHORITY: MHSUDS Information Notice No(s) (and all regulations references in these INs)
19-026 Authorization of Specialty Mental Health Services
17-040: Chart Documentation Requirement Clarifications
California Department of Health Care Services Managed Care All Plan Letter 17-010 (REVISED)" dated July 17, 2017.
BHRS Policy 19-05: Medical Necessity
BHRS Policy 19-01: Consumer Problem Resolution & NOA
BHRS Policy 20-02: Authorization of Adult Residential Services
BHRS Policy 20-03: Presumptive Transfer
BHRS Policy 20-04: Youth Authorization

Code of Federal Regulations (C.F.R.) §438.62(b)(1)-(2) Continued services to enrollees
42 (C.F.R.) §438.114(c-e) Emergency and post stabilization services
§438.208(b)(1)-(4) Coordination and continuity of care
§438.210(b), §438.210(d)(1)-(2), §438.210(e) Coverage and authorization of services
§438.242(a)(b)(1)-(4) Health information systems
§438.330(a)(1)-(3), §438.330(b), §438.330(c), §438.330(e)(1) Quality assessment and performance improvement program
§438.910(d) Parity requirements for financial requirements and treatment limitations
9 (CCR) §1810.405(c) Access Standards for Specialty Mental Health Services
§1820.205 Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services
§1820.220 MHP Payment Authorization by a Point of Authorization
§1820.230 MHP Payment Authorization by a Utilization Review Committee

DEFINITIONS:

Appeal: A review by BHRS or Contract Agency of an adverse benefit determination.

Assessment: A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.

Beneficiary: A Medi-Cal recipient who is currently receiving services from BHRS or a BHRS contracted provider.

Emergency: A Condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency (Health & Safety Code § 1797.07).

SCOPE:

This policy applies to all providers of Specialty Mental Health BHRS County Staff and Contract Providers, including Mental Health and Substance Use Disorder Services (as appropriate).

POLICY:

The Behavioral Health Recovery Services (BHRS) Utilization Management (UM) program supports the delivery of services provided by its County and Contracted partners, and ensures the delivery of high quality, medically necessary care through appropriate utilization of resources, in a cost effective and timely manner.

BHRS operates a UM program that ensures beneficiaries have appropriate access to SMHS. The UM program evaluates medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization procedures, or retrospectively, such as through retrospective authorization procedures.

Compensation to individuals that conduct UM activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a beneficiary. Such individuals shall annually sign the Affirmative Statement About Incentives.

BHRS has established and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to beneficiaries. This program includes mechanisms to detect both underutilization and overutilization.

Additionally, BHRS has implemented and maintains arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a

comprehensive compliance program (see details https://www.smchealth.org/bhrscompliance-program).

Requirements Applicable to Authorization of all SMHS:
BHRS has established and implemented written policies and procedures addressing the authorization of SMHS. Authorization procedures and UM criteria adhere to the following principles:

- Is based on SMHS medical necessity criteria and consistent with current clinical practice guidelines, principles, and processes;
- 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;
- Is evaluated, and updated if necessary, at least annually; and,
- Is disclosed to BHRS's beneficiaries and network providers.

BHRS ensures that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. BHRS 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.

BHRS provided this policy as notice in writing to DHCS and contracting providers 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.

Second Opinion:
At the request of the beneficiary, when BHRS or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, BHRS provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). BHRS provides a second opinion from a network provider or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. Any beneficiary may contact the ACCESS Call Center at (800) 686-0101 or TDD: (800) 943-2833 to request a second opinion outside the network at no cost to the beneficiary. The ACCESS Call Center will maintain record of this request and outcome.

Authorized Personnel to Make Authorization Decisions:
BHRS 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. BHRS shall notify the requesting provider in writing and give the beneficiary written notice of any decision by BHRS 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 as specified in BHRS Policy 19-01: Consumer Problem Resolution & NOA.

The UM program has the following components:

Utilization Management (UM):

The UM Program operates under the guidance of Medical Director and the Utilization Management Committee. The program is designed to detect and address over and underutilization of services and evaluates medical necessity and appropriateness of services provided to Medi-Cal beneficiaries prospectively, concurrently, and retrospectively. This policy outlines the standards and guidelines that detail how BHRS and its provider network system comply with the federal laws and Department of Health Care Services (DHCS) contract requirements pertaining to UM.

