Alameda County Behavioral Health Care Services MENTAL HEALTH & SUBSTANCE USE SERVICES	By: DocuSigned by: BA167BA0C0D444A Karyn L. Tribble, PsyD, LCSW, 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):** 1/18/2024

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
- Title 42, Code of Federal Regulations (CFR), Part 438. Managed Care Regulations including Parity Rule
- 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)
- DHCS Behavioral Health Information Notice (BHIN) 22-016 Authorization of Outpatient Specialty Mental Health Services (SMHS)
- Welfare and Institutions Code (W&I) sections 14197.1(b) and 14184.402(i)
- DHCS BHIN 21-073 Criteria for Beneficiary Access to SMHS, medical necessity and other coverage requirements

SCOPE

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

POLICY

Requirements Applicable to Authorization of all SMHS:

Alameda County MHP authorizes SMHS in accordance with the SMHS access criteria defined in DHCS BHIN 21-073 and the access criteria for beneficiaries under age 21

pursuant to the EPSDT mandate. Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT.

Alameda County MHP’s Authorization procedures and utilization management criteria are:

- consistent with current evidence-based clinical practice guidelines, principles and processes
- developed through a collaborative process with providers
- evaluated and updated when necessary and at least annually
- are available upon request to the MHP’s beneficiaries and network providers

All covered SMHS 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.

Alameda County Mental Health Plan ensures 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.

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 the 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 a MHP modifies or denies an authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination.

Alameda County MHP notifies the requesting provider in writing and gives the beneficiary written notice of any decision by the 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 meets the requirements pertaining to notices of adverse benefit determinations.

Alameda County has mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and consults with the treatment provider when appropriate.

PROCEDURE

SMHS authorization requests are evaluated both prospectively and retrospectively. Prospective evaluation occurs through prior or concurrent authorization procedures. Retrospective evaluation occurs through retrospective authorization procedures.

For SMHS, two authorization mechanism are utilized:

- Point of Authorization (POA)
- MHP Centralized Committee

I. MHP Concurrent Review and 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)

Concurrent review and authorization of the above listed service types is conducted through a POA. The Utilization Management Division within Alameda County Behavioral Health (ACBH) serves as the POA for the MHP.

During the concurrent review process, 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 treatment 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.

II. Prior Authorization or MHP Referral

The following outpatient services require prior authorization or MHP referral and are authorized through a Centralized Committee within ACBH's Children and Young Adult System of Care:

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

III. Outpatient Authorization Timeframe and Documentation Requirements

ACBH reviews and makes a decision regarding a provider's request for prior authorizations expeditiously as the beneficiary's mental health condition requires, and not to exceed five business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. For cases in which a provider indicates, or the MHP determines, that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP 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. ACBH may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:

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

ACBH referral or prior authorization specifies the amount, scope, and duration of treatment that has been authorized. ACBH documents determinations of whether a service requires a referral or prior authorization and maintains that documentation in accordance with Title 42 of the CFR, part 438.3(h).

If ACBH denies or modifies the request for authorization, ACBH will notify the beneficiary, in writing, of the adverse benefit determination. In cases where ACBH terminates, reduces, or suspends a previously authorized service, ACBH notifies 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.

IV. Retrospective Authorization Requirements

ACBH may conduct retrospective authorization of SMHS 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.

In cases where the review is retrospective, ACBH'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.

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 though secure methods such as email with secure encryption.

CONTACT

ACBH Office	Current Date	Email/Phone
Utilization Management	11/17/2023	um@acgov.org 510-567-8141

DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff
- ACBH Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Authors: Karen Capece, Quality Management Program Director
Original Date of Approval: 6/25/2020 by Dr. Karyn Tribble, PsyD, LCSW

Revision Author	Reason for Revision	Date of Approval by (Name, Title)
Juliene Schrick, UM Division Director	Update policy to be in accordance with DHCS BHIN 22-016	1/18/2024 by Karyn L. Tribble, PsyD, LCSW, Behavioral Health Director

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.
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.
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).
Retrospective Review and Authorization	Post-service review to determine if medical necessity criteria for reimbursement is met.
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.

APPENDICES

None