Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.08 ☒New ☐Revised
	SIGNATURE	DATE APPROVED
Deputy Director Behavioral Health Services	_Signature on File__	_12/10/2024_____

SUBJECT: Authorization for Outpatient Specialty Mental Health Services (SMHS) within the County of Orange Behavioral Health Plan

PURPOSE:

To establish guidelines and authorization procedures for ensuring Orange County Medi-Cal members have appropriate access to outpatient Specialty Mental Health Services (SMHS) based on federal and state requirements, including medical necessity criteria. To comply with federal and state requirements related to the authorization of SMHS.

POLICY:

County of Orange Health Care Agency (HCA), Behavioral Health Services (BHS) Adult and Older Adult (AOA) and Children and Youth Services (CYS), hereon referred to as the Behavioral Health Plan (BHP), evaluates medical necessity, appropriateness, and efficiency of all SMHS provided to its Medi-Cal members. All authorizations for SMHS will be developed with the involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice. The requirements will be disclosed to BHP members and network providers. This process will be evaluated and updated as necessary.

SCOPE:

This policy applies to all authorization decisions for outpatient SMHS furnished by the BHP.

REFERENCES:

Behavioral Health Information Notice No: 22-016 Authorization of Outpatient Specialty Mental Health Services (SMHS)

Behavioral Health Information Notice (BHIN) 21-073 Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements

Code of Federal Regulations (CFR), Title 42, § 438.210(b)(1)

Code of Federal Regulations (CFR), Title 42, § 438.920(b)(1)

California Code of Regulations (CCR), Title 9, Chapter 11, § 1830.205

Welfare and Institutions Code section 14184.402(a)

FORMS:

Pathways to Well-Being/Intensive Services Eligibility Assessment

Authorization/Referral for Therapeutic Behavioral Services Draft (Contact CYS TBS Coordinator for form)

DEFINITIONS:

Authorized representative - A parent/legal guardian, or medical provider acting on behalf of a member. For the purposes of this policy and procedure, "representative" includes a parent, guardian, conservator, or other legally authorized representative, unless otherwise specified.

Intake Coordinator - A behavioral health care professional who is competent to assess and evaluate the specific clinical issues involved in the SMHS requested by a member.

Member - A person with Medi-Cal coverage whose county of responsibility or county of residence is Orange.

Notice of Adverse Benefit Determination (NOABD) - Form used to notify the requesting provider, and give the enrollee written notice of any decision by the Plan to deny or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. There are multiple versions of this form, to be used depending on the situation.

PROCEDURES:

I. Requirements Applicable to Authorization of all SMHS

A. The BHP's authorization procedures shall comply with the Parity Rule, in accordance with requirements set forth in Title 42 of the CFR, part 438.910.

B. The BHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to achieve the purpose for which the services are furnished.

C. Authorization procedures are based on SMHS medical necessity criteria and are consistent with current clinical practice guidelines, principles, and processes.

D. The BHP 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 member's behavioral health needs.

E. No individual, other than a licensed physician or a licensed or licensed waivered mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested by a member or a provider, may deny, or modify

a request for authorization of SMHS for a member for reasons related to medical necessity.

F. The BHP 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 member.

G. The BHP shall also comply with the following communication requirements:

1. 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. Disclose to DHCS, the BHP's providers, members and members of the public, the Utilization Management (UM) or utilization review policies and procedures that the BHP, or any entity that the BHP contracts with, uses to authorize, modify, or deny SMHS. The BHP may make the criteria or guidelines available through electronic communication means by posting them online;

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

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

II. Authorization Procedures for Outpatient SMHS

A. Upon receiving a request for SMHS from a member and/or the member's authorized representative, the BHS Intake Coordinator (IC) at the BHP clinic location receiving the request, shall provide the member with an initial intake appointment according to the routine, urgent, or emergent nature of the request.