Utilization Management Affirmation Statement: BHRS does not provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. All efforts are made to reduce/eliminate fraud, waste and abuse.

BHRS shall maintain a health information system that collects, analyzes, integrates, and reports utilization data. BHRS shall conduct performance monitoring activities for UM/UR throughout its operations in order to detect both underutilization and overutilization of services. BHRS shall take steps to assure that decisions for UM shall be consistent with its care guidelines.

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 BHRS'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 BHRS denies or modifies the request for authorization, BHRS must notify the beneficiary, in writing, of the adverse benefit determination. In cases where BHRS, determines that care should be terminated (no longer authorized) or reduced, BHRS must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

Utilization Review (UR) Committee for Specialty Mental Health Services:
BHRS has implemented procedures to deliver care to and coordinate services for all of its beneficiaries, including a review of its UM activities annually, ensuring consistency in the authorization process and beneficiary and provider satisfaction. This includes, but is not limited to, reviewing services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports. This also includes how to address data from quality improvement activities specific to enrollee satisfaction and performance of providers.

Retrospective Authorization Requirements and Audit Program:
BHRS performs retrospective authorization of SMHS (inpatient and outpatient) services 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 BHRS 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

Care Coordination:
BHRS shall ensure continuity and coordination of care, which may include but is not limited to, transition or transfer to appropriate level(s) of care, Whole Person Care, long-term services and supports, and Non-Medical Transportation (NMT), for mental health, substance use disorder treatment services, and physical health care providers. BHRS shall coordinate between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays, with Fee-for-service Medical, and with other human services and community service agencies used by beneficiaries. In addition, BHRS shall assess the effectiveness of any agreements to integrate care with physical health care plans. BHRS will ensure each beneficiary has an ongoing source of care appropriate to his or her needs, and a person or entity designated for coordinating services accessed by the beneficiary. BHRS may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve

their purpose. Care coordination efforts shall ensure that the beneficiaries' privacy is protected.

Service Authorization:
The UM program is responsible for authorizing the following services:

All standard authorization decisions and notices will be processed as expeditiously the beneficiary's health condition requires and no more than 5 calendar days following receipt for request for service, with a possible extension of up to 14 additional days, if requested by the client or provider.

Expedited authorization decisions and notice, which could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function will be processed no later than 72 hours after receipt of the request for service. BHRS may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if BHRS justifies a need for additional information and how the extension is in the beneficiary's interest. BHRS shall act on an authorization request for treatment for urgent conditions within one (1) hour of the request.

Licensed/waivered behavioral health staff will be responsible for all authorization decisions. Relevant clinical information will be obtained and used for authorization decisions. The statewide medical necessity criteria will be utilized in authorization decisions, which are consistent with care guidelines reflecting the most current best practices and, in the amount, duration, and frequency appropriate for the presenting condition. When appropriate, the requesting provider will be consulted prior to making authorization decisions.

If at any point in the authorization process, there is a dispute about the authorization determination between the requesting entity and BHRS, the Medical Director or their designee will be available for consultation and resolution of the disputed request for authorization.

Denials will be clearly documented and communicated in writing to clients and providers. Written denial notice to the client includes denial decision to a service request or to authorize a service in an amount, duration, or scope that is less than requested. Such notices will include reference to the benefit provision, guideline, protocol, or other criterion for the denial; a statement that members can obtain a copy of the benefit provision, guideline, protocol, or other criterion for the denial, upon request; and information about the client problem resolution process. Appeals will be addressed through the Beneficiary problem resolution process.

Services Requiring Authorization:
Outpatient Authorization Timeframe and Documentation Requirements:

BHRS reviews and makes 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 BHRS's receipt of the information reasonably necessary and requested by BHRS to make the determination. For cases in which a provider indicates, or BHRS determines, that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, BHRS 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 service. BHRS may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:

- The beneficiary, or the provider, requests an extension; or,
- BHRS justifies (to the State upon request), and documents, a need for additional information and how the extension is in the beneficiary's interest.

