

ACBH SMHS Crisis Residential Treatment Authorization and Documentation Requirements Specialty Mental Health Services

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**Behavioral Health
Department**
Alameda County Health

Crisis Residential Treatment (CRT)

- Therapeutic or rehabilitative services provided in a non-institutional residential setting.
- A structured program as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis.
- For members who do not have medical complications requiring nursing care.

CRT Services

- A range of activities and services that support members in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems.
- Available 24 hours a day, 7 days a week.
- May include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.



CRT Service components

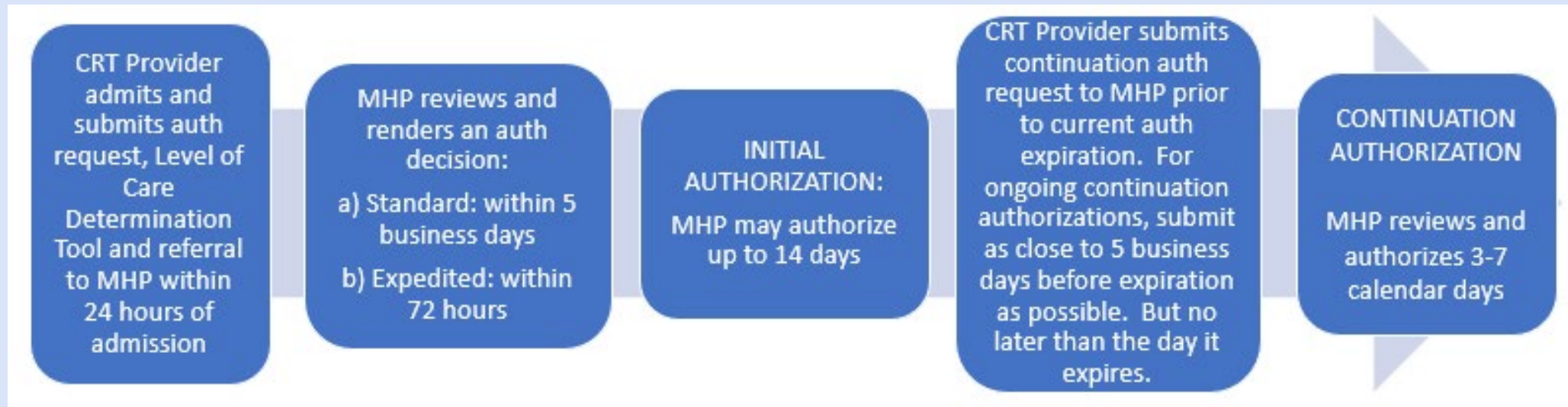
- Individual and group counseling
- Crisis intervention
- Planned activities
- Collateral contact with available members of the client's family, when indicated in the client's treatment/care plan
- Development of community support systems for client to maximize their utilization of non-mental health community resources
- Pre-vocational or vocational counseling
- Client advocacy, including assisting client to develop their own advocacy skills
- An activity program that encourages socialization within the program and general community, and which links the client to resources that are available after leaving the program
- Use of the residential environment to assist client in the acquisition, testing, and/or refinement of community living and interpersonal skills

Authorization

- The Department of Health Care Services [BHIN 22-016](#) states that Mental Health Plans must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS).
- This Information Notice further states that Mental Health Plans may not require prior authorization.



Authorization: CRT Provider Admission



Initial Authorization

Requesting Initial Authorization

- There are several forms that are used by providers to request initial or concurrent authorizations. These include the following:
- Admission Notification/Service Authorization Request (SAR)
- Level of Care Determination tool
- Completed referral form
- Additionally, the MHP uses the Authorization Decision Form to render an authorization decision
- Authorization related forms can be found on the ACBHD Provider's Website [here](#) under the section titled "1-3 Adult Residential Treatment and Crisis Residential Treatment Provider Authorization Requests".