B. The IC will assess the member for medical necessity for SMHS in accordance with Welfare and Institutions Code section 14184.402(a). This shall include determination of:

1. A diagnosed or suspected 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;

2. Impairments related to the mental illness, defined as distress, disability, or dysfunction in social, occupational, or other important activities or a

reasonable probability of significant deterioration in an important area of life functioning; and

3. Establishing if interventions can assist in reducing impairments related to the mental health condition.

4. For youth under 21 years of age, medical necessity shall also include consideration of high risk for a mental health condition as a result of trauma or involvement with child welfare or juvenile justice systems or experience of homelessness and a significant impairment or risk for impairment in functioning and a diagnosed or suspected mental health condition.

C. The BHP does not require prior authorization for the following services.

1. Crisis Intervention;
2. Crisis Stabilization;
3. Mental Health Services;
4. Targeted Case Management;
5. Intensive Care Coordination;
6. Medication Support Services; and,
7. Peer Support Services.

D. Prior authorization for SMHS is not required when such services are determined to be clinically appropriate or medically necessary and provided before the completion of a comprehensive assessment pursuant to California Welfare & Institutions Code §14184.402(f).

III. Prior authorization or BHP referral is required for the following services:

A. Intensive Home-Based Services (IBHS)

1. The BHP provider shall complete the Pathways to Well-Being (PWB)/Intensive Services (IS)/Therapeutic Foster Care (TFC) Eligibility Assessment form.

2. If the member is eligible for PWB, IS, or TFC, the provider shall complete the Intensive Care Coordination (ICC) Care Plan and complete the IHBS authorization section.

B. Therapeutic Behavioral Services (TBS)

1. The BHP provider shall complete the Authorization/Referral for Therapeutic Behavioral Services form.

2. The BHP provider shall submit the Authorization/Referral for Therapeutic Behavioral Services form to the BHP TBS Coordinator for review and signature.

C. Therapeutic Foster Care (TFC)

1. The BHP provider shall complete the Pathways to Well-Being (PWB)/Intensive Services (IS)/Therapeutic Foster Care (TFC) Eligibility Assessment form.

2. If the member is eligible for PWB, IS, or TFC the provider shall complete the ICC Care Plan and IHBS/TFC Authorization Progress Note, including written justification for TFC services, checking the appropriate TFC box and providing a signature.

3. If the member is eligible for TFC and no TFC homes are readily available, the BHP will explore options for intensive SMHS to ensure the member's higher level of care needs are met in conjunction with the Child and Family Team, until an appropriate placement is secured.

D. Day Treatment Intensive and Day Rehabilitation

1. BHP providers shall assess member needs and make appropriate referrals for Day Treatment Intensive or Day Rehabilitation services.

E. Referrals by one BHP program/treatment provider to another BHP program/treatment provider shall serve the same function as prior authorization for SMHS (e.g., referral from an BHP outpatient clinic to a County contracted TBS program).

F. For all prior authorization for SMHS, the BHP shall:

1. Review and make decisions regarding a provider's request for prior authorization within five business days from the BHP's receipt of the information reasonably necessary and requested by the BHP to make the determination, not to exceed 14 calendar days following BHP's receipt of the request for service. This timeframe may not be extended.

2. Make an expedited authorization decision and provide notice not to exceed 72 hours in cases where the BHP or provider has determined the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

IV. Retrospective Authorization Requirements

A. The BHP may conduct retrospective authorization of SMHS under the following limited circumstances:

1. Retroactive Medi-Cal eligibility determinations;

2. Inaccuracies in the Medi-Cal Eligibility Data System;

3. Authorization of services for members with other health care coverage pending evidence of billing, including dual-eligible members; and/or, member's failure to identify payer.

B. In cases where the authorization review is retrospective, the BHP's authorization decision will be communicated to the member who received services, and/or the member's representative, within 30 days of the receipt of information that is reasonably necessary to make this determination and will be communicated to the provider in a manner that is consistent with state requirements.