BHRS referral or prior authorization shall specify the amount, scope, and duration of treatment that BHRS has authorized. BHRS documents their determinations of whether a service requires BHRS referral or prior authorization and maintain that documentation in accordance with Title 42 of the CFR, part 438.3(h).

If BHRS denies or modifies the request for authorization, BHRS notifies the beneficiary, in writing, of the adverse benefit determination. In cases where BHRS terminates, reduces, or suspends a previously authorized service, BHRS must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services. The beneficiary's notice shall meet the requirements to notify beneficiaries of an adverse benefit determination

Therapeutic Behavioral Services
TBS referral acts as prior authorization. TBS service request and authorization is required.

Intensive Home-Based Services (IHBS)
IHBS services are provided according to an individualized treatment plan developed by an LPHA, which acts as prior authorization.

Out of plan service authorization requests (SARs, Presumptive Transfers):
BHRS will be responsible for authorization, provision, and payment of SMHS for foster children placed in a San Mateo County if San Mateo County is not the original county of jurisdiction, unless any exceptions to presumptive transfer apply, and are determined to necessitate the waiving of presumptive transfer, as specified in the following section.

Specialty Mental Health Outpatient Services:
BHRS does not require prior authorization for unplanned services including:

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

Provider is allowed 60 days from admission to provide UNPLANNED services while establishing medical necessity through the assessment and plan development process. If BHRS delegates to a network provider the responsibility for conducting Assessments (when the provider is an LPHA and is the client's care coordinator), prior authorization for assessment is not required.

Prior Authorization or MHP Referral for Outpatient SMHS:
BHRS does **not require** prior authorization for the following services/service activities:

- Crisis Intervention;
- Crisis Stabilization;
- Mental Health Services (assessment, plan development);
- Targeted Case Management (as part of the assessment process);
- Intensive Care Coordination; and,
- Medication Support Services (for urgent needs and assessment/plan development).

PLANNED SERVICES designed to meet the beneficiary's medical necessity needs at the lowest level of care appropriate to meet the client's current needs are based on the assessment conducted by an LPHA.

The LPHA's client plan is the formal authorization of services, and details the type, duration, and frequency of service authorized. The client plan/authorization will be completed at least annually. Any change in service within the year will be formalized and authorized by an LPHA utilizing the client plan addendum.

UM review of SMHS outpatient authorization. The BHRS audit team will audit charts to determine if medical necessity was met and to ensure that services were appropriate for the client's need and level of care. The UM process will review for over and under payment to providers. If services need to be modify based on the UM review the provider, and if appropriate, beneficiary will be notified in writing.

Fee-for-service (FFS)
Responsible UM Staff: The ACCESS UM Team is the responsible UM staff overseeing FFS PPN authorization.

Medically necessary outpatient services including examination, evaluation, individual or group treatment, and medication prescription and monitoring. Services can be provided in acute care

hospitals, individual, group or family therapy services in outpatient or clinic settings. The majority of the FFS contractors are Private Providers in the BHRS Network of care (PPN) primarily psychiatrists, licensed therapist, and psychologists, who provide office- based direct services with authorizations.

Institute for Mental Disease (IMD) admissions:
Responsible UM Staff: The Adult Resource Management Team (ARM) and Collaborative Care Team (CCT) are the responsible UM staff overseeing IMD admissions and authorization.

All admissions to the IMDs including Mental Health Rehab Center (MHRC) are subject to the Prior Authorization must meet County's criteria for such treatment. The length of stay in this setting is approved for up to 6 months days. Extensions may be granted if the client is deemed appropriate for this level of care. Clients entering this setting must either be on a temporary or permanent conservatorship.

Inpatient Hospitalization & Treatment Authorization Requests (TARS):
Responsible UM Staff: Adult Resources Management and the Collaborative Care Team include UM staff for acute and sub-acute services, as well as overseeing Inpatient Hospitalization prior authorization and concurrent review.

Emergency inpatient psychiatric services are not subject to prior authorization, whether the admission is voluntary or involuntary. BHRS shall authorize out of network services when a beneficiary with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospitals or psychiatric health facility services. Following an emergency, we will follow-up with appropriate care.