Admission Notification/Service Authorization Request (SAR)

Within one business day of admission, the provider submits the following information to ACBH:

- Admission notification using the Service Authorization Request (SAR) form
- Completed Referral Form used by program
- Level of Care Determination Tool to support medical necessity

All initial authorization requests for Crisis Residential Programs should be sent to The Utilization Management Department at UM@acgov.org.

		Behavioral Health Department Alameda County Health		Karyn Tribble, PsyD, LCSW, Director 2000 Embarcadero Cove, Suite 400 Oakland, Ca 94606 510-567-8100 / TTY 510-533-5018	
Specialty Mental Health Services (SMHS) Crisis Residential Treatment Service Authorization Request (SAR)					
SMHS RESIDENTIAL TREATMENT TYPE					
☐ Adult Residential Treatment (ART) Choose an item					
☐ Crisis Residential Treatment (CRT) Choose an item					
PROVIDER INFORMATION					
Referring Clinician Name:		Contact #:	Email:	Fax:	
CLIENT INFORMATION					
Client Name:		DOB:		Age:	
Client SmartCare#:		Medi-Cal: ☐ Yes ☐ No		Alameda County Resident? ☐ Yes ☐ No	
Private or Other Health Insurance:					
SERVICE AUTHORIZATION REQUEST					
☐ Initial	If Initial, include admission date here: Click or tap to enter a date.				
☐ Continuation	If Continuation, include expiration date of current authorization here Click or tap to enter a date.				
☐ Break in Service	If Break in Service, provide dates here: From 9/24/2024 to 9/24/2024				
Additional Comments:					
Click or tap here to enter text. Print Name		_____ Signature		Click or tap here to enter text. Date	

Level of Care Determination Tool

This tool was created to replace the Brief Screening Tool.

It includes two sections:

- Adult Residential
- Crisis Residential

Complete the section that applies to your program type.

The bottom section labeled “Pertinent Current/Past Information” should be completed by everyone.



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Level of Care Determination Tool for SMHS Residential Services

Client's Name _____ Client's Date of Birth _____

Diagnosis (if known at time of screening) _____

Purpose and Instructions: This form should be used when requesting authorization for adult residential and crisis residential services. It contains the admission criteria for these levels of care. Please complete the section that applies to your facility type as well as the Pertinent Current and Past Information section at the bottom of the form. Send your completed form to the ACBH staff member who completes your initial authorizations along with the Service Authorization Request (SAR) and referral form.

ADULT RESIDENTIAL TREATMENT ADMISSION CRITERIA

Please screen for the following and check each box as appropriate

☐ The beneficiary has one or both of the following: Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities and/or a reasonable probability of significant deterioration in an important area of life functioning (please describe below).

☐ The beneficiary's condition as described in paragraph (1) is due to either of the following: a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems and/or a suspected mental disorder that has not yet been diagnosed.

☐ Beneficiary is not sufficiently stable to be treated outside of a highly structured 24-hour therapeutic setting, but does not require a crisis or emergency higher level of care.

☐ Beneficiary's behavior or symptoms, as evidenced by initial screening and/or assessment are likely to respond to treatment.

☐ Beneficiary has sufficient cognitive capacity to respond to active, intensive and time-limited behavioral health treatment and intervention.

☐ Beneficiary has only poor-to-fair community supports sufficient to maintain him/her within the community with treatment at a lower level of care.

☐ Beneficiary requires a time-limited period for stabilization and lower-level-of care and community resource connection for successful community reintegration.

☐ Beneficiary does not have medical complications that can only be treated at a medical/surgical setting or requires nursing care.

☐ Beneficiary (or guardian as appropriate) is willing to participate in treatment voluntarily.

Reference: Behavioral Health Information Notice (BHIN) No: 21-073



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CRISIS RESIDENTIAL TREATMENT ADMISSION CRITERIA

Please screen for the following and check each box as appropriate

☐ Beneficiary has one or both of the following: Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities and/or a reasonable probability of significant deterioration in an important area of life functioning (please describe below).