Authorization of Administrative Days:
Starting with the day the beneficiary is placed on administration day status. Specifically, 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.

Non-Emergency Medical Transportation (NEMT):
Emergency transportation does not require prior authorization. BHRS requires prior authorization of all Non-Emergency Medical Transport services for eligible beneficiary (including Health Plan of San Mateo HPSM): Care Advantage SMI clients). Transportation includes but is not limited to Litter/Gurney Van, Wheelchair Van, or Ambulance medical transportation for *non-emergency* care of any Medi-Cal beneficiary.

NEMT trips require prior authorization in order for these services to be reimbursed. To do so, the provider rendering care for the beneficiary completes the prior authorization form and physician certification statement (PCS) and submits to HPSM. All requests go through HPSM for all Medi-Cal beneficiaries, including SMI/Specialty Mental Health Services clients. The form is located at https://www.hpsm.org/provider/authorizations/specialty-provider#nemt.

The treating physician can submit a request for NEMT services that is consistent with the member's authorized treatment. Authorizations may cover a period of up to 12 months. One form may cover a single member for a single type of ride (e.g., a wheelchair van) for a 12-month period. If multiple types of rides (e.g., a wheelchair van and Basic Life Support vehicle, which are billed using different CPT codes) are needed for the same member, then a separate authorization will need to be submitted for each type of transport needed for that member.

Partial hospitalization program (PHP):
Responsible UM Staff: The Adult Resources Management Team (ARM) and Collaborative Care Team (CCT) are the responsible UM staff overseeing PHP admissions and authorization.

The PHP will be Dual Diagnosis Capable (DDC) to address the relationship between the mental and substance-related disorders (SUD). Level 2.5 PHP will have direct access to psychiatric, medical, and laboratory services, and are designed to meet the identified needs which warrant daily monitoring or management, but which can be appropriately addressed in a formal structured outpatient setting. The program will discern their effect on the client's readiness to change and relapse and recovery environmental issues. Readiness to change needs will be assessed for both substance abuse (SU) and mental health problems.

Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services:
Responsible UM Staff: The Adult Management Team (ARM) and Collaborative Care Team (CCT) are the responsible UM staff overseeing CRTS and ARTS admissions and authorization.

BHRS conducts referral, concurrent review, and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS).

All clients are referred from BHRS to CRTS or ARTS, the referral serves as the initial authorization. The referral will specify the number of days authorized. BHRS will then reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.

Crisis Residential:
Entering into this treatment setting must have an accepted mental health diagnosis or exhibit

acute symptoms of mental illness and at risk for re-hospitalization. The length of stay in this setting is approved for up to 30 days. Extensions may be granted if the client is deemed appropriate for this level of care. The BHRS referral will be the initial authorization. Concurrent review and reauthorization will be based on the client's current needs as specified in the referral/authorization.

Skilled Nursing Facilities (SNF):
BHRS contracts with skilled nursing facilities to provide medical and psychiatric services for adults 18 years of age and older and residents of San Mateo County. All clients must have a primary psychiatric diagnosis and have a medical condition that requires a skilled nursing level of care. All services must be pre-authorized by the 24-Hour Care Unit. Clients requiring a locked SNF must either be on temporary or permanent LPS conservatorship.

SUDS Residential:
The Behavioral Health Recovery Services –Substance Use Treatment manages residential capacity, authorization, and placement. All referrals to residential must meet eligibility for medical necessity, ASAM level of care criteria (American Society for Addiction Medicine) and be authorized by SUDS administration. Residential 3.1 is appropriate for those who need supportive living in conjunction with low-intensity treatment. Residential 3.3 is for beneficiaries who have cognitive impairments and need a slower pace while receiving high intensity treatment. Residential 3.5 is appropriate for beneficiaries who are in imminent danger and require 24-hour stabilization services.

Other Medi-Cal beneficiary services as appropriate:
The authorization requirements shall comply with parity requirements in specialty mental health and substance use disorder benefits and shall at least include a beneficiary's request for the provision of a service.

Approved: *Signature on File*
Scott Gilman, MSA
BHRS Director

Approved: *Signature on File*
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