☐ Beneficiary's condition as described in paragraph (1) is due to either of the following: a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems and/or a suspected mental disorder that has not yet been diagnosed.

☐ Beneficiary is experiencing an acute psychiatric episode or crisis and:

a) Requires a 24-hour structured setting and if not admitted will likely require acute psychiatric hospitalization.

b) It is expected that the proposed interventions will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning.

c) Does not present with imminent risk to self or others requiring a higher level of care (i.e. acute psychiatric hospitalization).

d) Cannot be safely treated in a less restrictive setting.

☐ Beneficiary does not have medical complications that can only be treated at a medical/surgical setting or requires nursing care.

☐ Beneficiary (or guardian as appropriate) is willing to participate in treatment voluntarily.

Pertinent Current/Past Information (please specify current functional impairments in a care area of life due to the condition(s) being treated):

Current symptoms and functional impairments: _____

Brief relevant history: _____

Clinician Name: _____ Clinician Title: _____

Clinician Signature: _____ Screening Date: _____

Reference: Behavioral Health Information Notice (BHIN) No: 21-073

ACBH Review

- Upon receipt of the initial SAR and related paperwork, the appointed MHP delegate(s) will review the paperwork and make a medical necessity determination.
- Within 5 business days, the MHP delegate will render a decision and send the decision to the program in writing, via the Authorization Decision Form.
- Initial Authorization will be up to 14 days.



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SMHS Residential Authorization Decision
To Be Completed by Alameda County Behavioral Health (ACBH) Staff

Client Name:		Client InSyst# (PSP):	
Date of Receipt:		Date of Completion:	
SMHS RESIDENTIAL TREATMENT TYPE			
☐ Adult Residential Treatment (ART) Choose an item			
☐ Crisis Residential Treatment (CRT) Choose an item			
AUTHORIZATION DECISION			
☐ Authorized	For choose an itemdays	From	to
☐ Break in Service	For choose an itemdays	From Click or tap to enter a date. to Click or tap to enter a date.	
☐ Authorized	For choose an itemdays	From Click or tap to enter a date. to Click or tap to enter a date.	
☐ Denied		From choose date to choose date	
☐ Authorization Delay			
If Denial, provide rationale here:			
If Authorization Delay, indicate what additional documentation and/or information is needed:			
Deadline for requested documentation and/or information: choose date			
NOABD Issued? ☐ Yes If yes, choose reason: Choose an item.			
Additional Comments:			
LPHA Printed Name		Signature	Date Signed

Authorization is not a guarantee of payment. Payments are contingent on and not limited to the following: a beneficiary's continued insurance eligibility, medical necessity, and the provider's good standing with applicable contractual agreements, licenses, permits and certificates required by Federal, State, County and/or municipal laws and regulations.

SMHS Access Criteria- Under Age 21

Meet **either** of the following criteria, (1) or (2):

Criteria 1)

The member has a condition placing them at high risk for a mental health disorder due to the experience of trauma evidenced by any of the following:

- Scoring in the high-risk range under a trauma screening tool approved by DHCS*
- Involvement in the child welfare system
- Juvenile justice involvement
- Experiencing homelessness. **OR criteria 2**



*The ACE questionnaire and the PEARLS tool are approved by DHCS and available [here](#)

SMHS Access Criteria- Under Age 21

Criteria 2) The member meets both “a” and “b”:

a) The member has at least **one** of the following:

- A significant impairment.
- A reasonable probability of significant deterioration in an important area of life functioning.
- A reasonable probability of not progressing developmentally as appropriate.
- A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal Managed Care Plan (MCP) is required to provide.

AND

b) The member’s condition is due to one of the following:

- A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD.
- A suspected mental health disorder that has not yet been diagnosed.
- Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

SMHS Access Criteria- Over age 21

Meet both of the following criteria, (1) and (2) below:

- 1) The member has **one or both** of the following
 - a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
 - b. A reasonable probability of significant deterioration in an important area of life functioning. **AND**
- 2) The member's condition is due to **either** of the following:
 - a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD)
 - b. A suspected mental health disorder that has not yet been diagnosed.

Medical Necessity Criteria for Residential Services

The beneficiary (or guardian, as appropriate) is willing to participate in treatment voluntarily and

- Requires a 24-hour structured setting and if not admitted, will likely require acute psychiatric hospitalization
- Is not presenting with imminent risk to self or others requiring a higher level of care (i.e. acute psychiatric hospitalization)
- Cannot be safely treated in a less restrictive setting
- Does not have medical complications that can only be treated at a medical/surgical setting, or require nursing care
- It is expected that the proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning.

Continuation Authorization

Requesting Continuation Authorization (For Continuation 1 & 2)

Before the current authorization expires, the program submits a new SAR along with the following to UM@acgov.org:

- Progress notes documenting services since the last authorization cycle
- Problem List (only if updated since last authorization cycle)
- Assessment (only if updated since last authorization cycle)
- Authorization related forms can be found on the ACBHD Provider's Website [here](#) under the section titled "1-3 Adult Residential Treatment and Crisis Residential Treatment Provider Authorization Requests".

Requesting Continuation Authorization (For Continuation 3 & Forward)

- Starting with Continuation 3 (the 4th authorization cycle), the program submits a new SAR along with supporting documentation (listed in previous slide) to CRTAuth@acgov.org and copy Helene.Hoenig@acgov.org.
- Helene Hoenig is the Critical Care Manager (CCM) with ACBHD that oversees extension requests for CRT programs past 28 days.
- It is no longer necessary to submit a separate extension request for clients needing to stay beyond 28 days as the CCM will complete extension requests and authorization determinations at the same time effective 5/20/2026.
- Authorization related forms can be found on the ACBHD Provider's Website [here](#) under the section titled "1-3 Adult Residential Treatment and Crisis Residential Treatment Provider Authorization Requests".

Medical Necessity Criteria for Continued Residential Services

- All the following criteria must be met:
- Beneficiary continues to meet admission criteria.
- A less restrictive level of care would not be adequate to safely and effectively treat the beneficiary's current condition.
- Treatment is still necessary to reduce symptoms and improve functioning, so that beneficiary may be treated in a less restrictive level of care.
- There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care.
- Beneficiary progress is monitored regularly, and the treatment plan is modified if the beneficiary is not making substantial progress toward a set of clearly defined and measurable goals.

Medical Necessity Criteria for Continued Residential Services (Cont'd)

- Beneficiary is engaged in treatment and amenable to goals/interventions set forth by the treatment team.
- Family/guardian/caregiver/significant others are participating in treatment as clinically indicated and appropriate, or engagement is underway.
- Medication assessment has been completed, when appropriate, and medication trials have been initiated or ruled out.
- There is evidence of coordination of care and active discharge planning to a less intensive level of care, with beneficiary's active involvement, beginning from admission.
- Coordination of care and discharge planning activities involve provider referral/linkage, teaching/coaching, development and connection to appropriate aftercare and non-mental health community supports.

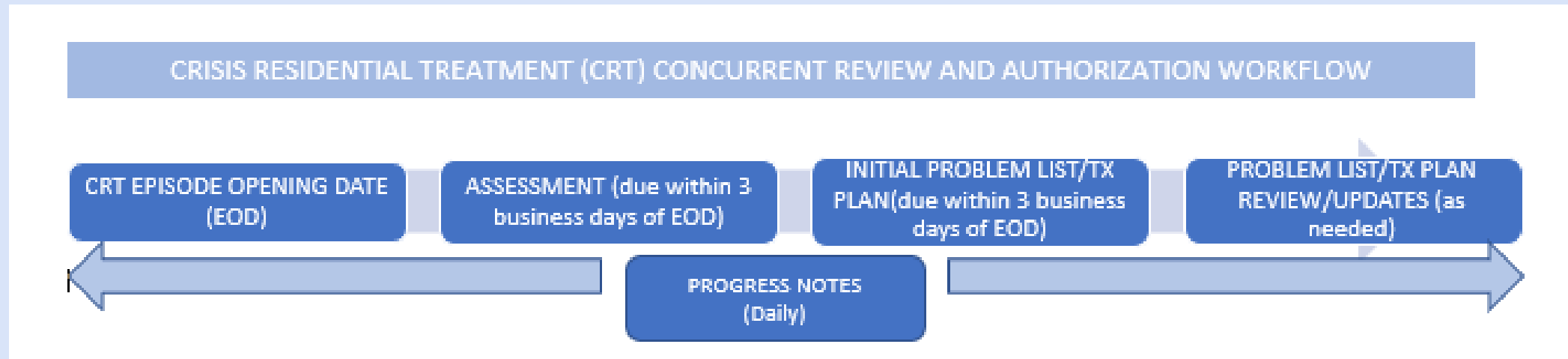
Discharge

Medical Necessity Discharge Criteria

- Any one of the following criteria must be met for discharge to occur:
- Beneficiary no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive.
- Beneficiary or parent/guardian withdraws consent for treatment and the beneficiary does not meet criteria for involuntary/mandated treatment.
- Beneficiary does not appear to be participating in the treatment plan.
- Beneficiary is not making progress toward goals, nor is there expectation of any progress.
- Beneficiary's individual treatment plan and goals have been met, and when indicated, beneficiary's support systems agree with the aftercare treatment plan.

Note – Discharge Criteria listed above are limited to Medical Necessity scenarios only. There may be additional reasons for discharge unrelated to medical necessity criteria.

ACBHD Documentation Requirement Timelines for Authorization



Documentation Standards

Documents Required During ACBHD and DHCS Chart Audits

- ACBHD and DHCS perform periodic audits of programs, involving service and documentation review.
- Chart audits typically involve review of daily progress notes, documentation of monthly contact with support person(s), documentation of total number of minutes or hours of program attendance, as well as other required documentation details.

Documents Required during ACBHD and DHCS Chart Audits

In addition to the previously mentioned documents, the following documents are required from residential programs during audits:

- Assessments
- Treatment Plans
- Problem Lists
- Progress Notes
- Discharge Summaries
- CQRT Checklists/Tracking Tool

The following slides provide additional information regarding these requirements.

Assessment

Assessment

- The assessment template was updated in Clinician's Gateway with 7 Domains to match CalMHSA documentation guidance.
- It is recommended that providers use the ACBHD Assessment template provided in PDF formats on the ACBHD Provider website.
- If using an Electronic Health Record, you may add but not remove items from the assessment template.

Treatment Plans

Treatment Plan Timeframes

- An initial Treatment Plan must be completed as follows:
- Within **72 hours** of episode opening for **Crisis Residential**.
- Within **30 days** of episode opening for **Adult Residential**.



Plan Development

- Plan Development involves creating an individualized care/treatment plan, monitoring progress toward plan goals, applying plan revisions and additions, as necessary.
- It is a collaborative process that includes the guidance and organizational skills of the provider and the input and direction of the member.
- Care plans may be documented in a Progress Note or a specific Plan Template.
- If documenting the care plan in a Progress Note, it is recommended that providers use language or labels to make them easily identifiable (e.g., TCM Care Plan, goals, action steps, transition plan, etc.)
- Although care plans are recommended for all service types, State and/or Federal regulations **require** them for certain treatment services, including Crisis Residential Treatment

* For more services that require care plans, See [BHIN 26-068](#) Appendix for more information

Treatment Plan Requirements

Treatment Plans must include **all** the following:

- ☐ Specify the goals and actions to address the mental health symptoms, medical, social, educational and other services needed by the member.
- ☐ Include activities such as ensuring the active participation of the member and working with the member and others to develop those goals.
- ☐ Identify a course of action to respond to the assessed needs of the member.
- ☐ Identify a transition plan when the member has achieved the goals of the care plan.

Problem List

Problem List

- The Problem List is a dynamic log and should be updated initially when the client is admitted, and as new problems are identified, or existing problems are deferred or resolved.
- By adding your initials or name to the Added By and Ended By fields, you are attesting that to the best of your knowledge, the information you entered is accurate.

Problem List

Client First and Last Name:		Date of Birth:		InSYST #:		RU #/Provider's Full Name and Credentials :			
Instructions: • The Problem List is a dynamic log and should be updated as new problems are identified or existing problems are deferred or resolved. • Field Details: ○ Code = ICD-10 codes ○ Description = ICD-10 description ○ Begin Date = Date the problem is added to list ○ End Date = Date the problem is deferred or resolved ○ Added By and Ended By = Full Name of person editing the Problem List. If only one provider is utilizing this template, the provider's name should be noted on top of the form and initials entered in the Added By and Ended By fields when they are updated. ○ Job Title/Credentials = Title and credentials of the person editing the Problem List. If only one provider is utilizing this template, the provider's credentials should be added to the top of the form and N/A used for these fields. • By adding your initials or name to the Added By and Ended By fields, you are attesting that to the best of your knowledge, the information you entered is accurate.									
Problem Number	Identified by Beneficiary or Support	ICD-10 Code	Description	Begin Date	Added By	Job Title/Credentials	End Date	Ended By	Job Title/Credentials
1	☐								
2	☐								
3	☐								

Progress Notes

Progress Notes

- Date services are provided
- Type of services (assessment, therapy, groups, collateral) provided throughout the day
- Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code
- The service provider's typed or legibly printed name, Medi-Cal credential, signature and date of signature
- Narrative sections to include the following:
 - Description of services provided throughout the day, including how the services addressed the person's behavioral health needs (e.g. symptom, condition, diagnosis and/or risk factors).
 - Treatment plan changes or progress made towards achieving treatment goals.
 - Groups attended, significant information shared during groups, concerns about participation, insights or progress made during groups.
 - Next steps, including but not limited to planned action steps by the provider or client, collaboration with the client, other providers, family or significant others and any updates to the problem list, as appropriate.

Discharge Planning

Discharge Notes and Summaries

- Discharge Notes and Discharge Summaries are two distinct note types.
- Only one is required in a chart.
- Discharge Summaries are primarily used to transition a beneficiary from one program to another and include relevant information that will be useful in the transition.

Discharge Note

A Discharge Note must contain the following:

- Reason for discharge/transfer
- Date of discharge/transfer
- Referrals made, if applicable
- Follow-up care plan

Discharge Summary

A Discharge Summary must include all the components of a Discharge Note, as well as a summary of the following:

- Treatment provided
- Overall efficacy of interventions (including medications, their side effects/sensitivities and dosage schedules)
- Progress made toward the mental health goals/objectives
- Clinical decisions/interventions: Treatment planning recommendations for future services relevant to the final Client Plan, and/or referral(s) for aftercare/community support services

Clinical Quality Review Team (CQRT)

Clinical Quality Review Team

- Department of Health Care Services requires ACBHD to certify that all services billed to Medi-Cal meet the State's requirements.
- To meet this expectation, ACBHD requires providers to participate in the County's CQRT program.
- The CQRT process involves monthly chart review by providers to ensure compliance with the State's requirements.
- All new Residential programs participate in the ACBHD supervised CQRT process until training is completed and the agency is released to begin the CQRT process independently.
- See Section 8 of the provider manual for more details regarding the CQRT process and expectations: [CQRT Procedures for SMHS](#).

References

- [BHIN-22-016 Authorization of Outpatient Specialty Mental Health Services](#)
- [BHIN 23-068 SMHS Documentation Requirements](#)
- [BHIN 26-002 Access Criteria](#)
- [DMH Information Notice No: 01-04](#)
- [SMHS-Billing Manual 25/26](#)
- [CalMHSA Documentation Guide](#)



- For questions, contact QATA@acgov.org